

February 2, 2001

Ms. Liz Trias  
Health Care Financing Administration  
Region X, MS: RX-43  
2201 Sixth Avenue  
Seattle, Washington 98121

Dear Ms. Trias:

We are submitting for your review and approval an amendment to Section 3.1 of Section 3 in Washington's Title XXI State Plan to be effective January 1, 2001. We are filing this amendment now with the expectation that it will take effect on January 1, 2001. There is no fiscal impact anticipated from this change.

The purpose of this request is to amend the State Plan to allow for the assignment of eligible children into CHIP managed care health plans and to make eligibility requirements similar to the eligibility processes of the Washington State Medicaid program. No longer must an applicant choose a health plan or attest through signature that they will pay premiums to be found eligible. CHIP applicants need only meet income and insurance requirements. These amendments will help in our efforts to bring about more efficiency and consistency between the two programs.

In addition to this request, we have incorporated into Washington's Title XXI State Plan the additional information we submitted on August 6, 18, and 30, 1999, for the approval of our State Plan. The incorporated language does not represent a change in policy. It is our goal to have one all-inclusive document from which we all can work and refer, rather than the State Plan as it was originally submitted and three separate correspondences between the State and HCFA. We have incorporated the language into the following sections:

- (1) Section 1 General Description and Purpose of the State Child Health Plan.
- (2) Section 2 General Background and Description of State Approach:
  - (a) Section 2.1;
  - (b) Section 2.2.1.

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(3) Section 3 General Contents of the State Child Health Plan:

- (a) Section 3.1;
- (b) Section 3.2.

(4) Section 4 Eligibility Standards:

- (a) Section 4.3;
- (b) Section 4.4.3.

(5) Section 5 Outreach and Coordination:

- (a) Section 5.1.

(6) Section 7 Quality and Appropriateness of Care:

- (a) Section 7.1.

(7) Section 8 Cost Sharing and Payments:

- (a) Section 8.1;
- (b) Section 8.2.1;
- (c) Section 8.2.3;
- (d) Section 8.5.

If you have questions or need further clarification, please contact either Rich Pannkuk at (360) 725-1715 or Selia Evans at (360) 725-1415.

Sincerely,

DENNIS BRADDOCK  
Secretary

Enclosure

CC: James C Wilson  
Steven Wish

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

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

State/Territory: State of Washington

As a condition for receipt of Federal funds under Title XXI of the Social Security Act,

Dennis Braddock

\_\_\_\_\_  
(Signature of Secretary of the Department of Social and Health Services, Washington State, \_\_\_\_\_ Date  
Signed)

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

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: HCFA, 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 (Section 2101)**

The state will use funds provided under Title XXI primarily for (Check appropriate box):

- 1.1  Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (Section 2103); **OR**
- 1.2.  Providing expanded benefits under the State's Medicaid plan (Title XIX); **OR**
- 1.3.  A combination of both of the above.

The state of Washington assures that the Title XXI State Plan will be conducted in compliance with all civil rights requirements.

Washington's CHIP will offer comprehensive health coverage to children through age 18, who reside in households with incomes between 200% and 250% of the federal poverty level (FPL). CHIP is a non-entitlement program, with coverage offered within available state funds appropriated by Washington's legislature. Families will be required to pay a modest premium and copayments for coverage. CHIP benefits will be the same as the state's Medicaid program for children. The program will utilize the state's Medicaid managed care delivery system. ~~Its system wherever practicable and will employ Medicaid income eligibility criteria. However, the CHIP eligibility and enrollment requirements and process will be different due to restrictions about existing insurance.~~ CHIP will be administered by DSHS's Medical Assistance Administration (MAA) in coordination with other DSHS administrations and other state agencies including the Department of Health, Governor's Office and Health Care Authority.

**Section 2. General Background and Description of State Approach to Child Health Coverage**  
(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 section 2110(c)(2)). 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).

Based on data from the 1998 Washington State Population Survey (WSPS)<sup>1</sup>, 93% of all children in Washington had health insurance coverage in April/May 1998<sup>2</sup> - 1998<sup>3</sup>. Approximately 135,000 (93%) of the children with incomes between 200% and 250% of the federal poverty level (FPL) had coverage. About 10,000 children in this income range were without health insurance. These children would be eligible insurance and will be the target population for coverage under Washington's CHIP.

Children's health coverage varied across income levels. Approximately 14% of children in households families with incomes up to 200% of FPL did not have health coverage at the time of the 1998 WSPS. These children are eligible for coverage under Washington's current Medicaid program and are being targeted for coverage through several statewide outreach initiatives. In comparison, the uninsured rate for children between 200% and 250% of FPL was 7%, and was less than 4% for children in households above 250% of FPL.

Based on this WSPS data, there is not a significant difference in the overall age/sex composition of families based on income. There were slightly more (32%) younger children (age 0 through 5) in the Medicaid income population compared to the CHIP income population (30%) and higher income families (28%). In part, this may be due to younger families with less income than older families. There appeared to be slightly more female children (54%) in the CHIP income population compared

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1 A list of all abbreviations used in this application is found in Appendix 1.

~~2 Washington State has implemented a biennially Washington State Population Survey (WSPS) to provide a profile of residents between decennial censuses. The WSPS is designed to replicate the Bureau of the Census's national 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 in the Washington State Title XXI Application is household member's status at the time of the interview (April and May 1998).~~

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to Medicaid and higher income families (49%). However, the uninsured rates for children were significantly more influenced by income levels than any children's age/sex attributes.

The distribution of children by race varies across income levels. There were proportionately more Black, Native American, and Asian children in the Medicaid income population level than White children. The distribution of CHIP income level children by race was not different than the higher income families, expect that proportionately fewer Asian children were in the CHIP income range.

The source of children's health coverage also varied across income levels. In 1996, 53% of Washington's children in households below 200% of FPL obtained coverage through the state's Medicaid financed programs, 30% had employer-related coverage, and only 3% had individual coverage<sup>4</sup>. Consistent with national trends, employer-based coverage was the principal source of coverage for higher income children. Approximately 84% of children in households above 200% of FPL obtain coverage through their family's employer or union, and 9% had coverage purchased in the individual health insurance market.

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

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 currently covers 455,000 children in state subsidized health care programs. This represents 28% of the entire state population of children. Washington has employed four strategies to provide health coverage to its children. This includes major Medicaid expansions; implementation of the state subsidized Basic Health Plan, comprehensive health insurance reforms, and Medicaid outreach initiatives.

First, the Washington Department of Social and Health Services (DSHS) has been a national leader in expanding Medicaid coverage to children. In 1989, DSHS implemented its "First Steps Program" to improve birth outcomes. This included expanded Medicaid coverage to pregnant women and infants in households up to 185% of FPL. In 1991, children's health coverage was made available to all children up to age 18 residing in households with income up to 100% of FPL. This program was converted to Medicaid in 1992, and eligibility was expanded to include children up to age 19. In 1994, Medicaid coverage was expanded to 200% of FPL for children through age 18. Prior to the enactment of CHIP in 1997, Washington was one of only four states with Medicaid coverage at or above 200% of FPL.

