

**Section 3. General 3. General Contents of State Child Health Plan (Section 2102)(a)(4))(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 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. ~~system.~~ This managed care system consists of contracts with health carriers for 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.~~ transportation. MAA will start taking CHIP applications in January 2000, with service delivery starting in March 2000.

MAA contracts with health carriers 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). For 1999, the 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, 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.

CHIP enrollees will be required to enroll in managed care arrangements ~~to and~~ receive 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>1</sup> of the existing HO

<sup>1</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.

children's enrollment, there should be sufficient capacity. MAA will assess if there is sufficient access by comparing carrier's CHPHCIP provider network with their HO and other state plan networks with respect to the number and geographic distribution of providers across the county.

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 plans 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." 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.~~

~~-year.~~

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

~~causes":~~

- ~~1. An American Indian or Alaska Native (AI/AN) child who voluntarily selects a plan wants to disenroll from managed care;~~
- ~~1. enroll from managed care;~~
- ~~2. A child's family moves out of the service 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 of network adequacy problems; or~~
- ~~8. To rectify a documented department error.~~
- ~~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.

## 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.~~

### 8.2.3. Coinsurance:- None

~~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.~~

### 8.5.8.5 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, Inc.) has calculated the aggregate actuarial value of the copayment and premium requirements to not be more than \$25.00 per member per month per member per month (PMPM). These amounts would not exceed 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. 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, the family will be able to submit necessary documents and receive a refund for amounts in excess of the limit.~~

~~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.~~

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The annual aggregate cost-sharing for a family will not exceed 5 percent of a family's annual income as the monthly premium charge of \$10 per month (\$30 per month

household maximum) is less than 2% of gross annual income for families between 200% and 250% FPL.