

**Questions and Comments on Washington State's Children's Health
Insurance Program
Title XXI State Plan**

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

1. Please provide assurances 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.

Answer:

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

**Section 2 General Background and Description of State Approach
Section 2.1**

2. According to the Washington State Population Survey (WSPS), about 10,000 children in the state between 200% and 250% of the Federal Poverty Level (FPL) have no health insurance coverage. Is this the target population for Washington CHIP?

Answer:

Yes, these children are the CHIP target population.

Section 2.2.1

3. How is the State targeting diverse cultural populations for CHIP outreach and enrollment?

Answer:

As part of the current outreach contracting process, the Medical Assistance Administration (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, aliens, immigrants, and homeless individuals. These plans are evaluated, and must be approved, by MAA staff. MAA staff also participate in routine community meetings with outreach contractors and

community based representatives to discuss outreach activities.

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

**Section 3 General Contents of the State Child Health Plan
Section 3.1**

4. Mental health services will be provided through prepaid health plan coverage which the State's Mental Health Division contracts with public Regional Support Networks (RSN's) to provide such services. What efforts has there been to ensure coordination of referral and service provisions between Medical Assistance Administration (MAA), Mental Health (MH) and the Division of Alcohol and Substance Abuse (DASA) for mental health or alcohol/substance abuse treatment services? Please explain the coordination efforts between the HO and/or FFS contractor and the RSN?

Answer:

Substance Abuse Services

The CHIP managed care contracts will parallel the Healthy Options (HO) contracts. 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 out-patient treatment providers. Each county has a Alcohol and Drug Coordinator who administers the drug and alcohol programs for their county. These procedures will be followed for CHIP clients as well.

Mental Health Services

In September 1998, the Mental Health Division (MHD) and Medical Assistance Administration (MAA) completed a series of meetings with stakeholders to create a joint mental health policy statement. Included in these meetings were representatives from Regional Support Networks (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. 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 a treatment that is expected to be necessary if more than 12 hours is needed to stabilize a patient in a given 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 Mental Health Division (MHD) to assure coordinated care. MAA sends a monthly tape to the MHD identifying Medicaid clients and their eligibility group. MAA will append to this list those clients covered by CHIP.

5. Please describe any lock-in and disenroll requirements for participating managed care plans. If a child is determined to be eligible for CHIP, is there a time frame (30, 60 days) in which the enrollee has to choose a managed care plan. If the child does not select a plan, will the State auto assign the child to a plan.

Answer:

Unlike the state's Medicaid program, a household must select a plan for their child as part of the application process. Clients will not be assigned to managed care plans.

Once enrolled in managed care, clients will have a 60-day grace period. During this grace 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 selected a plan wants to disenroll 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 network adequacy problems; or,
8. To rectify a documented department error.

Section 3.2

6. The State has described the utilization controls that will be used for HO plan. Does the State have utilization control methods for mental health and alcohol/substance abuse services?

Answer:

As described above, MAA and the managed care plans provide very limited substance abuse and mental health benefits to HO enrollees. To the extent such services are provided, their utilization is managed in accordance with federal requirements and contract terms. This will also be the case for CHIP clients.

The vast majority of mental health and alcohol/substance abuse services are provided by DASA and the mental health Regional Support Networks (county entities.) Once a client is referred to DASA or an RSN, those entities manage utilization in accordance with federal laws and rules, (currently approved) Medicaid waivers, and state laws and rules.

Section 4 Eligibility Standards Section 4.3.

7. Under methods of establishing eligibility (Section 4.3, p. 14), "clients will not need to provide proof of income; declared amounts will be sufficient. Similar to the Categorically needy program, only non-citizens will have to show proof of their immigration status. We recommend that the State clarify this section to ensure that only non-citizens applying for benefits must show proof of immigration status, and not others in the household or those who may actually be filing out the application. HCFA's September 10, 1998 letter to State Health officials states, "Children... who are qualified aliens must present documentation of their immigration status. The citizenship or immigration status of non-applicant parents (or other household members), however, is irrelevant to their children's eligibility. States may not require that parents disclose this information.

Answer:

The client application asks whether the applicant is a citizen. The question is directed toward those for whom an application is being made. We do not ask the immigration

status of the parents, when they are applying for the child. Also, procedures for financial workers state that the citizenship or immigration status of non-applying parents is not considered when making a determination regarding the child's eligibility.