Second, Washington implemented the Basic Health Plan (BHP) in 1988 to provide state subsidized health coverage to low-income persons. Until Medicaid was expanded to 200% of FPL in 1994, BHP offered subsidized coverage to children and their families up to 200%. Today, there are 80,000

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<sup>4</sup> This data is from a Robert Wood Johnson Foundation funded Family Insurance Survey conducted by RAND. The survey over-sampled Medicaid families. However, it was not adjusted for under-reporting of Medicaid.

Medicaid-financed covered children whose parents receive subsidized BHP coverage.

Third, in 1993, Washington enacted legislation to implement comprehensive health reform. The goal of this legislation was to ensure that all residents had health coverage by 1997. Although major portions of the law were repealed in 1995, the state did retain comprehensive insurance reforms on limiting preexisting conditions to three-months and requiring health carriers to guarantee portability and re-issuance. Non-subsidized BHP coverage was implemented through the Health Care Authority (HCA) to offer group-rated coverage to individuals above 200% of FPL. Funding was provided to expand subsidized BHP coverage and to expand children's Medicaid coverage up to 200% of FPL. Currently, BHP is authorized to cover 133,000 people.

As a result of the first three strategies, Washington has a significantly lower uninsured rate for children than most other states. The Urban Institute estimated that Washington's 1994-95 uninsured rate for children below 200% of FPL was 8.1% compared to 14.3% nationally, and that the overall uninsured rate for children was 5.9% compared to 10.4% for the nation.<sup>5</sup> nation.<sup>6</sup>

The fourth strategy in the effort to identify and enroll uncovered children includes several outreach efforts to publicize the availability of coverage. These efforts include: public notifications, such as posters and bus posters; contracting with several of the large county Health Districts to identify potential eligibles and assist them in applying for coverage; and educating Medicaid providers and health care plans.

As part of the current outreach contracting process, MAA requires contractors to develop and document specific activities for conducting targeted outreach activities to diverse communities at the local (community) level. Specifically, the contractor must describe special efforts to contact and enroll ethnic minorities, non-citizens, immigrants, and homeless individuals. These plans are evaluated and must be approved by MAA staff. MAA staff also participates in routine community meetings with outreach contractors and community based representatives to discuss outreach activities. (A description of the Medicaid Client Outreach program is included in Appendix 2.)

Each region in the state has a Limited English Proficiency coordinator to help address cultural and

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<sup>5</sup> Kaiser Commission on the Future of Medicaid, Child Health Facts (January 1998). The data is from the Urban Institute's TRIM using adjusted March 1995 and 1996 Current Population Survey (CPS) data. TRIM inputs Medicaid enrollment rates to offset under-reporting of Medicaid coverage. As a result, the Urban Institute's uninsured rate estimates are significantly lower than either CPS or WSPS rates for low-income children and adults.

<sup>6</sup> Kaiser Commission on the Future of Medicaid, Child Health Facts (January 1998). The data is from the Urban Institute's TRIM using adjusted March 1995 and 1996 Current Population Survey (CPS) data. TRIM inputs Medicaid enrollment rates to offset under-reporting of Medicaid coverage. As a result, the Urban Institute's uninsured rate estimates are significantly lower than either CPS or WSPS rates for low-income children and adults.

communication issues. MAA also routinely translates client materials into 13 different languages. In addition, if a county has 100 or more clients who are not English speaking, MAA translates materials into the particular language needed.

In spite of the mentioned efforts to offer affordable health coverage to children in households below 200% of FPL, there are still nearly 70,000 children residing in Washington who do not have coverage. There is also growing concern nationally ~~that~~ those low-income families who are eligible for Medicaid may not be seeking this coverage due to welfare reform. Many families are unaware that they can continue to receive Medicaid after leaving the Temporary Assistance for Needy Families (TANF) program. In response, DSHS's Medical Assistance Administration (MAA) has ~~initiated~~ begun several initiatives, as described below.

1. Fewer Requirements: With the implementation of WorkFirst, MAA exercised the option not to require families applying for Medicaid to participate in WorkFirst activities such as job search and completion of the individual personal responsibility plan (IPR).

There are also no deprivation requirements for TANF-related medical programs. DSHS's Economic Services Administration (ESA) request legislation passed in April 1999, removing deprivation requirements for cash TANF and State Family Assistance (SFA), effective August 1999. CSO staff will no longer need to consider deprivation due to absence of a parent, unemployment or work quarters for TANF-related cash or medical benefits.

2. Outreach: MAA has implemented a statewide, community-based Medicaid Client Outreach Project. This project targets pregnant women, children and families. MAA staff trained outreach contractors about general Medicaid eligibility requirements, the application process, and managed care enrollment.
3. Joint Childcare and Medical Application: MAA and ESA are developing a joint childcare and children's medical application. A family will only need to complete one application for both childcare and children's medical.
4. Interviews Waived: MAA has waived the interview requirement for Family (TANF-related) medical. Working families are able to apply for benefits without taking time off from work for an interview.
5. Client Notices: MAA is working with Employment Security (ES) and ESA to develop post-employment materials. One example is a mailing to all cash TANF clients who become employed, describing medical coverage, including the availability of transitional Medicaid.
6. Training Financial Workers: MAA eligibility staff will be training CSO field staff on TANF-related medical programs in summer 1999. This training will emphasize the difference between cash TANF and medical coverage. Trainers will stress the need to complete a redetermination when terminating cash TANF.
7. Medical Extensions: When a client is terminated from TANF due to earned income, the Automated Client Eligibility System (ACES) prompts the CSO field staff to provide the client with the earned income 12-month medical extension. In addition, staff are encouraged to use the 3 months retro-eligibility to establish Medicaid coverage in the "last 3 out of 6 months".
8. Continuity of Coverage for Children: MAA has implemented the option to allow for 12 months of continuous eligibility for children. ACES will be modified to assure that the children of TANF clients automatically receive medical benefits under Children's Medicaid, when a family exits TANF.
9. Educating Families about Transitional Medicaid benefits: Staff are reviewing ACES notices to clients to assure they notify clients of coverage they may be able to receive. MAA will also review WorkFirst materials to ensure adequate/appropriate information about medical eligibility. MAA staff has trained outreach contractors on these benefits and will provide refresher training in the coming year.

Other than death, moving out of state and lost of contact when a worker terminates a cash TANF, a family medical status (F04) will be opened for 3 months. The reason for this

time frame, is that it will put the case in eligibility review cycle. Either the worker will redetermine eligibility or the client will submit a review.

