GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH

AUG 10 1998

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Mr. Richard Fenton
Deputy Director
Family and Children's Health Programs Group
Center for Medicaid and State Operations
Family and Children's Health Programs Group
7500 Security Boulevard
Baltimore, MD 21244-1 850

Dear Mr. Fenton:

Enclosed are the Department of Health's responses (and supporting documents) to the set of inquiries related to the District of Columbia's CHIP application. We have finalized our responses after lengthy discussions with both the Regional and Central Office staffs of the Health Care Financing Administration ("HCFA").

The assistance we received from the application review team under the leadership of Diona Kristian was useful in helping us to clarify the questions and formulate responsive answers. On behalf of the Department, I would like to express our sincere appreciation for your assistance and join with you in looking forward to the implementation of this important initiative.

Sincerely,

Marlene N. Kelley, M.D.
Acting Director

Enclosures

cc: Paul Offner, DOH Deputy Director
Rosemary Field, Philadelphia Office

Responses to Federal Inquiries
Regarding Child Health Insurance Program Application
for the
District of Columbia

Section 1 General Description and Purpose of the State Child Health Plan

Inquiry 1 Please Provide an Assurance that the Title XXI State Plan will be conducted in compliance with all civil rights requirements. This assurance is necessary for all programs involving continuing Federal financial assistance.

Response The District of Columbia's Title XXI State Plan shall be conducted in compliance with all Federal (Including, but not limited to Title IX of the Civil Rights Act of ***1975,*** as amended; the Americans with Disabilities Act of 1990, as amended, Title IX of the Education Amendments 1972, as well as other related laws) and District of Columbia civil rights laws, rules, regulations, and policies.

Section 2 General Background and Description of State Approach of Child Health Coverage

Section 2.1
Inquiry 2 The District states that it expects 1,729 (or 40%) of the 4,333 children with private insurance coverage to drop their private insurance coverage and enroll in CHIP. However, no crowd-out strategy is included in the District's CHIP plan submittal. What steps will the District take to prevent substitution? How will the District identify those children who drop private health insurance to enroll in CHIP? How will the District verify that a child has no other health insurance coverage?

Response The District will verify that a child has no other health insurance coverage by asking (on the application) the adult making the application to declare *underpenalty of perjury* that the child is not privately insured at the time the application is made.

The District will identify those children who drop private health insurance coverage to enroll in CHIP by asking (on the application) the adult making the application to declare *under penalty of perjury* whether the child has been privately insured during the three (3) month period prior to the date of making the application.

The District's policy to prevent substitution is as follows: (a) monitor the situation for one (1) year to determine if substitution is a *significant* problem *(significant* problem will be defined as greater than 12 percent of applicants who indicate on the enrollment application that they have had private insurance coverage within a three (3) month period of applying for CHIP); (b) if it is determined that substitution is a *signifcant* problem (as defined above), the District will consider feasible alternatives to prevent substitution including the institution of a three (3) month (from the date the insurance was dropped) waiting period between the time the individual drops private coverage and applies for CHIP; (c) in no case will an applicant be counted as part of the 12 percent of people who drop private coverage or be subjected to a three (3) month waiting period if the applicant is involuntarily terminated from participation in a private insurance plan.

Inquiry 3

Please describe the interaction between ***Healthy** DC **Kids*** and the two private initiatives, ***Kids Care*** and ***Kaiser Kids.*** Both of these private initiatives prohibit children from participating if they have access to other insurance. Will the children in these programs lose their eligibility if they are eligible for ***Healthy** DC **Kids?***

Response

Capitol Community Health Plan ("CCHP") will phase out ***Kids Care*** and transition eligible children into CHIP. ***Kids Care*** is funded by a private donor who has indicated that he no longer intends to fund the program after the CHIP Program is initiated. Kaiser Permanente also plans to transition eligible ***Kaiser Kids*** into CHIP. Kaiser has not decided whether it will continue the program with a higher income level, serve a different population, or terminate the program.

CCFIP and Kaiser are working with the District's Medicaid program to develop a plan for transitioning children into CHIP with the least possible break in coverage. Both CCHP and Kaiser are working with the Medical Assistance Administration ("Medicaid") to develop letters that will be mailed to their enrollees informing them of the upcoming transition to CHIP. The letters will include a brief description of CHIP and a telephone number to call for more information. Children who transition from these privately funded programs into CHIP ***will not*** be counted in that percentage of children who have substituted health insurance coverage.