If the applicant is a non-citizen, there is a second level of questions asking if the applicant is a lawful permanent resident and the entry date. Only at this point, do we ask for proof of the status. These questions resulted from negotiations with Columbia Legal Services.

9. The Medical Assistance Administration (MAA) will use two standardized application forms to make eligibility determinations - one for clients applying for the Medicaid children's medical program and the other form 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. States may require Social Security Number (SSN) only for applicants for and beneficiaries of Medicaid benefits, and may not be required for other persons in the household. Please clarify if Washington's application meets these requirements.

Answer:

Yes, the application meets HCFA's requirements. MAA will not require CHIP applicants to have a Social Security Number. If otherwise eligible, clients will be enrolled into CHIP without having a Social Security Number.

9. Please provide details concerning the process for appeal of eligibility denials.

Answer:

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 call the Office of Administrative Hearings (OAH) to set up a hearing. OAH notifies the client and the agency's Fair Hearings 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 needed to the courts.

Section 4.4.3

10. Section 2101(b)(3)(c) requires that the State describe procedures to assure that CHIP does not substitute for coverage under group health plans. The crowd out concerns increase at higher levels of poverty. If Washington will not impose "waiting periods" for eligibility if the child previously had other health insurance coverage, what procedures does the State plan to implement to avoid families dropping private coverage for the State's CHIP plan.

Answer:

Washington will not initially impose an "eligibility waiting period" as a strategy to address potential CHIP "crowd out." Applicants will be required to report whether they currently have any health insurance coverage and whether they had coverage within the prior six-months. As required under Section 2110(b)(1)(C), applicants currently having creditable health insurance coverage will be denied eligibility. Applicants reporting that they had insurance coverage within the past six months will not be denied eligibility on that basis.

To monitor for crowd out, MAA will contact all applicants' households reporting insurance coverage within the past six months to determine why the applicant did not have insurance coverage at the time of CHIP application. MAA will develop the telephone survey instrument in coordination with HCFA to ensure that both agencies' concerns about why applicants no longer have coverage are addressed. The interview findings will be reported on a semi-annual basis to HCFA, the Governor, and State Legislative Committees.

If it is found that 10% or more of the CHIP enrollees had other insurance coverage prior to CHIP enrollment and elected to drop that coverage in order to enroll in CHIP, MAA will develop other strategies to reduce crowd out. These may include waiting periods, increased premium payment requirements, and/or other methods. MAA will submit these strategies to HCFA for review prior to taking necessary legislative or rule making action.

Although Washington will not be adopting waiting periods for CHIP, the program will have cost-sharing requirements that discourage crowd out. Families will be required to pay a \$10 per child monthly premium, with a \$30 family maximum. In addition, the family will be required to make co-payments for physician, certain drug prescriptions and emergency room usage. On average, the family will incur \$25 per month per child in cost-sharing requirements.

We have summarized research on crowd out in Attachment 1.

Section 5 Outreach and Coordination
Section 5.1

11. MAA is reimbursing contractors a monthly rate and a \$20.00 incentive for each client a contractor helps to enroll. How does the state reconcile the actual cost per program?

Answer:

All contractors are governmental entities (i.e., county government, health districts, or tribal authorities) and are required to account for federal outreach funds in accordance with federal requirements. MAA reimburses contractors using a combination of a set rate and a \$20 fee for each HO enrollment. When a contractor assists a client to make application, they may also help the client complete and mail in a managed care enrollment form. If so, they insert a two-digit code on the top of the form and MAA staff enter that information once the enrollment is approved and entered to the payment system.

Section 7 Quality and Appropriateness of Care
Section 7.1

12. As mental health and alcohol/substance abuse services are contracted separately, what methods (external and internal monitoring) will the State use to assure quality, and appropriateness of care for these services?

Answer:

As described above, MAA and the managed care plans provide very limited substance abuse and mental health benefits to HO enrollees. To the extent such services are provided, quality assurance is monitored in accordance with federal requirements and contract terms (many of which are NCQA

standards.) This will also be the case for CHIP clients.

The vast majority of mental health and alcohol/substance abuse services are provided by DASA and the mental health Regional Support Networks (county entities.) Once a client is referred to DASA or an RSN, those entities monitor quality assurance in accordance with federal laws and rules, (currently approved) Medicaid waivers, and state laws and rules.