10. When an application for cash benefits is denied for “no show interview”, there will be an edit that will force a determination for medical, since medical has no interview requirement.

11. Reviewing closed TANF cases: MAA staff are researching whether MMIS can be used to generate a list of clients terminated from TANF and then notify likely eligibles of the programs they may be eligible for.
12. Eliminating auto-denials for medical coverage: Staff are examining options for modifying the auto-denial processes in ACES so more clients may continue receiving medical coverage.

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 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). ~~However, they are required to pay a minimum financial contribution.~~ About 23,000 BHP adults and children enrollees are receiving coverage through these sponsorship arrangements.

Employers can also purchase group coverage for themselves and their employees through both the BHP subsidized and nonsubsidized programs. 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 4,500 BHP adults and children enrollees 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. Children in these families are able to receive full-scope Medicaid coverage without ~~cost sharing~~ cost sharing through the BHP +Plus program <sup>7</sup>-Plus program. <sup>8</sup> Children are able to receive this coverage through the same health plan and provider network as their family members. About 4,300 Medicaid funded BHP +Plus children are connected to a family member receiving sponsorship or employer coverage.

MAA is coordinating its outreach efforts with BHP and private organizations, including the Seattle

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<sup>7</sup> This is part of the Health Care Authority's subsidized health care program.

<sup>8</sup> This is part of the Health Care Authority's subsidized health care program.

Campaign for Kids 2001 and the Washington Campaign for Kids 2001, which is a Robert Wood Johnson Foundation (RWJF) funded outreach project. One noteworthy project has been the Seattle Campaign's coordination with the Seattle School District to identify children eligible for Medicaid. A campaign work group has revised the Free & Reduced Lunch application to include a checkbox for the family to apply for Medicaid. In Washington, nearly all children receiving free and reduced lunches are also eligible for Medicaid.

The Department of Health provides funding to the "Healthy Moms/Healthy Babies" program for a statewide 1-800 telephone number. This number provides information on Medicaid eligibility for those clients who might qualify for services.

- 2.3. Describe how the new State Title XXI program(s) is (are) designed to be coordinated with such efforts to increase the number of children with creditable health coverage so that only eligible targeted low-income children are covered:  
(Section 2102)(a)(3)

In order to increase the number of children with creditable health care coverage, MAA will:

- Provide on-site training and technical assistance to Medicaid outreach contractors on identifying potential eligibles and assisting them to apply for benefits;
- Require Medicaid Outreach contractors to assist clients to enroll in CHIP, when family income is between 200- and 250% of FPL;
- Allow clients to apply at multiple sites, including DSHS's Community Service Offices (CSOs) and through the MAA's centralized Medical Eligibility Determination Services (MEDS) section;
- Develop a referral protocol with the BHP so clients eligible for CHIP will be encouraged to apply; and
- Allow clients to use the existing children's medical application, as well as the standard benefits application, to apply for benefits. These applications are available in a broad array of public and community locations.

When a client applies at the a CSO, ACES will use the submitted data to first determine whether the client is eligible for Medicaid, and then CHIP. This will assure that all clients who are eligible for Medicaid will be directed to that program. If the family income is too high, the system will evaluate

eligibility for CHIP, unless creditable health care coverage precludes this eligibility. Once a client is determined eligible for CHIP by the CSO, the case will be transferred to MEDS where it will be maintained.

As described above, HCA offers health coverage through BHP. Subsidized coverage is offered to individuals and families at or below 200% of FPL. Families and individuals with incomes above this income level can purchase HCA offered coverage by paying a monthly nonsubsidized premium. Currently, 1,800 children are receiving nonsubsidized coverage. Approximately, 700 of these children are in households between 200% and 250% of FPL. MAA will coordinate with HCA to offer these children CHIP coverage, which is permissible under the special rule provision of Title XXI, Section 2110(b)(3).

**Section 3. General Contents of State Child Health Plan (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: (Section 2102)(a)(4)

Washington's CHIP will utilize Washington's Medicaid managed care delivery system wherever practicable. This managed care system consists of contracts with health carriers for capitated medical care coverage, contracts with Regional Support Networks for mental health care, and fee-for-service (FFS) for primary care case management (PCCM) clinics. Other Medicaid services are "carved out" of managed care and provided on a "wrap around" FFS basis. These include dental coverage, chemical dependency services, eyeglasses, hearing aid devices, abortions, and non-emergent transportation.

MAA will start taking CHIP applications in January 2000, with service delivery starting in March 2000.

MAA contracts with health carriers licensed by registered with the state's Office of Insurance Commissioner (OIC) to provide full-scope medical coverage on a full-risk capitation basis. This program is called Healthy Options (HO) (HΘ). For 1999, the HΘ HO program is contracting with 10 health carriers to provide medical coverage in all 39 counties of the state (see Appendix 3 for a chart of carriers by county). As of June 1999, currently, 416,000 Medicaid clients are enrolled in these plans. Eighty two percent (339,000) of these enrollees are children.

The CHIP managed care contracts will parallel the Healthy Options (HO) contracts. All HO contractors will be offered an opportunity to contract for CHIP coverage. The scope of the managed care coverage will be the same as the Medicaid HO schedule of benefits. In addition, contractors currently offering coverage to state employees or BHP may be offered an opportunity to contract for CHIP coverage.

MAA's HO program also contracts with Indian Health Service (IHS) and tribal operated health clinics to provide PCCM coverage to American Indians/Alaska Natives. Currently, 3,800 tribal members are receiving care through these PCCM arrangements.

~~DSHS's Mental Health Division (MHD) contracts with public Regional Support Networks (RSN) to offer mental health services through prepaid health plan coverage. There are 14 RSNs providing mental health coverage in all 39 counties of the state. Currently, 7 RSNs are providing both prepaid~~

~~community inpatient and outpatient care to Medicaid clients. The other RSNs are providing outpatient coverage and managed community inpatient coverage, but DMHD pays hospitals directly for the care on a FFS basis. By October 1999, all the RSNs will provide community inpatient care. All Medicaid children are required to enroll in the RSNs providing coverage in their county of residence in order to receive mental health care.~~

~~All HO contractors will be offered an opportunity to contract for CHIP coverage. The scope of the managed care coverage will be the same as the Medicaid HO schedule of benefits. In addition, contractors currently offering coverage to state employees or BHP may be offered an opportunity to contract for CHIP coverage. Mental health coverage with by will be provided through the existing RSN system.~~

CHIP enrollees will be required to enroll in managed care arrangements to receive HO and mental health care benefits. If at the same schedule of benefits as HO clients. If HO contractors do not contract for CHIP coverage in a given county or a contracting plan's network is not able to provide sufficient access throughout the county, enrollees will be allowed to receive coverage through FFS. Given that CHIP enrollment will be less than 3%<sup>9</sup> of the existing HO children's enrollment, there should be sufficient capacity. MAA will ~~access~~ assess if there is sufficient access by comparing carrier's CHIP provider network with their HO and other state plan networks with respect to the number and geographic distribution of providers across the county.