Inquiry 4

The District has a Section 1 115 waiver program for disabled children who are covered by SSI. It is anticipated that some disabled children will be enrolled in CHIP, since the income threshold for SSI is relatively low. Will CHIP children with special health care needs, whose family income exceeds the SSI income levels, have an option to choose between the Section 1115 waiver delivery system and the Section 1915(b) waiver delivery system?

Response

The District provides care to children who are receiving SSI through a voluntary Section 1115 waiver. Approximately 2,000 children are enrolled in the waiver. The waiver expires at the end of November 1998. The District is in the process of seeking a one year extension on the waiver from the Health Care Financing Administration ("HCFA"). The request for extension will be submitted to HCFA in early August 1998 and will include a road map of activities associated with developing a new waiver application.

The District will not make any substantive changes to the waiver in its request for an extension. That is, the waiver will continue to serve only SSI children. During the one year period during which the waiver continues (should the extension be granted), the District will develop **a** new waiver application and explore ways to serve additional children with special health care needs, including TANF-related children, foster care children and CHIP children whose family income exceeds the SSI income levels, through the Section 1115 waiver delivery system.

During the interim period, all ***targeted*** low-income children (including those who have special health care needs) will be enrolled in the Section 1915(b) managed care delivery system. Our networks have the capacity to provide high quality services for these children as they now do for TANF-related children (foster care children are currently ***carved out*** of our mandatory managed care system). We will continue to monitor network capacity on an ongoing basis by reviewing claim denials, service waiting periods, financial solvency, and other indicators as appropriate.

Section 5.1

Inquiry 5 The Districts plan provides guiding principles upon which the outreach strategy will be developed and states that the District will hire an outreach coordinator to assist in the development of its outreach strategy. Please provide the specific outreach plan that the District will implement as required by Section 2 102(cXl), including additional activities designed to reach targeted low-income children and Medicaid eligible children.

Response The District's outreach plan has five components: (a) basic principles; (b) public education; (c) materials development; (d) media strategy; (e) in-person application assistance. In addition, the District plans to establish a CHIP telephone ***hotline*** that will receive calls related to CHIP and regular Medicaid. (See Attachment A)

Inquiry ***6*** The plan states that "The District is currently developing an enrollment process for CHIP and income-based Medicaid applicants." ... and that "the District is considering certain activities". Please provide the specific activities that the District will use to determine eligibility for both CHIP and Medicaid applicants and to enroll eligible children into the appropriate program in order to meet the District's aggressive enrollment projections. Please clarify the process the District will use to educate enrollees on how to access services, particularly for the period between establishment of eligibility and enrollment in an MCO.

Response The District has recently developed a two-page application that will be used by CHIP applicants as well as those individuals who are applying for Medicaid solely on the basis of income. The application can either be mailed in (business reply mail) or brought into a service center (See Attachment B). Applicants will be required to verify income (e.g. two check stubs) and submit proof of residence in the District (e.g. telephone bill).

Outreach workers and telephone ***hotline*** workers will be trained to assist individuals to complete the application and will have enough information to identify those who should be enrolled in CHIP and those who should be enrolled in regular Medicaid. The application will have a detachable cover page that explains eligibility for CHIP and eligibility for regular Medicaid (including an income scale) to assist individuals in determining which program they are eligible for. Parents of qualified immigrant children who are applying for the program on behalf of the child will be required to complete a third page on the application that captures information regarding the immigration status of the child. All applicants are required to sign the application under penalty of perjury.

Outreach workers will be trained to inform potential enrollees about the service delivery option(s) available to them (e.g. managed care). Additionally, the outreach workers will inform potential enrollees about what to expect once they are enrolled in Medicaid (e.g. they will receive a packet of information about managed care in the mail; subsequent to that, they will be contacted by an enrollment broker; and, that they will need to choose from among seven health plans, etc.). In addition to information about managed care, new enrollees will also receive (in the mail) information about using the fee for service delivery system during the period between their enrollment in Medicaid and their enrollment in managed care (no more than ninety days).

Please note that the application is presented in *draft* form and is still undergoing revisions. We will be adding questions regarding previous insurance (within the last three months) to monitor crowd-out and a question regarding whether or not the applicant is currently insured. We welcome any useful comments for improvement of the draft application.

A telephone hotline number will be disseminated throughout the community and will provide information about CHIP, regular Medicaid, enrollment procedures and the service delivery system upon request.

Section 9 Strategic Objectives and Performance Goals for the Plan Administration

Section 9.1
Inquiry 7 Please clarify Strategic Objective 4, "Those newly enrolled in CHIP and regular Medicaid (income based) will express satisfaction with the new enrollment process." Does the District have a specific target that it wants to reach? How will the District measure whether it has been successful in achieving this objective?