Section 8 Cost Sharing and Payment

Section 8.1

13. The State has opted to impose cost-sharing for children under the plan. Will the State impose cost sharing for American Indians/Alaska Natives?

Answer:

No. American Indians/Alaska Natives (AI/AN) will not be subject to either CHIP premium or co-payment cost-sharing requirements. AI/AN stakeholder groups have been notified of this policy.

Section 8.2.1 Premiums

14. Failure to make premium payments, in accordance, with MAA's due process, will result in disenrollment and a waiting period to reenroll. What type of disenrollment procedures will be in place to notify the family and to give them a chance to make the premium payments before they are disenrolled and subject to a waiting period to reenroll? How is the family notified? How many disenrollments warning do they receive before actual disenrollment? How long is the waiting period before the beneficiary may reenroll?

Answer:

Households will be required to make premium payments for their children in CHIP. The monthly premium will be \$10 per child, with a family maximum of \$30 per month. On average, the CHIP premium amounts are less than 2% of the household's monthly gross income.

At the time a child is determined eligible for CHIP, the household will be sent a billing statement indicating the monthly amount due (i.e., \$10 per child, with a \$30 family

maximum). Households will not be required to send in the premium amounts as a condition of initial CHIP eligibility. Households may make monthly payments or make additional payments for any prospective period (month, quarter, year, etc.).

Thereafter, households with enrolled children will receive monthly billing invoices. The monthly statements will include the amount due for the current month and the amount past due. For past due accounts, clients will receive information on MAA's payment policies and appeal rights. Households will be able to carry a past-due balance for a minimum of three months and still retain coverage for their child.

Children with delinquent balances beyond those described above (i.e., a minimum of 3 months), will be terminated from CHIP. There will be no policy exceptions. It should be noted that any households incurring a loss of income will be able to immediately enroll their child into Medicaid, which offers the same coverage through the same plans with no cost-sharing requirements. Thus, the child's continuity of care will be assured. Also, CHIP rules will allow for MAA to have "exception to policy authority" to allow the state to grant exceptions for extenuating circumstances.

If a child is terminated from CHIP for failure to pay outstanding premiums, they will be prohibited from re-enrolling for a minimum of 90 days. To become eligible and re-enroll in CHIP, the household will be required to pay for delinquent premium payments.

The issuance of billing statements, receipt of premiums, and managing an accounts receivable system will be administered by DSHS, Division of Finance, Office of Financial Recovery (OFR). The decision to terminate a child for failure to pay outstanding premiums will be made by MAA Division of Client Support, Medical Eligibility Determination Services section (MEDS).

Section 8.2.3 Coinsurance

15. The State has proposed to charge a \$5.00 co-payment for name brand drugs. In instances where there is no generic substitute will the State still charge the \$5.00 co-payment?

Answer:

Yes. The \$5 name brand prescription drug co-payment will be charged when there is a name brand with no generic substitute.

Section 8.5

16. How will the state ensure that families who reach the 5% limit are no longer held liable for cost-sharing. Will the State develop instructions for enrollees on how to document and track expenditures and how to request a relief when the cap amount is reached?

Answer:

As described in Section 8.5 of Washington's CHIP application, MAA's consulting actuary (Milliman & Robertson, Inc.) has calculated that the aggregate actuarial value of the CHIP cost-sharing (premiums and co-payments) will be no more on average than \$300 per-child per-year, with a \$900 annual family maximum. This amount is no greater than 3.0% for any household, and on average is less than 2.0% of household income.

However, an individual family could incur greater cost-sharing due to high co-payments from extraordinary medical costs. The DSHS CHIP enrollee handbook will include information on family maximum cost-sharing limits and how to submit necessary documentation to MAA for repayments of amounts in excess of the 5.0% limit. It should be noted that Medicaid Medically Needy (MN) beneficiaries are already required to track and document medical expenditures to obtain and retain MN medical coverage.

During the next contracting cycle for managed care services, MAA will discuss with plans whether they can track and administer a maximum annual co-payment amount for their members. If this is possible, MAA may include this provision in future contracts. This option would eliminate the requirement for households to track and document medical expenditures for managed care services.

Section 9 Strategic Objectives and Performance Goals for the Plan Administration

Section 9.2

17. Performance goals for the five objectives do not include measurable rates. Please indicate such and provide us

with the specific goals and measurements. Please see the enclosed attachment from the HCFA web page for examples of the type of information which we are seeking.