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<sup>9</sup> This percentage was calculated using the figures for the 10,000 CHIP eligible children listed in Section 2.1, and the 339,000 children enrolled in the Health Options program listed in Section 3.1.

Like the state's Medicaid program, a household is not required to select a plan for their child as part of the application process. Clients will be assigned to managed care plan when there are two or more plans in their community. Once enrolled in managed care, clients will have a 60-day grace period. During this period, a client can change plans without "good cause." Thereafter, CHIP enrollees will have an opportunity to change plans annually during an open enrollment period, which will occur prior to the start of a new calendar and contract year.

Outside the grace period and open enrollment periods, clients can change plans for the following "good causes":

1. An American Indian or Alaska Native (AI/AN) child who voluntarily select a plan wants to disenroll from managed care;
2. A child's family moves out of the services area(s) covered by their existing plan;
3. To assure that all family members are in the same CHIP, Healthy Options, or Basic Health Plan (BHP);
4. To protect the child or other family members from perpetrators of domestic violence, abuse or neglect;
5. The CHIP enrollee prevails in an adjudication hearing as a result of an access or quality of care grievance;
6. The enrollee's plan merges with another plan resulting in substantial service or network changes;
7. The client's plan has to stop providing services in the client's county because network adequacy problems; or,
8. To rectify a documented department error.

DSHS's Mental Health Division (MHD) contracts with public Regional Support Networks (RSN) to offer mental health services through prepaid health plan coverage. There are 14 RSNs providing mental health coverage in all 39 counties of the state. Currently, 7 RSNs are providing both prepaid community inpatient and outpatient care to Medicaid clients. The other RSNs are providing outpatient coverage and manage community inpatient coverage, but MHD pays hospitals directly for the care on a FFS basis. By October 1999, all the RSNs will provide community inpatient care. All Medicaid children are required to enroll in the RSNs providing coverage in their county of residence in order to receive mental health care.

In September 1998, the Mental Health Division (MHD) and MAA completed a series of meetings with stakeholders to create a joint mental health policy statement. Included in these meetings were representatives for RSNs, Community Mental Health Centers (CMHC), managed care health plans, mental health client advocates, agency staff, and others. This policy statement recognized that:

1. There is overlap of benefit coverage between RSNs and the HO managed care plans;
2. There is a strong need for managed care plans and RSNs to coordinate services;
3. Managed care plans, should they authorize accessing a specialty mental health provider, can manage the mental health benefit differently; and

4. MAA and MHD would expect that if, after a mental health assessment/evaluation has been made, a patient is determined to have a condition requiring him/her to receive more than 12 hours of treatment over 12 months, the patient is immediately referred to the RSN for treatment. In other words, the managed care plan is not responsible for the first 12 hours of treatment that is expected to be necessary if more than 12 hours is needed to stabilize a patient in a give year. Conversely, if the patient is assessed and found to need 12 hours or less of therapy, the managed care plan would be responsible for these services.

Mental health services for CHIP clients will be managed in the same fashion. Managed care plans will provide the limited mental health services described above. Clients requiring further care will be referred to the local RSN.

MAA has developed procedures with MHD to assure coordinated care. MAA sends a monthly tape to MHD identifying Medicaid clients and their eligibility group. MAA will append to this list those clients covered by CHIP.

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. To have the alcohol and drug treatment paid through the medical assistance program, patients enrolled in HO must receive substance abuse treatment from state certified treatment agencies.

MAA has developed procedures with the Division of Alcohol and Substance Abuse (DASA) to assure coordinated care. DASA provides services based on clinical need, not insurance coverage. MAA will notify DASA which clients are covered by CHIP. Assessments to determine the extent of the problem and course of treatment are determined by one of the county-identified outpatient treatment providers. Each county has an Alcohol and Drug Coordinator who administers the drug and alcohol programs for their county. These procedures will be followed for CHIP clients as well.

**3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children: (Section 2102)(a)(4)**

**HO plans are required to manage service utilization according to standards in the state's Quality Improvement Program Standards.**

~~Utilization controls under the plan for targeted low-income children on managed care coverage will be assured through contracts with MCOs, as they are for the current Medicaid Healthy Options program. Managed Care Organizations (MCOs) have the responsibility to implement national utilization management standards, specified in contract, to assure medically necessary and appropriate~~

services Before being approved for participation in the program, health plans must have in place utilization review infrastructure and protocols for, but not limited to:

- ~~Prior approval~~ Determination of medical appropriateness and denial of services;
- ~~Referrals~~ 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 and hospital discharge planning for them, case management, and coordination of special needs;

**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~~ 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))

- 4.1.1.  Geographic area served by the Plan: The entire state of Washington.
- 4.1.2.  Age: Children under the age of nineteen.
- 4.1.3.  Income: Above 200% Federal Poverty Level (FPL) up to and including 250% FPL.
- 4.1.4.  Resources (including any standards relating to spend downs and disposition of resources):

There is no resource test.

- ~~4.1.5.~~ ~~Residency: A Washington resident who is: currently intends to continue living here; or entered the state looking for a job or entered the state with job commitment. (WAC 388-468-0005)~~
- 4.1.5.  Residency: A Washington resident who intends to continue living here; or entered the state looking for a job or entered the state with 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 continuous months.~~
- 4.1.8.  Duration of eligibility: Twelve continuous months.

4.1.9.  Other standards (identify and describe):

None.

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))

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)).

MAA will use two standardized application forms to help staff make eligibility determinations. One form is used for clients applying for the Medicaid children's medical program (a 4-page 1-page form). The other form is used for clients applying for cash benefits, food stamps, medical coverage and other benefits. Potential CHIP eligibles can apply for medical coverage by using either form. Both forms will be processed by centrally through our MAA's Medical Eligibility Determination Services (MEDS) section or by the local Community Service Offices (CSOs).

Information from the application will be entered into the state's i.e. ACES, which will automatically generate CHIP eligibility notices and yearly reviews. ACES will transfer eligibility information to the Medicaid Management Information System (MMIS). MMIS information will be used to enroll clients into managed care.

~~Clients will not need to provide proof of income; declared amounts will be sufficient. Similar to the Categorically Needy (CN) program, only non-citizens will have to show proof of their immigration status. There will be no interview requirement. The application asks the citizenship status of only those children who are seeking benefits. Since disclosure of the Social Security Number is optional, children will be enrolled into CHIP without having a Social Security Number.~~

CHIP applicants will have the same appeal rights as Medicaid applicants. Applicants who are denied

eligibility are sent a letter with information on their rights for a Fair Hearing. Clients may call the Office of Administrative Hearings (OAH) to set up a hearing. OAH notifies the client and the agency's Fair 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 a Fair Hearing. At the Fair Hearing, an Administrative Law Judge gathers information from the client and agency staff. Hearings can be done via telephone or in person. The Judge's decision is mailed to the client and Coordinator. Either party may appeal the decision for additional review and if need to the courts.