Response The District's target for satisfaction with the new enrollment process is 75 percent of those who: (a) enroll in the Medicaid or CHIP through the new enrollment process; and (b) complete and mail the evaluation postcard.

The new enrollment process will be defined as utilization of any one or more of the following: (a) the new two-page application; (b)the mail-in process; (c) assistance from a community-based outreach worker; (d) assistance from a telephone ***hotline*** worker; or (e) assistance from attendance at a public education session.

The District will distribute an evaluation postcard. Customers will be asked to complete them and mail them in. The District will tabulate the results. The results will be maintained on file with the Medicaid Agency and incorporated into the annual report submitted to HCFA.

In addition to the formal process (described above), the District will also maintain open lines of communication with advocacy groups, the school system and other community groups in order to receive informal feedback on the process.

Section 9.2
Inquiry 8 The Performance Goal for Strategic Objective 5 states the District will work through its managed care enrollment broker to obtain satisfaction information from enrollees. Please explain the role of the enrollment broker and describe the coordination between the managed care enrollment broker and the outreach coordinator.

Response We have reconsidered our previous response and request the response to be read as follows: There will not be a formal relationship between the managed care enrollment broker and the outreach contractor. However, the CHIP Coordinator and the Managed Care staff (in the Medicaid office) will work closely to communicate information to each of the entities on an *as* ***needed*** basis. (See Response to Inquiry #7 above).

Section 9.3
Inquiry **9** Please clarify how data used in reports developed by the Medical Assistance Administration ("MAA") are "readily verifiable through the contracted Managed Care Organization and may be independently verified through the MCOs," other than through the use of an EQRO. Is the employment of an EQRO an additional step in the verification process?

Section 5 Outreach and Coordination

Response — The response to this inquiry in the May 14th submission was intended to convey the following information: (a) MCOs report aggregate data to state Medicaid agency; (b) MCOs keep raw data in their own files; (c) state Medicaid agency tabulates data received from MCOs; (d) state Medicaid agency reports such data to its EQRO for independent verification; (e) state Medicaid agency receives results of EQRO' s independent verification; (1) results of verification process forwarded to HCFA in the annual CHIP report.

Inquiry 10 — Please clarify how "performance measures that do not lend themselves to numeric summation" can be "tabulated." Similarly, this section notes that tabulations and data will be maintained on file by the MAA for independent verification. Does this apply to the desk-auditing of enrollment forms to be done by the MAA to assess satisfaction? To which performance measures does this situation apply?

Response — The response to this inquiry in the May 14th submission meant to convey the following information: (a) some responses indicating performance (e.g. satisfaction with outreach process, satisfaction with telephone ***hotline,*** or satisfaction with mail-in application process) do not lend themselves to numerical tabulation; (b) the state Medicaid agency will collect the completed satisfaction survey; (c) the state Medicaid agency will tabulate and categorize the qualitative responses; (d) such tabulations will remain on file with the state Medicaid agency; and, (e) reports will be incorporated into the Agency's monthly report to HCFA.

Section 9.10

Inquiry 11 — The enrollment projections for FY 1999 assume that 92% of all potential CHIP enrollees will be enrolled in CHIP for all 12 months for FY 1999. The District projects that it will be operational for 2 months in FY 1998, in which ***5%*** of all potential CHIP enrollees will be enrolled. Please clarify how the District will meet its FY 1999 enrollment projection.

Response — CHIP enrollment will begin on October 1, 1998. We assume that there will be a 24-month lag in the time it will take for newly eligible persons to learn of their eligibility based upon analysis of patterns of enrollment growth over time under prior Medicaid eligibility expansions. We assume that enrollment will gradually build over the first two years of the program reaching 8,346 children per month by September 30,2000. (See Appendix C).

Based upon these data, we estimate that average monthly enrollment in FY 1999 will be equal to *65* percent of the projected 8,346; that average monthly enrollment in FY 2000 will be equal to 92 percent of the projected 8,346 children by the end of that year. Thereafter, the estimates are adjusted for each year to reflect Census Bureau projections that indicate a population decline in the District through year 2000 followed by slow population increases in each year thereafter. Enrollment projections are as follows:

(a) In FY 1999, we expect an average monthly enrollment of 5,479 children.

(b) In FY 2000, we expect an average monthly enrollment of 7,678 children.

(c) In FY 2001, we expect an average monthly enrollment of 8,429 children.