Answer:

STRATEGIC OBJECTIVES & PERFORMANCE MEASURE GOALS

- 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))

Performance Goal 1.1

- ! Increase the number of children between 200% and 250% of FPL who have health care coverage.

Performance Measure 1.1:

- ! Increase the number of children between 200% and 250% of FPL who have health care coverage.
- ! Baseline: Number of children in 1998 who were insured. The Office of Financial Management's (OFM) Forecasting Section is revising the 1998 estimates for an under-count of children and other adjustments.
- ! Target: The percent increase in the insured number of children between 200% and 250% of FPL in 2000 will be greater than the general increase in Washington State's children's population.
- ! Source: Washington State Population Survey. The survey is conducted every two years. Therefore, the performance measure will be reported every two years.

Performance Goal 1.2

Reduce the percentage of uninsured children between 200% and 250% of FPL.

Performance Measure 1.2:

- ! Reduce the percentage of uninsured children between 200% and 250% of FPL.
- ! Baseline: Percentage of children in 1998 who were uninsured. OFM Forecasting Section is revising the 1998 estimates for an under-count of children and other adjustments.
- ! Target: The reduction in the uninsured percent of children between 200% and 250% of FPL in 2000 will be greater than the change in the rate for children in households greater than 250% of FPL.
- ! Source: Washington State Population Survey. The performance measure will be reported every two years.

Performance Goal 1.3

Increase the number of children below 200% of FPL who have health care coverage.

Performance Measure 1.3:

- ! Increase the number of children below 200% of FPL who have health care coverage.
- ! Baseline: Number of children in 1998 who were insured. OFM Forecasting Section is revising the 1998 estimates for an under-count of children and other adjustments.
- ! Target: The percent increase in the number of insured number of children below 200% of FPL in 2000 will be greater than the general increase in children's population.
- ! Source: Washington State Population Survey. The

performance measure will be reported every two years.

Performance Goal 1.4

Reduce the percentage of uninsured children below 200% of FPL

Performance Measure 1.4:

- ! Decrease the percentage of uninsured children below 200% of FPL.
- ! Baseline: Percentage of children in 1998 who were uninsured. OFM Forecasting Section is revising the 1998 estimates for an under-count of children and other adjustments.
- ! Target: The reduction in the uninsured percent of children below 200% of FPL in 2000 will be greater than the change in uninsured rate for children in households greater than 250% of FPL.
- ! Source: Washington State Population Survey. The performance measure will be reported every two years.

Performance Goal 1.5

Track the satisfaction and health care of CHIP children compared to Medicaid children and non-Medicaid children.

Performance Measure 1.5.A:

- ! CHIP enrollee satisfaction with their personal doctor or nurse, specialist, health care, and health plan.
- ! Baseline: CHIP enrollee rating of their personal doctor or nurse, specialist, health care, and health plan. Baseline will be obtained from the 2001 survey of enrollees based upon their experience in 2000. Because of the small CHIP population, the composite measures will be for the CHIP program, and not individual plan basis.
- ! Target: The CHIP rating will be at least the same as their Medicaid children's counterparts for these four

composite measures. Because of the small CHIP population, the composite measure comparisons will be on an overall program basis, and not individual plan basis.

- ! Source: Medical Assistance Administration's (MAA) Consumer Assessment of Health Plans (CAHPS). MAA administers the CAHPS survey annually. Because the survey protocol requires enrollees to be in a health plan for at least six-months, the first CAHPS survey of CHIP enrollees will be conducted in 2001 as part of the Medicaid CAHPS survey process.

Performance Measure 1.5.B:

- ! Percent of CHIP enrolled children who turned two during the reporting year who received their childhood immunizations.
- ! Baseline: The baseline immunization rate will be calculated in 2002 for enrollees who turned two during 2001. Because of the small CHIP population, the immunization rate will be for the CHIP program, and not individual plan basis.
- ! Target: The CHIP immunization rate will be at least the same as their Medicaid children's counterparts for this measure. The CHIP and Medicaid children also will be compared with their "commercial population" counterparts. Because of the small CHIP population, the rate comparisons will be on an overall program basis, and not individual plan basis.
- ! Source: MAA will contract with its external review organization to measure CHIP childhood immunization rates using the HEDIS Childhood Immunization Status measure protocols for the Medicaid population. Because HEDIS requires the child to have been continuously enrolled in their health plan for the prior 12 months, the measure cannot be obtained for 2000.

