
Table of Contents

State/Territory Name: Washington

State Plan Amendment (SPA) #: WA-20-0003

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) State Plan Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850



Children and Adults Health Programs Group

November 3, 2021

Charissa Fotinos, Interim Medicaid Director
Health Care Authority
626 8th Avenue SE
Post Office Box 45502
Olympia, WA 98504-5502

Dear Ms. Fotinos:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) number WA-20-0003, submitted on June 30, 2020, with additional information received on October 10, 2021, has been approved. Through this SPA, Washington has demonstrated compliance with section 5022 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act. This SPA has an effective date of October 24, 2019.

Section 5022 of the SUPPORT Act added Section 2103(c)(5) to the Social Security Act (the Act) and requires child health and pregnancy related assistance to include coverage of services necessary to prevent, diagnose, and treat a broad range of behavioral health symptoms and disorders. Additionally, Section 2103(c)(5)(B) of the Act requires that these behavioral health services be delivered in a culturally and linguistically appropriate manner. Washington provided the necessary assurances and benefit descriptions to demonstrate compliance by providing a range of behavioral health services in a culturally and linguistically appropriate manner.

Your Project Officer is Shakia Singleton. She is available to answer your questions and other CHIP-related matters. Her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-8102
E-mail: Shakia.Singleton@cms.hhs.gov

Page 2 – Ms. Charissa Fotinos

If you have additional questions, please contact Emily King, Deputy Division Director, Division of State Coverage Programs, at (443) 478-6811. We look forward to continuing to work with you and your staff.

Sincerely,

/Signed by Amy
Lutzky/

Amy Lutzky
Deputy Director

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

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new Title XXI, the State Children's Health Insurance Program (CHIP). Title XXI provides funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR Part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

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

State/Territory: **Washington**

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40 (b))

(Signature of Governor, or designee, of State/Territory, Date Signed)

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

The following State officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: **Sue Birch**

Position/Title: Director, Health Care Authority

Name: **Charissa Fotinos** Position/Title: Medicaid and CHIP Director, Health Care Authority

Name:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this Form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 1005-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children’s Health Insurance Program (CHIP). In February 2009, the Children’s Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, further modified the program. The HEALTHY KIDS Act and The Bipartisan Budget Act of 2018 together resulted in an extension of funding for CHIP through federal fiscal year 2027.

This template outlines the information that must be included in the state plans and the State plan amendments (SPAs). It reflects the regulatory requirements at 42 CFR Part 457 as well as the previously approved SPA templates that accompanied guidance issued to States through State Health Official (SHO) letters. Where applicable, we indicate the SHO number and the date it was issued for your reference. The CHIP SPA template includes the following changes:

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
 - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
 - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
 - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
 - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
 - Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
 - Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
 - Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.
- Added new provisions related to delivery methods, including managed care, to section 3 (81 FR 27498, issued May 6, 2016)

States are not required to resubmit existing State plans using this current updated template. However, States must use this updated template when submitting a new State Plan Amendment.

Federal Requirements for Submission and Review of a Proposed SPA. (42 CFR Part 457 Subpart A). In order to be eligible for payment under this statute, each State must submit a Title XXI plan for approval by the Secretary that details how the State intends to use the funds and fulfill other requirements under the law and regulations at 42 CFR Part 457. A SPA is approved in 90 days unless the Secretary notifies the State in writing that the plan is disapproved or that specified additional information is needed. Unlike Medicaid SPAs, there is only one 90-day review period, or clock for CHIP SPAs that may be stopped by a request for additional information and restarted after a complete response is received. More information on the SPA review process is found at 42 CFR 457 Subpart A.

When submitting a State plan amendment, states should redline the changes that are being made to the existing State plan and provide a “clean” copy including changes that are being made to the

existing state plan.

The template includes the following sections:

1. **General Description and Purpose of the Children’s Health Insurance Plans and the Requirements-** This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR, 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination-** This section should provide general information related to the special characteristics of each state’s program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls-** This section requires the State to specify its proposed method of delivery. If the State proposes to use managed care, the State must describe and attest to certain requirements of a managed care delivery system, including contracting standards; enrollee enrollment processes; enrollee notification and grievance processes; and plans for enrolling providers, among others. (Section 2103); (42 CFR Part 457. Subpart L)
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)
5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42 CFR 457.90)
6. **Coverage Requirements for Children’s Health Insurance-** Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))
7. **Quality and Appropriateness of Care-** This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State’s use in monitoring and

evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality-of-care function. (Section 2107); (42 CFR 457.495)

8. **Cost Sharing and Payment-** This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance, and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration-** The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low-income children under the plan for maximizing health benefits coverage for other low-income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations-** Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low-income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)
11. **Program Integrity-** In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections-** This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

Program Options. As mentioned above, the law allows States to expand coverage for children through a separate child health insurance program, through a Medicaid expansion program, or through a combination of these programs. These options are described further below:

- **Option to Create a Separate Program-** States may elect to establish a separate child health program that are in compliance with title XXI and applicable rules. These states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children and also must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid.
- **Option to Expand Medicaid-** States may elect to expand coverage through Medicaid. This option for states would be available for children who do not qualify for Medicaid under State rules in effect as of March 31, 1997. Under this option, current Medicaid rules would apply.

Medicaid Expansion- CHIP SPA Requirements

In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:

- 1 (General Description)
- 2 (General Background)

They will also be required to complete the appropriate program sections, including:

- 4 (Eligibility Standards and Methodology)
- 5 (Outreach)
- 9 (Strategic Objectives and Performance Goals and Plan Administration including the budget)
- 10 (Annual Reports and Evaluations).