(d) In FY 2002, we expect an average monthly enrollment of 8,513 children.

Inquiry 12 Please provide additional detail on the budget. It appears from Attachment **A,** Table **4,** that the per member per month cost includes a 3.41 percent allowance for program administrative costs. Is this allowance for administrative costs that are included in the capitation payment to managed care organizations or administrative costs associated with the District's administration for the Program?

Response The 3.41 percent allowance included in the per member per month cost reflects administrative costs *no* ***longer*** incurred by the state Agency that are now ***incurred*** by the MCO. The 3.41 percent ***does not*** reflect any portion of the administrative cost to be incurred by the State Agency in administering the CHIP Program.

Inquiry 13 Please provide more detail on the planned use of administrative funds. How much does the State expect to spend on outreach costs and other program-related administration costs?

Response The District is currently involved in the process of procuring an outreach contractor and is not in a position to know the amount of the contract at this time. The District is well aware that Federal law restricts administrative costs of CHIP (which include direct administration, outreach, and direct services) to an amount that is ten (10) percent (or **less)** of program expenditures. The District will comply with Federal law and limit administrative expenditures to no more than ten (10) percent of program expenditures no matter how that ten (10) percent is allocated among the three permissible uses.

(e)In F/Y 2003, we expect **an** average monthly enrollment of *8,599* children.

Attachment **A**

District **of** Columbia
CHIP Outreach Program

Statement **of** Purpose

The purpose of the District's outreach plan is to select a qualified entity ("Contractor") to perform, either directly or through qualified subcontractor(s), a variety **of** coordinated tasks designed to maximize the enrollment of children into the District's CHIP program. Specifically, the Contractor will be required to (a) identify ***targeted*** low-income children who are residents of the District; and (b) assist the ***targeted*** population to enroll in CHIP.

Five Major Components **of** the Outreach Plan

The District's outreach plan has five ***(5)*** distinct but interrelated components: (a) basic principles; (b) public education; (c) materials development; (d) media strategy; (e) in-person application assistance. In addition, the District plans to establish a CHIP ***hotline*** that will receive calls related to CHIP and regular Medicaid. The components of the outreach plan are described below:

Basic Principles

The outreach plan is based upon a set of basic principles that must be incorporated into every activity associated with the outreach initiative. The basic principles component requires the contractor to implement the outreach plan in accordance with a set of basic principles established by the Medicaid agency. These principles include: implementation of outreach strategy on a City-wide basis; responsiveness to language and cultural needs of the City's immigrant community; community-wide dissemination of new, two-page Medicaid application; involvement of members of the local community whenever possible; responsiveness to the needs of the District's hearing impaired, visually impaired, deaf and blind communities; development and implementation of an effective media strategy; commitment to ongoing communication between the Contractor and a variety of community-based entities; and development of a sustainability plan.'

Materials Development

The materials development component requires the Contractor to develop and disseminate written materials (e.g. flyers, billboards, posters, etc.) throughout the community. The Contractor is required to develop all written materials at appropriate literacy levels and to translate and print all materials in language(s) used regularly by five ***(5)*** percent or more of the District's population. All materials must be approved by DOH in draft form prior to printing.

Public Education

The Public Education component of the outreach plan calls for the Contractor to develop and implement a City-wide public education strategy that will reach "key" City governmental entities (e.g. schools, WIC, foster care, public housing, etc.) as well as "key" nongovernmental entities (e.g. nonprofit clinics, local churches, and local business.

'**A** sustainability plan is a plan to ensure that ***key*** governmental entities are educated about Medicaid and CHIP eligibility criteria and processes and have the ability to continue outreach activities after the outreach contract ends.

Attachment A

Media Strategy

The media strategy component of the outreach plan requires the Contractor to design, develop, and implement a media strategy consistent with the goals of this Initiative. The Contractor is required to consider the District's ethnic media markets and outlets and shall describe in detail how such markets may be utilized to accomplish the goals of the Initiative.