4.4. Describe the procedures that assure:

- 4.4.1. -Through intake and follow-up screening, that only targeted low-income children who are ineligible for either Medicaid or other creditable coverage are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A))

At the time of application, eligibility staff will first determine whether an applicant is eligible for Medicaid. If the applicant is not Medicaid eligible, staff will assess eligibility for CHIP and enroll them, if appropriate. To assist in this process, eligibility staff will utilize ACES automated protocols. Also, there is a question on the application that asks whether the applicant currently has health insurance, and whether they had coverage within the past six months.

questions on the application that asks about the child's health insurance status.

- 4.4.2. -That children found through the screening to be eligible for medical assistance under the state Medicaid plan under Title XIX are enrolled for such assistance under such plan. (Section 2102)(b)(3)(B))

At the time of application, eligibility staff will first determine whether an applicant is eligible for Medicaid. If the applicant is not Medicaid eligible, staff will assess eligibility for CHIP and enroll them if appropriate. To assist in this process, eligibility staff will utilize ACES automated protocols. Also, there is a question on the application that asks whether the applicant currently has health insurance.

- 4.4.3. -That the insurance provided under the state child health plan does not substitute for coverage under group health plans. (Section 2102)(b)(3)(C))

The CHIP application asks a series of five questions about the health insurance status of the applicant's children. These questions ask (1) if there is existing insurance; (2) if there is, does it include doctor, hospital, ex-ray, and laboratory services; (3) if they have had job-related health insurance in the last 4 months; (4) if they do, will include information on whether the applicant currently has health insurance. If so, the applicant will be denied CHIP coverage did it cost less than \$50 per month for dependents? If they answer affirmatively to any one of these questions, we ask the applicant to list the name of the insurance company or employer providing the insurance. MAA's Coordination of Benefits Section also may check automated data sources to see if the CHIP enrollee has creditable health coverage, if needed.

(COB) Section verifies whether the insurance is creditable. This Section also

The CHIP application also will ask whether the applicant had insurance within the past six months if so, what was the source (Medicaid, Washington State Basic Health Plan, employer or union plan, plan bought buy household member, provided by someone outside the household, other). MAA will track this information, and will conduct follow-up surveys to assess why the coverage was discontinued. CHIP will not impose "waiting periods" for coverage if the child previously had other health insurance coverage.

requests and reviews a monthly report for creditable insurance.

We use eight exception criteria where households have lost employee dependent coverage. Exceptions to the four-month waiting period may be granted when:

1. Parent lost job that covered children.
2. Parent with insurance died.
3. Child has a medical condition that, without treatment, would be life threatening or cause serious disability or loss of uncton.
4. Employer ended job-related dependent coverage
5. Dependent coverage terminated because the client reached the maximum lifetime coverage amount.
6. Coverage under a COBRA extension period expired.
7. Dependent coverage was not reasonable available (e.g., client has to travel to another city or state to get care for children).
8. Domestic violence led to the loss of this coverage.
9. The family's total out-of-pocket maximum for employer sponsored dependent coverage is fifty dollars per month or more

- 4.4.4. -The provision of child health assistance to targeted low-income children in the state who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c). (Section 2102)(b)(3)(D))

Targeted low-income children who are American Indians or Alaska Natives (AI/AN) will be subject to the same eligibility criteria as other low-income children. MAA has coordinated 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 MAA 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 receive services on a fee-for-service basis or fee-for-service.

- 4.4.5. Coordination with other public and private programs providing creditable coverage for low-income children. (Section 2102)(b)(3)(E))

Washington's CHIP program will coordinate with the Basic Health BHP's application process. Currently, Washington's Medicaid program already has an interagency agreement with the Washington Health Care Authority's Basic Health program HCA's BHP to cover children under 19 years of age with family incomes at or below 200 percent of the federal poverty level. Families applying for medical for children meeting the age and income criteria can choose between receiving medical coverage through HO or BHP Plus.

The Washington Health Care Authority HCA will refer those clients applying for the Basic Health program BHP who meet the income criteria for the Children's Health Insurance Program CHIP to Washington's Medicaid's Healthy Options program for CHIP to MAA.

#### ADDENDUM TO SECTION 4.

### STATE CHILDREN'S HEALTH INSURANCE PROGRAM STATE PLAN TEMPLATE

#### Section 4. Eligibility Standards and Methodology (section 2102(b))

##### 4.1.3. Income:

X All wages paid by the Census Bureau for temporary employment related

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**to Census 2000 activities are excluded.**

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**Section 5. Outreach and Coordination (Section 2102(c))**

Describe the procedures used by the state to accomplish:

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

In 1998, the Washington State Legislature authorized ~~Medical Ass~~ MAA to spend up to \$14.0 million (federal matching funds) for outreach to Medicaid eligibles. The program focuses on outreach to:

- Children up to 200% of the ~~Federal Poverty Level (FPL);~~ FPL;
- Pregnant women up to 185% of the FPL; and
- ~~Temporary Assistance for Needy Families (TANF)-related~~ TANF-related clients – sometimes called the “Family Medical” program covering children and adults of single or two-parent households who meet TANF financial eligibility standards. Many of these families choose to “bank” their cash grants, while continuing to receive Medicaid coverage.

MAA has contracted with 31 community-based organizations covering 34 of the state’s 39 counties. Contractors include health districts, county social service departments and Indian tribes. MAA provided local training to project staff on outreach strategies, eligibility criteria, and enrollment process. MAA is reimbursing contractors by paying a monthly set rate AND paying a \$20 incentive for each client a contractor helps enroll.

Contractors are required to:

- Account for federal outreach funds in accordance with federal requirements;
- Identify people likely to be eligible for coverage;
- Educate potential eligibles on the benefits of participating in the Medicaid program and eligibility requirements;
- ~~A~~ Assist potential eligibles to complete applications for Medicaid eligibility;
- Educate new Medicaid recipients on how to access services; and
- Assist new Medicaid recipients to select a Healthy Options health care plan that will best meet their needs.

To facilitate rapid implementation of the outreach project, MAA developed a web site and posted; general information, the project application, answers to questions submitted by potential applicants and links to other sites. The web site can be reached at <http://www.maa.dshs.wa.gov>.

To implement CHIP, MAA will require Medicaid Outreach contractors to also assist clients to enroll in CHIP, when family income is between 200 – 250% of FPL. MAA has a training team that provides on-site training and technical assistance on identifying potential eligibles and assisting them to apply for benefits.