Performance Measure 1.5.C:

- ! Percent of CHIP enrolled children whose 13th birthday was the reporting year and who received their

adolescent immunizations.

- ! **Baseline:** The baseline immunization rate will be calculated in 2002 for enrollees who turned 13 during 2001. Because of the small CHIP population, the immunization rate will be for the CHIP program, and not individual plan basis.
- ! **Target:** The CHIP immunization rate will be at least the same as their Medicaid adolescent counterparts for this measure. The CHIP and Medicaid adolescent rates also will be compared with their "commercial population" counterparts. Because of the small CHIP population, the rate comparisons will be on an overall program basis, and not individual plan basis.
- ! **Source:** MAA will contract with its external review organization to measure CHIP adolescent immunization rates using the HEDIS Adolescent Immunization Status measure protocols for the Medicaid population. Because HEDIS requires the child to have been continuously enrolled in their health plan for the prior 12 months, the measure cannot be obtained for 2000.

Section 9.10

18. Please provide a budget for three years. As part of this budget, please provide additional detail on administrative spending and the assumptions on which the budget is based including estimated enrollment.

Answer:

Enclosed is an Excel spreadsheet with the requested 3-year budget estimates.

Exhibit 1 is the estimated number of uninsured children who would be eligible for CHIP. These estimates are derived from the 1998 Washington State Population Survey (WSPS). They are the most current and accurate estimates of the number of Washington State's uninsured children between 200% and 250% of the federal poverty level.

Exhibit 2 is a table with the caseload growth rates for Washington's Medicaid children expansion from 100% to 200% of FPL that was implemented in July 1994. This caseload growth rate was used to develop the Governor's 1999-2001

CHIP budget request that was funded by the 1999 State Legislature for July 1, 1999 through June 30, 2001.

Exhibit 3 is a table with CHIP administrative staffing workload estimates. These estimates assume a full-time CHIP program manager plus the estimated workload impact on MAA's eligibility staff (MEDS), enrollment/complaint lines, and MMIS claims processing. The workload estimates are based on Medicaid standards. These estimates were developed to determine whether there would be a Title XXI matching shortfall due to the 10% administrative limits.

Exhibit 4 is the set of assumptions and projections used in the Governor's 1999-2001 CHIP budget request. The estimates include CHIP caseload and per-capita cost estimates used to estimate total program costs, administrative costs estimated at 10% of program costs, non-Title XXI matching start-up costs, and source of fund estimates. The per-capita costs are based on the November 1998 projected per-capita costs that were included in the Governor's 1999-2001 budget request. The per-capita costs have been off-set for a \$25.00 per-month cost-sharing (premiums and co-payments). The per-capita costs were increased at the rate of 3.9% for each state fiscal year (SFY). This trend factor was in the November 1998 forecast used to develop the Governor's request legislation. The source of fund estimates use Washington's rate for federal fiscal year (FFY) 1998 CHIP match rate, which is 66.28%. It should be noted that the \$100,000 start-up costs are financed by only state funds, because of the 10% administrative limit. The above assumptions have been used to generate preliminary budget estimates for FFY 2000 through 2002.

Exhibit 5 is a summary table with Washington's preliminary CHIP budget for both the 1999-2001 state biennium and FFY 2000-2002. The 1999-2001 appropriation act funded Washington's CHIP at the levels set forth in this document.

These estimates were based on the best available information as of December 1998. There are a number of factors impacting these estimates that will likely change. The caseload estimates assume that nearly all uninsured children will be enrolled in CHIP by April 2001 and that there will be 2,000 children enrolled at the start of the program in January 2000. These are optimistic estimates that may need to be revised due to the deterioration in BHP Nonsubsidized coverage of children, effectiveness of the Medicaid Outreach Project, and the impact of cost-sharing

Answer:

The State of Washington makes assurances that it will not claim administrative match in excess of the limits set forth in Title XXI of the Social Security Act. Administrative expenditures in excess of this limit will be borne by the state.

21. Please include in your budget any offsets of cost from cost sharing amounts collected from enrollees. In preparing the budget, the cost sharing amounts received by the state should reduce the program expenditures.

Answer:

As required under Title XXI, the state will off-set collected premiums in determining the amount of expenditures to be claimed under Title XXI. Also, the CHIP rates paid to contractors will be offset for co-payment amounts that are to be paid by CHIP enrollees or their households.