Application Assistance

The Contractor is required to design and implement a District-wide in-person application assistance program to accomplish the following objectives: (a) place adequately trained (training materials supplied by the Medicaid Agency) application assistance workers in community-based sites (public and private) on a work demand basis; (b) respond to the needs of all of the District's language minorities, the hearing impaired, the visually impaired, the deaf and the blind; (c) provide all aspects of application assistance ***with the exceptions of*** taking possession of completed applications, evaluating information supplied on the application for purposes of eligibility determination and making representations regarding eligibility determination; (d) provide all potential applicants with information related to Medicaid's basic benefits package, including EPSDT; (e) provide potential applicants with information about the Medicaid recertification process; (f) provide all potential applicants with verbal information so that they know that once they are enrolled in the Medicaid program they must select a doctor from a predetermined network of providers, that there are seven networks to select from, and that they will receive more information in the mail about selecting a doctor once they are officially enrolled in the Medicaid program; (g) provide all potential applicants with printed material about the District's mandatory managed care program and the telephone number of the Medicaid managed care ***hotline.***

Telephone Assistance

The District plans to engage its fiscal intermediary to run a CHIP ***Hotline*** that will handle inquiries related to CHIP and regular Medicaid, enrollment processes and other questions. The purpose of the telephone assistance program is to assist potential CHIP applicants with all aspects of the application process and to answer questions related to eligibility and other general questions about the program. Telephone services shall be provided in a language appropriate, culturally sensitive manner and shall accommodate the needs of the hearing impaired.

Telephone assistance shall include the following: (a) instructing persons about their potential eligibility for regular Medicaid, CHIP, and 1931(b) Medicaid; (b) answering questions that individuals may have about the application form, the application process or the required documentation; (c) translating the application form if applicable; (d) assisting language minorities to understand the process, including the required documentation; (e) assisting persons to complete the application form.

Training of Workers

The Medical Assistance Administration shall be responsible for the development of all training materials associated with the implementation of all aspects of the outreach initiative.

Evaluation

The District will develop performance based measures to evaluate the performance of its outreach contractor and its telephone ***hotline*** service. Performance will be measured based on the achievement of the overall objective of the initiative: enrollment of children in CHIP. Actual measurement criteria are currently under development.

Attachment A

Caveat

The District is in the process of procuring an outreach contractor. An important component of the District's solicitation is the flexibility built into the process. Although the District identified a set of tasks that it believes may be effective, there is no data to support such choices. We are merely relying upon specific activities that other states are using as CHIP outreach strategies.

Therefore, the District has built into its solicitation, components that allow the contractor, upon whose expertise in social marketing the District seeks to rely, to use his or her judgement, based upon other social marketing campaigns , to alter specific tasks if he or she believes (based upon past experience) that they will not be effective and to substitute tasks that he or she believes (based upon past experience) will be more effective.

Whenever the Contractor makes any change (e.g. add or subtract) in task(s), he or she is required to do the following: (a) provide a rationale for such change; and (b) obtain DOH approval for such change. In all cases, the Contractor is required to comply with Federal and District laws, rules, regulations, and policies in carrying out the CHIP Outreach Initiative.

ATTACHMENT B

Exhibit VII-2
PART 2: QUESTIONS FOR IMMIGRANTS

DC Healthy Families
DC Healthy Kids

Application for Health Insurance

PART 2: QUESTIONS FOR IMMIGRANTS

Leave this page blank if you answered YES to question 9 on Part 1 of this application.
Fill out this page if you answered NO to question 9 on Part 1 of this application.

	(circle one)	
Is any family member on active duty, or a veteran of the United States Armed Forces with an honorable discharge, or did you serve under U.S. command during World War II or in Vietnam? If YES, you may stop here. If NO, go on to the next question.	YES	NO
Is any family member the spouse, widow, or dependent of a person on active duty or veteran described above? If YES, you may stop here. If NO, go on to the next question.	YES	NO
Is any family member a victim of domestic abuse who is no longer living with the abuser? described above? If YES, you may stop here. If NO, you must complete the rest of Part 2 of the application.	YES	NO

Immigration Status: Complete the chart below for each family member who is not a U.S. citizen and who is applying for benefits. Enclose copies of both sides of all immigration cards (or other documents that show immigration status). List all statuses that have applied to each person since the person entered the U.S.

Use these codes to describe your status:

1. Amerasian admitted pursuant to Section 584 of Public Law 100-202
2. Asylee
3. Conditional Entrant
4. Cuban/Haitian Entrant
5. Deportation Withheld
6. Legal Permanent Resident
7. Native American with at least 50% Indian blood born in Canada
8. Parolee
9. Refugee
10. Person with a temporary visa
11. Person residing under color of law (PRUCOL)

Name (Last, First, Middle)	Status Codes (List all that apply)	Date Status Awarded	U.S. Entry Date	For Office Use Only

The simplified form requires the applicant to complete only two pages. The application itself will be longer than two pages due to instructions for filling out the form, information on rights and responsibilities and the EPSDT program, and additional language that may be required from a legal standpoint. The application package will also include a second part that non-citizen families must complete (see ***Exhibit VII-2: Part 2: Questionsfor Immigrants).*** Until all the required legal language has been finalized, it cannot be determined how long the entire application package will be, which in turn, will impact the format of the final form. It is envisioned that the applicant will be able to complete the two-page application, and the supplemental form for non-citizens if required, and retain the remaining information for later reference.