5.2. Coordination of the administration of this program with other public and private health insurance programs: (Section 2102(c)(2))

Washington's CHIP will be administered by DSHS, which is Washington's ~~single-state~~ single state Medicaid agency. DSHS's ~~the Medical Assistance Administration (MAA)~~ will be responsible for overseeing eligibility determinations, capitation payments, premium collection systems, and outreach efforts. CHIP will be incorporated into the existing HO ~~program~~ service delivery system to the extent that it is possible.

A ~~joint~~ single application for children's medical has been developed. It will be used for the existing Medicaid children's medical program and ~~the~~ CHIP. This integrated approach will facilitate the application process.

**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.)

6.1.1.  Benchmark coverage; (Section 2103(a)(1))

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

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

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

6.1.2.  Benchmark-equivalent coverage; (Section 2103(a)(2)) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4). See **instructions**.

6.1.3.  Existing Comprehensive State-Based Coverage; (Section 2103(a)(3)) [Only applicable to New York; Florida; 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))

Washington's CHIP will provide the same scope of coverage as provided under its Medicaid program. The following chart lists the medically necessary services available to children eligible for

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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
Home Health Services	Yes	Yes
Hospice	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
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

SERVICE	MEDICAID CN	CHIP
Prosthetic Devices/Mobility Aids	Yes	Yes
Psychiatric Services	Yes	Yes
Psychological Evaluation	L	L
Rural Health Services & FQHC	Yes	Yes
Substance Abuse/Outpatient	Yes	Yes
Surgical Appliances	Yes	Yes
Total Enteral/Parenteral Nutrition	Yes	Yes
Transportation Other Than Ambulance	Yes	Yes
X-Ray and Lab Services	Yes	Yes

**Key:**  
Yes: Service is covered (may require prior approval or have other requirements)  
L: Limited coverage.

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

- 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 prepregnancy family services and supplies (Section 2110(a)(9))
  
- 6.2.10.  Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
- 6.2.11.  Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))
- 6.2.12.  Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
- 6.2.13.  Disposable medical supplies (Section 2110(a)(13))
- 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.  Dental services (Section 2110(a)(17))
- 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. **Waivers - 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 waiver. Review and approval of the waiver application(s) will be distinct from the state plan approval process. To be approved, the state must address the following: (Section 2105(c)(2) and (3))

Washington State will not request waivers to implement CHIP.

- 6.3.1.  **Cost Effective Alternatives.** 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~~ low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted ~~low-income~~ low-income children and other ~~low-income~~ 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:

6.3.1.1. Coverage provided to targeted ~~low-income~~ 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))

6.3.1.2. 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; and Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii))

6.3.1.3. The coverage must be provided through the use of a ~~community-based~~ 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(d)(5)(F) or 1923 of the Social Security Act. Describe the ~~community-based~~ community-based delivery system. (Section 2105(c)(2)(B)(iii))

- 6.3.2.  **Purchase of Family Coverage.** Describe the plan to provide 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(e)(3))

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Washington's CHIP will not initially offer family coverage options. However, after implementation of the program, MAA will assess whether family coverage is viable under Title XXI, Section 2105(c)(3). If so, the state may amend its state plan to offer this coverage.

- 6.3.2.1. Purchase of family coverage is ~~cost-effective~~cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted ~~low-income~~low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the ~~low~~low-income children.)** (Section 2105(c)(3)(A))
- 6.3.2.2. 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))-

## 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))

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

The State will contract only with MCOs that are regulated by the Office of the Insurance Commissioner (OIC), which oversees, among other areas, regulates and monitors financial solvency and other consumer protection safeguards.

MAA will monitor 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;
- Annual client satisfaction/health status surveys for both managed care and FFS 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 will be performed through the following actions:

- Requiring the same encounter data reporting (form, format, periodicity) as required under the current HO program;
- Generating of HEDIS reporting and the above mentioned quality measures with the same criteria as the HO program and similar FFS review;
- Applying utilization controls for FFS coverage that are consistent with all current utilization review requirements of Title XIX 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 routine on-site quality and operational reviews of the MCO contractors;
- Reviewing of the MCOs and contract data 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 law regulations (42 CFR 434.34);
- Performing annual client satisfaction surveys;
- Monitoring of complaints and grievances 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 will be guidelines for contract requirements and monitoring, as they are for the current HO program. 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 Recredentialing;
- Members' Rights and Responsibilities; and
- Preventive Health Services and Medical Records.

Quality standards for FFS will be consistent with all quality utilization review requirements of Title XIX 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 childhood 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 according to the same criteria as the current HO program. The current complaint management system will be, as it is currently, 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 Title XIX under the state's Medicaid plan.

7.1.4.  Quality improvement strategies

The following strategies and activities will be implemented to be consistent with the current HO and the FFS programs:

- Monitor 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;

- Annual client satisfaction/health status surveys for both managed care and FFS 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 access to covered services, including emergency services. (2102(a)(7)(B))

The methods to assure access to covered services, including emergency services, will be based on the current HO program. The methods, including monitoring, will be the following:

Availability of practitioners-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. Like the regular Medicaid HO procurement, MAA will request MCOs to submit their provider networks, ~~and networks.~~ MCOs must collect and analyze data to measure performance against these standards, ~~and implementing interventions to correct when not met~~ 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 MAA/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. MAA and HCA are implementing a new Integrated Provider Network Data Base (IPND) which will allow the two agencies to conduct ongoing GeoNetwork analysis to ensure there continues to be an adequate network during the contract period, and to assess whether there is a significant turnover of participating providers. MAA will apply this same analysis to its CHIP plans.

- Non-urgent, symptomatic (i.e., routine care) office visit within 7 days;
- Urgent, symptomatic (i.e., presentation of medical conditions requiring immediate attention, not life-threatening) office visit within 24 hours, and
- Emergency medical care within 24 hours per day, seven days per week.

MCOs must collect and analyze data to measure its performance against the above standards. FFS quality standards and utilization controls are consistent with all quality and utilization review requirements of Title XIX under the state's Medicaid plan.

Emergency care

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, seven 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-emergent. In such instances, the MCO must cover facility and professional services for medical screening examinations as defined in the contract.