South Carolina is printing their redesigned application form in different colors for distribution to various sites. Such an approach would enable the District to assess how applicants are being reached and to gauge the effectiveness of its outreach efforts. For example, applications distributed through school and day care mailings can be printed in one color, applications provided to contracted application assistance sites another color, and those available at IMA service centers still another color.

2. VERIFICATION AND DOCUMENTATION REQUIREMENTS

Related to the issue of what data to capture on the application form is the question of what data must be verified. For each data element captured by the application--for example, the customer's name, date **of** birth, citizenship, and income--the District must determine whether verification is required, and if ***so,*** what form that verification will take.

The tradeoff in this instance is between ease of application for the customer versus accuracy of eligibility determination for the District. The more documentation that the District requires of CHIP applicants, the more cumbersome the process will become and the less realistic a process built around the mailing of applications. Conversely, the more the District accepts without verification the information provided on the application, the more likely that eligibility errors will be made due to accidental or deliberate misinformation given by the applicant.

MAXIMUS recommends that no more than two types of documentation be required of applicants to support verification of information provided on the application:

- Copy of valid District driver's license or other proof of residence, such as, rent/mortgage receipt, non-relative landlord statement, or a utility bill; and

- Documentation of income, such as **W-2** statements, copies of check stubs, employer verification, self-employment records, and child support agreements.

This approach strikes a balance between ease of application and the District's responsibility to ensure that only eligible applicants be enrolled in CHIP. The documentation requirements are limited enough that applicants can reasonably be expected to copy and mail the required materials.

Exhibit VII-1 (Page 3 of 3)
APPLICATION FORM

RIGHTS AND RESPONSIBILITIES

I understand that I will be asked to provide proof of the information that I have given in this application. If the Department has reason to get a verification for me, the Department will obtain my signed permission first. If I refuse to provide the proof or if I refuse to give my permission. I understand that my application for Medical Assistance may be denied.

I understand that the Department of Human Services will verify some of the information that I have given by using the computer matching system. My permission is not required for this. During this process, the Department will take care to protect my rights to confidentiality.

I understand that I must report any changes in my situation that might affect my eligibility and I agree to report such changes no later than 10 days afler the changes occur.

I understand that my case may be chosen for a Quality Control review. This is a detailed review of all of the information in the case record and may include some personal interviews. If my case is chosen, I agree to cooperate fully with the state or federal Quality Control representatives. If I do not cooperate, my Medical Assistance may be terminated.

I understand that if I believe I have been discriminated against because of my race, color, national origin, mental or physical handicap, or any other reason, I may file a complaint with 180 days to the D.C. Department of Human Services.

I understand that if I am dissatisfied with any action or lack of action by the Department I may ask for a fair hearing.

I understand that in the event of my death the Department will make a claim against my estate for the amount of Medical Assistance paid on my behalf afler my 65th birthday. The Department will not make a claim if I die leaving a surviving husband or wife or a child who is under age 21 or who is blind or permanently and totally disabled.

I understand that if I am eligible for Medical Assistance I am required to use all other available resources such as my health insurance, Medicare, Blue Cross/Blue Shield, veterans' insurance, and veterans' medical facilities before I use my Medical Assistance coverage.

I understand that by signing this application I am assigning to the Department the right to collect payments from any health insurance company, other kind of insurance company. or any other person or organization that is responsible for my medical expenses. If I receive a payment directly from an insurance company or from someone else for a medical bill that has been paid by the Department, I agree to repay the Department from the money I receive.

I understand that by signing this application I am accepting responsibility for this application, and that I am liable to criminal penalties if I have made any false or misleading statements, if I have willfully withheld information, or if I fail to report changes promptly. I understand that the maximum penalty for welfare fraud is a fine of $1,000 and a jail sentence of three years.

MEDICAID WELL-CHILD PROGRAM

The Well-Child Program provides free check-ups and treatment to Medicaid eligible children under age 21. The Well-Child Program is very important and can be obtained from any doctor or clinic participating in the Medicaid program. The Well-Child Program also helps in scheduling appointments and providing transportation to the doctor's office., For help in scheduling appointments and providing transportation. call 1-800-MOM-BABY. For more information about the program, call (202) 727-0725.

PLEASE DETACH AND KEEP THIS PAGE. MAIL THE COMPLETED AND SIGNED APPLICATION, TOGETHER WITH PROOF OF YOUR INCOME AND PROOF THAT YOU LIVE IN THE DISTRICT OF COLUMBIA, TO:

DC Healthy Families
Post Office Box #####
Washington, DC #####-####

Exhibit VII-1 (Page 2 of 3)
APPLICATION FORM

Source of Income	Who Receives This Income?	Amount of Income	How Often Is the Income Received?
Child Support		$	
Alimony		$	
Social Security Benefits		$	
SSI		$	
Other (please explain)		$	

5. If you pay for child care (or care for an adult who cannot care for himself) so that someone in your household can work, please give us the following Information

Name of Person Who Works	Person(s) *Cared* For	Monthly Amount Paid

6. If you make payments to support someone not included in the household, please give us the following

Name of Person Who Pays Support	Amount Paid	How Often Paid?	For Whom Is the Support Paid	Relationship
	$			
	$			

Name(s) of Applicant(s) With Health Insurance	Type of Insurance (major medical, HMO. cancer. etc.)	Name of Insurance Company	Group Number	Policy Number

Signature of Applicant _____ **Date:** _____
(LEGAL SIGNATURE **OR** "X" MARK)

Signature of Witness to an "X" Mark _____ **Date:** _____
(A witness is required only if the applicant makes an "X" mark instead of signing his or her name.)

If you need help completing this form, please call us at ###-####

Exhibit VII-1 (Page 1 of 3)
APPLICATION FORM

DC Healthy Families
DC Healthy Kids

M		
Home Phone	Work Phone	Phone for Messages

2. List everyone living in your household (attach extra page if necessary)

Name (Last, First, Middle)	Date of Birth	Sex (M/F)	Race	Pregnant (Y/N)	Relationship to You	Applying for Benefits (Y/N)	Social Security Number (if applying for benefits)

. List all income received from employment by memb s of the household (including self-employment)

Your Gross Income	Spouse's *or* Other Household Membeh Gross Income
Amount earned: $_____	Amount earned: $_____
Hourly Weekly Monthly Yearly (drdeone)	Hourly Weekly Monthly Yearly (drdeone)
Hours worked each week _____	Hours worked each week: _____
Employer Name and Phone Number:	Employer Name and Phone Number:
If y check here and itt: lis of n and phone numbers SELF EMPI	I s I p e c here I: list of customers and phone numbers ____ S I

	Date Received: _____	Local Office: _____
OFFICE USE ONLY	DCID Number: _____	Case Number: _____
	Worker: _____	Date of Disposition: _____

ATTACHMENT C

BUDGET PRINCIPLES

The District's CHIP Program--Healthy *DC Kids*--will provide health insurance coverage to all uninsured children who: (a) are under age 19; (b) are District residents; (c) who live in families with income up to 200 percent of the federal poverty level (FPL); (d) who are not Medicaid eligible under current eligibility criteria; and (e) who meet all other statutory eligibility requirements.

It is estimated that approximately 8,401 children will enroll in CHIP. CHIP enrollees will receive the same benefits package as that received by children enrolled in the regular Medicaid Program. In addition, the District plans to provide services to CHIP-enrollees through the same delivery model designed for TANF and TANF-related mothers and children--managed care. As in the regular Medicaid program, behavioral health services and long-term care services will be carved out and reimbursed on a fee-for-service basis.

Using a per-capita cost for covering children under the existing Medicaid managed care plans for AFDC and AFDC-related persons (plus an allowance for mental health services and other costs not included under capitation), it is estimated that the average per person per month cost of providing coverage to CHIP-enrolled children is $114 per month in fiscal year 1999.

An average annual rate of growth in per-capita costs for this group--3.75 percent--was arrived at based on the estimated average annual rate of growth in per-capita costs for children in the District's Medicaid Program between 1993 through 1997. Thus total costs over fiscal years 1999 through 2003 will be an estimated $57,403 million, of which, 79 percent ($45,348 million) will be paid by the federal government. The District's share of program costs are approximately $12,055 million over the same period of time.

The District plans to begin enrolling children in CHIP beginning October 1998. Therefore, we expect an average monthly enrollment of 5,479 children in F N 1999 at an average per person per month cost of $114. The City plans to spend the full 10 percent (the maximum allowed by federal law) of the total amount of benefits expenditures on some combination of the following: (a) costs associated with operating CHIP; (b) costs associated with making changes in the eligibility determination system; and (c) costs associated with the development and implementation of an outreach and education strategy.