**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 states Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan?

8.1.1. YES

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

8.1.2.  NO, skip to question 8.5.

8.2. Describe the amount of cost-sharing and any sliding scale based on income:  
(Section 2103(e)(1)(A))

8.2.1. Premiums: Households or sponsors will be required to pay a \$120 per month premium for each child enrolled in CHIP, with a family maximum of \$30 per month. Payments can be made for periods greater than one month. ~~The household or sponsor will have up to three months to submit the applicant's one month. Eligibility will end if premiums are not paid for four consecutive months.~~

~~initial premium. Failure to make payments, in accordance with MAA's due process, will result in disenrollment and a waiting period to reenroll. Households with enrolled children will receive monthly billing invoices. These monthly statements include the amount due over 30 days, 60 days, 90 days and 120 days. On the front of the statement it says, "Accounts over 90 days past due may result in loss of CHIP coverage." Below this sentence, there is information about changes in income and household that might warrant a re-evaluation of their status for Medicaid. On the back of the statement, there is a complete description of their payment responsibilities. When a client reaches 90 days and 120 days in back premiums, a warning flyer is sent to the client advising that their children's insurance may be terminated.~~

~~If a child is terminated from CHIP for failure to pay premiums for four consecutive months, the household will receive a letter outlining their rights and responsibilities. The letter says they will not be able to re-enroll for four months and must pay all delinquent premium payments.~~

8.2.2. Deductibles: None

8.2.3

8.2.3 Coinsurance: Enrollees will be required to pay a copayment for physician services, prescription drugs, and hospital emergency room services. The

physician copayment will be \$5.00 for each visit to a primary care provider or physician specialist. The drug copayment will be \$5.00 for brand name prescription drugs even when there is no generic substitute. The emergency room copayment will be \$25.00 for each visit that does not result in an inpatient hospital admission. There will be no copayment requirements for well-baby and well child care services, including age appropriate immunizations.

8.2.4 Other: None

8.3. Describe how the public will be notified of this cost-sharing and any differences based on income:

~~State published~~State-published CHIP brochures and summary documents will include information about enrollee cost-sharing requirements. The CHIP application packet will include detailed information about

enrollee cost-sharing requirements. CHIP enrollment and health plan enrollment documents also will include all cost-sharing requirements.

- 8.4. The state assures that it has made the following findings with respect to the cost sharing and payment aspects of 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))
  - 8.4.2.  No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2))
  - 8.4.3.  No child in a family with income less than 150% of the Federal Poverty Level will incur cost-sharing that is not permitted under 1916(b)(1).
  - 8.4.4.  No Federal funds will be used toward state matching requirements. (Section 2105(c)(4))
  - 8.4.5.  No premiums or cost-sharing will be used toward state matching requirements. (Section 2105(c)(5))
  - 8.4.6.  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))
  - 8.4.7.  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))
  - 8.4.8.  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))
  - 8.4.9.  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))

- 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 annual income for the year involved:  
(Section 2103(e)(3)(B))

MAA's consulting actuary (~~Milliman & Robertson~~Robertson, Inc.), ~~has~~Robertson, Inc.) has calculated the aggregate actuarially value of the copayment and premium requirements to not be more than \$25.00 per-member-per-month (-PMPM). These amounts would not exceed ~~45.00%~~4.0% of families with gross annual income between 200% and 250% of FPL. However, there will also be an annual "cap" of \$300 per child per year with a \$900 family maximum. ~~This is well below the federal cap of 5%.~~ These caps will limit family's annual expenditures to no more than 3% of their annual income. If a child's actual copayment experience results in total cost-sharing above their ~~cap 5%~~ limit, ~~the family will be encouraged to cap,~~ the family will be able to submit necessary documents and receive a refund for amounts in excess of the limit.

For families who have met their cost-sharing maximum, MAA has developed a letter stating the enrollee is exempt from co-pays for a specified time period. They would take this letter to all provider appointments.

We are also exploring ways to have our MMIS track copayments for CHIP clients not covered under managed care.

- 8.6. The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan:

~~8.6.1. The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR~~

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

~~8.6.2.  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 6.3.2. of the template). Preexisting medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2109(a)(1),(2)). Please describe:~~

8.6.2.  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 6.3.2. of the template). Preexisting

medical conditions are permitted to the extent allowed by  
HIPAA/ERISA (Section 2109(a)(1), (2)). Please describe:

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**Section 9. Strategic Objectives and Performance Goals for the 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))

Washington's CHIP strategic objective is to increase the number of children in households between 200% and 250% 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))

The following performance goals have been identified:

1. Increase the number of children between 200% and 250% of FPL who have health care coverage.
2. Reduce the percentage of uninsured children between 200% and 250% of FPL.
3. Increase the number of children below 200% of FPL who have health care 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))

MAA and the Governor's Office of Financial Management's (OFM) Forecast Section will analyze WSPS data to measure the number and percentage of children who are uninsured and the percent who are uninsured. The WSPS is a comprehensive survey conducted under contract with the 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 will be based on MAA's work with the Consumer Assessment of Health Plans (CAHPS). MAA has conducted two CAHPS surveys to date. These surveys were conducted in accordance with CAHPS Consortium (a group of national survey experts associated with the Harvard Medical School, RAND, and the Research Triangle Institute) protocols. MAA's 1997 survey measures clients' satisfaction with the health care and services received through the Medicaid Healthy Options (HO) program. The 1998 survey included both HO enrollees and Medicaid FFS clients. To the extent possible, a similar survey approach will be used to assess CHIP enrollees' satisfaction with care.

MAA has been utilizing HEDIS and EPSDT related measures to assess the effectiveness of its HO contractors to provide medically appropriate services to Medicaid clients since 1996. These Similar measures are now being applied to Medicaid FFS clients. MAA will contract with these same standardized measures and 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: MAA will assess whether there is a sufficient number of CHIP enrollees who give birth while on CHIP to warrant tracking birth outcomes through the DSHS' First Steps Database. MAA also will track and compare CHIP dental access and utilization 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))

9.5. ~~The state assures it will comply with the annual assessment and evaluation required under Section 10.1. and 10.2. (See Section 10) Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2))~~

9.5.  The state assures it will comply with the annual assessment and evaluation required under Section 10.1. and 10.2. (See Section 10) Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2))

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 250% of 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))

9.7.  The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.

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))

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 1115 (relating to waiver authority)

9.8.5.  Section 1116 (relating to administrative and judicial review), but only insofar as consistent with Title XXI

- 9.8.6.  Section 1124 (relating to disclosure of ownership and related information)
- 9.8.7.  Section 1126 (relating to disclosure of information about certain convicted individuals)
- 9.8.8.  Section 1128A (relating to civil monetary penalties)
- 9.8.9.  Section 1128B(d) (relating to criminal penalties for certain additional charges)
- 9.8.10.  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)).

Over the past five years 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.
  - MAA 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 reflect in the Governor's proposal and MAA's CHIP operational design.
  - During the development of the CHIP state plan, MAA involved representatives of various stakeholder groups including; state medical association, 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 this plan submittal were jointly sponsored by MAA and the Children's Alliance – a state-wide children's advocacy group.
  - MAA sponsors fourteen local community groups to provide feedback on the Healthy Options program. The Healthy Options Committees will be asked to provide input, as well as provide feedback throughout implementation.
  - MAA is consulting with the American Indian Health Commission of Washington State and the Northwest Portland Area Indian Health Board on the design of CHIP. CHIP has been an item of discussion for over a year with these groups. Although the total number of Indian children to be served by CHIP is expected to be small (approximately 300), the increased commitment by the State to Indian health issues is viewed by the Tribes as an important move.
- ◆ MAA also will provide an opportunity for all interested parties to review and comment on the proposed State Plan application through MAA's CHIP Website<sup>10</sup>.