In F/Y 2000 we expect average monthly enrollments of 7,678 children and a per member per month coverage rate of $118. Again, we plan to spend 10 percent of the total amount of benefits expenditures on activities as cited above. In F/Y 2001 we expect average monthly enrollments of 8,429 and a per member per month coverage rate of $123.

ATTACHMENT C

Fiscal Year 1999 CHIP Budget

Benefits Expenditures'	$7,495,272.00
Administrative Expenditures	$ 832,808.00
Total Expenditures	$8,328,080.00
Federal Share of Expenditures	$6,579,183.00
State Share of Expenditures	$1,748,897.00

Fiscal Year 2000 CHIP Budget

Benefits Expenditures[2]	$10,872,048
Administrative Expenditures	$ 1,208,053
Total Expenditures	$12,080,053
Federal Share of Expenditures	$ 9,543,212
State Share of Expenditures	$ 2,536,841

'Benefit expenditures derived as follows: Projected average monthly enrollment of 5,479children x 12 months in FN 1999 x $114 per person per month cost of providing coverage = $7,495,272.

[2]Benefit expenditures derived as follows: Projected average monthly enrollment of 7,678children x 12 months in F/Y 2000 x $118 per person per month cost of providing coverage = $10,872,048.

ATTACHMENT C

Fiscal Year 2001 CHIP Budget

Benefits Expenditures[3]	$12,441,204
Administrative Expenditures	$ 1,382,356
Total Expenditures	$13,823,560
Federal Share of Expenditures	$ 10,920,612
State Share of Expenditures	$ 2,902,948

Fiscal Year 2002 CHIP Budget

Benefits Expenditures[4]	$12,973,812
Administrative Expenditures	$ 1,441,534
Total Expenditures	$14,415346
Federal Share of Expenditures	$ 11,388,123
State Share of Expenditures	$ 3,027,223

[3]Benefit expenditures derived as follows: Projected average monthly enrollment of 8,429children x 12 months in F N 2001 x $123 per person per month cost of providing coverage = $12,441,204.

[4]Benefit expenditures derived as follows: Projected average monthly enrollment of 8,513children x 12 months in F/Y 2002 x $127 per person per month cost of providing coverage = $12,973,812.

ATTACHMENT C

Table 4
The Cost of Covering Children through 200 Percent of Poverty in the District under the Children's Health Insurance Program (CHIP)

	Assumptions					
	Average Monthly Number of Children a/	Per Member Per Month Cost b/	Percent Growth in Per-Capita Costs c/	Total Spending (in thousands)	Federal Share (in thousands)	District Share (in thousands)
1998	--	$110	-4.44%	--	--	--
1999	5,479 a	$114	3.75%	$7,495	$5,921	$1,574
2000	7,678	$118	3.75%	$10,872	$8,589	$2,283
2001	8,429	$123	3.75%	$12,441	$9,828	$2,613
2002	8,513	$127	3.75%	$12,974	$10,249	$2,725
2003	8,599	$132	3.75%	$13,621	$10,760	$2,861
1998 - 2003				**$57,403**	**$45,347**	$12,056

a/ Lewin Group estimates using the District of Columbia subsample of a pooled cross-section of Current Population Survey (CPS) data for 1995 and 1996, developed by the Bureau of the Census. Enrollment is adjusted in each year to reflect Bureau of the Census projections showing a trend towards reduced population in the District through the year 2000 followed by slow population growth thereafter.

b/ Per-capita costs in 1998 were estimated based upon actual District managed care payment rates in 1998 adjusted to reflect the actual age composition of the newly eligible population. These rates were adjusted further to include mental health, long-term care, and retrospective eligibility month costs. Estimates also include an allowance for program administrative costs equal to 3.41 percent of benefits costs.

c/ Per-capita costs were assumed to grow at the average annual rate of growth in costs over the 1993 through 1997 period for children in the District of Columbia (3.75 percent).

d/ Enrollment is assumed to begin on October 1, 1998. Based upon an analysis of enrollment growth under prior Medicaid expansions, we assumed that enrollment will phase in over a 24-month period as newly eligible persons learn of their eligibility between October 1, 1998 and September 30, 2000. We assume that enrollment in the initiative will reach 8,346 children by September 30,2000. Average monthly enrollment in 1999 would be equal to 65 percent of enrollment at the end of FY 2000. Average monthly enrollment in 2000 is assumed to be equal to 92 percent of enrollment at the end of FY 2000.

Source: Lewin Group estimates using the State Medicaid Eligibility Model (SMEM).