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<sup>10</sup> <http://maa.dshs.wa.gov/CHIP/Index.html>

The combination of ~~state-wide~~statewide and local input will provide a robust mechanism for assuring broad input into the planning and implementation stages of CHIP.

9.10. ~~9.10.~~—Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (Section 2107(d))

<b>Washington State Children's Health Insurance Program FFY 2000-2001 Summary Budget</b>			
	<b>Total Cost</b>	<b>Federal Match</b>	<b>State Match</b>
<b>FFY 2000</b>			
Program Costs	\$3,064,972	\$2,031,463	\$1,033,509
Administrative Costs	\$306,497	\$203,146	\$103,351
Start-Up Costs	\$100,000	\$0	\$100,000
Total	\$3,471,469	\$2,234,609	\$1,236,860
<b>FFY 2001</b>			
Program Costs	\$10,260,381	\$6,800,581	\$3,459,800
Administrative Costs	\$1,026,039	\$680,059	\$345,980
Start-Up Costs	\$0	\$0	\$0
Total	\$11,286,420	\$7,480,640	\$3,805,780
<b>2000-2001 Total</b>			
Program Costs	\$13,325,353	\$8,832,044	\$4,493,309
Administrative Costs	\$1,332,536	\$883,205	\$449,331
Start-Up Costs	\$100,000	\$0	\$100,000
Total	\$14,757,889	\$9,715,249	\$5,042,640

**Notes**

(1) The source of non-Federal share is from the Washington State Health Services Account (HSA). These funds are non-federal and their sources are permissible as set forth in Title XXI and XIX of the Social Security Act.

(2) WA CHIP FMAP is 66.28%.

**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))~~ 2108(a)(1), (2))

- 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
- 10.1.2.  Report to the Secretary, January 1 following the end of the fiscal year, on the result of the assessment.

Below is a chart listing the types of information that the state's annual report might include. Submission of such information will allow comparisons to be made between states and on a nationwide basis.

Attributes of Population	Number of Children with Creditable Coverage		TOTAL
	XIX	OTHER CHIP	
Income Level:			
< 100%			
≤ 133%			
≤ 185%			
≤ 200%			
> 200%			
Age			
0-4			
0-1			
1-5			
1-5			
6-12			

- 10.2.2.1.  The characteristics of the children and families assisted under the state plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the state plan and after eligibility for the state plan ends;
- ~~10.2.2.2. The quality of health coverage provided including the types of benefits provided (NOTE: Certain measures, such as HEDIS and CAPHS types measures cannot be reported until a full year of experience plus time to collect and analysis the data. Therefore, the "quality of care measures" will not be reported until the fall of 2001.);~~
- 10.2.2.2.  The quality of health coverage provided including the types of benefits provided (NOTE: Certain measures, such as HEDIS and CAPHS types measures cannot be reported until a full year of experience plus time to collect and analyze the data. Therefore, the "quality of care measures" will not be reported until the fall of 2001.);
- 10.2.2.3.  The amount and level (including payment of part or all of any premium) of assistance provided by the state;
- 10.2.2.4.  The service area of the state plan;
- 10.2.2.5.  The time limits for coverage of a child under the state plan;
- ~~10.2.2.6. The state's choice of health benefits coverage and other methods used for providing child health assistance; and~~
- 10.2.2.6.  The state's choice of health benefits coverage and other methods used for providing child health assistance; and
- 10.2.2.7.  The sources of non-Federal funding used in the state plan.
- 10.2.3.  An assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children.
- 10.2.4.  A review and assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.

- 10.2.5.  An analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.
- 10.2.6.  A description of any plans the state has for improving the availability of health insurance and health care for children.
- 10.2.7.  Recommendations for improving the program under this Title.
- 10.2.8.  Any other matters the state and the Secretary consider appropriate.

~~10.3. The state assures it will comply with future reporting requirements as they are developed.~~

10.3.  The state assures it will comply with future reporting requirements as they are developed.

10.4.  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.

Appendix APPENDIX 3

**1999 BHP+/HEALTHY OPTIONS PLANS – June 1, 1999**

\* = BHP+ ONLY X = HO & HP+ + = HO ONLY

	Aetna U.S. Healthcare of WA (AUSH) 7502545	Clara United (CUF) 7500416	Comm. Health Plan of WA (CHPW) 7502453	Group Health (GH) 7502502	Kaiser (KFI) 750010	Knap Ph. Services (KPS) 750044	Northwest Medical Bureau (NMB) 7502560	Primer Blue Cross (PBC) 7502546	QualMed (QMD) 750053	Regence WA Health (RWS) 7502457
Adams	X		X					X	+	
Asotin								X		X
Benton			X					X	+	
Chelan	X		X					X	+	
Clallam						+				X
Clark		X			X					
Columbia				X				X	+	
Cowlitz			X		X				+	X
Douglas	X		X					X	+	
Ferry			X	*				X	+	
Franklin			X					X	+	
Garfield								X	+	X
Grant	X		X					X	+	
Grays Harbor	X		X					X		X
Island			X	*			X	X	+	
Jefferson						X				
King	X		X	X				X	+	X
Kitsap			X	X		X		X	+	
Kittitas								X	+	
Klickitat			X					X		
Lewis	X		X	*					+	X
Lincoln			+	*					X	

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	Aetna-U.S. Healthcare of WA (AUSH) 7502545	Clark United (CUP) 7500416	Comm. Health Plan of WA (CHPW) 7502453	Group Health (GH) 7502602	Kaiser (KFHP) 7500010	Kitsap-Phy. Services (KPS) 7500044	Northwest Medical Bureau (NWMB) 7502560	Premiera Blue Cross (PBC) 7502586	QualMed (QMD) 7500952	Regence WA Health (RBS) 7502487
Mason	X		X	*		X		X	+	
Okanogan	X		X					X		X
Pacific	X							X	+	
Pend Oreille			X	*				X	+	
Pierce	X		X	X				X	+	X
San Juan				*			X	X	+	
Skagit			X	*			X	X		
Skamania			X		X			X		
Snohomish	X		X	X			Stanwood Only	X	+	X
Spokane			X	X				X	+	
Stevens			X	*				X	+	
Thurston	X		X	X		X		X	+	X
Wahkiakum					X			X		
Walla Walla			X	X				X	+	
Whatcom			X				X	X	+	
Whitman				*				X	+	
Yakima			X					X	+	X

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