Medicaid Expansion- Medicaid SPA Requirements

States expanding through Medicaid-only will also be required to submit a Medicaid State plan amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the description of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:

- 3 (Methods of Delivery and Utilization Controls)
- 4 (Eligibility Standards and Methodology)
- 6 (Coverage Requirements for Children’s Health Insurance)
- 7 (Quality and Appropriateness of Care)
- 8 (Cost Sharing and Payment)
- 11 (Program Integrity)
- 12 (Applicant and Enrollee Protections)
- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted low-income children in families with incomes of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under “Option to Expand Medicaid” would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in “Option to Create a Separate Program” would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

Where the state’s assurance is requested in this document for compliance with a particular requirement of 42 CFR 457 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date.

Proposed State plan amendments should be submitted electronically and one signed hard copy to the Centers for Medicare & Medicaid Services at the following address:

Name of Project Officer
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244
Attn: Children and Adults Health Programs Group
Center for Medicaid and CHIP Services

Mail Stop - S2-01-16

TABLE OF CONTENTS

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101).

1.1 The State will use funds provided under Title XXI primarily for (42 CFR 457.70)...1
1
1.211
1.311
1.411

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A-)).....17

2.1.17
2.2.18
2.3.20

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4)).....21

3.1.21
3.2.30
3.331
3.4.33
3.5.38
3.6.45
3.7.52
3.8.55
3.9.56
3.10.63
3.11.69
3.12.70

Section 4. Eligibility Standards and Methodology (Section 2102(b)).....84

4.1.84
4.2.89

4.3.	.....	90
4.4.	.....	95
Section 5.	Outreach (Section 2102(c)).....	97
Section 6.	Coverage Requirements for Children’s Health Insurance (Section 2103).....	100
6.1.	.....	100
6.2.	.....	107
6.3.	.....	125
6.4.	.....	125
Section 7.	Quality and Appropriateness of Care.....	132
7.1.	.....	133
7.2.	.....	136
Section 8.	Cost Sharing and Payment (Section 2103(e)).....	140
8.1.	.....	140
8.2.	.....	141
8.3.	.....	142
8.4.	.....	143
8.5.	.....	146
8.6.	.....	146
8.7.	.....	146
8.8.	.....	148
Section 9.	Strategic Objectives, Performance Goals and Plan Administration (Section 2107)	
9.1.	.....	149
9.2.	.....	149
9.3.	.....	150
9.4.	.....	152
9.5.	.....	152
9.6.	.....	152
9.7.	.....	152
9.8.	.....	153
9.9.	.....	153
9.10.	.....	156

Section 10. Annual Reports and Evaluations (Section 2108)	158
10.1. Annual Reports.....	158
10.2.....	158
10.3.....	158
Section 11. Program Integrity (Section 2101(a))	159
11.1.....	159
11.2.....	159
Section 12. Applicant and Enrollee Protections (Sections 2101(a))	160
12.1. Eligibility and Enrollment Matters.....	160
12.2. Health Services Matters.....	160
12.3. Premium Assistance Programs.....	161
Key and Glossary.....	164
Appendix 1: Superseding SPA templates:	
WA-14-0001 (CS7, CS15, CS9).....	166
WA-14-0002 (CS14).....	173
WA-14-0004 (CS24).....	175
WA-14-0003 (CS17, CS18, CS19, CS20).....	181
WA-14-0005 (CS21, CS27).....	189
Appendix 2: Hospital Presumptive Eligibility SPA	
WA-15-0001 (CS28, CS30)	193
Appendix 3: Children of Public Employees (CS10) .....	.

Section 1. General Description and Purpose of the Children’s Health Insurance Plans and the Requirements

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) (Section 2101)(a)(1)); (42 CFR 457.70):

Guidance: Check below if child health assistance shall be provided primarily through the development of a separate program that meets the requirements of Section 2101, which details coverage requirements and the other applicable requirements of Title XXI.

1.1.1. Obtaining coverage that meets the requirements for a separate child health program (Sections 2101(a)(1) and 2103); OR

Guidance: Check below if child health assistance shall be provided primarily through providing expanded eligibility under the State’s Medicaid program (Title XIX). Note that if this is selected the State must also submit a corresponding Medicaid SPA to CMS for review and approval.

1.1.2. Providing expanded benefits under the State’s Medicaid plan (Title XIX) (Section 2101(a)(2)); OR

Guidance: Check below if child health assistance shall be provided through a combination of both 1.1.1. and 1.1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the State’s Medicaid program). Note that if this is selected the state must also submit a corresponding Medicaid state plan amendment to CMS for review and approval.

1.1.3. A combination of both of the above. (Section 2101(a)(2))

Washington’s CHIP offers comprehensive healthcare coverage to children

through age 18, who reside in households with incomes up to 312% of the federal poverty level (FPL). Healthcare coverage for children in households with incomes up to 250% of FPL is a state mandated entitlement. Coverage for children in households with incomes above 250% of FPL is offered within available state funds appropriated by Washington's legislature. Families are required to pay a modest premium for coverage. CHIP benefits are the same as the state's Medicaid program for children. The program uses the state's Medicaid managed care delivery system and employs Medicaid income eligibility criteria.

1.1-DS The State will provide dental-only supplemental coverage. Only States operating a separate CHIP program are eligible for this option. States choosing this option must also complete sections 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template. (Section 2110(b)(5))

1.2. Check to provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

1.3. Check to provide an assurance that the State complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

Washington State assures that the state complies with all applicable civil rights.

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has

increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

- 1.4. Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan

Effective Date: January 1, 2000

Implementation Date: January 1, 2000

Amendment 1 - This amendment allowed the assignment of eligible children into managed care plans and created eligibility requirements similar to the Washington State Medicaid program.

Submitted: February 8, 2001

Approved: May 7, 2001

Effective date: January 1, 2001

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

Submitted: April 3, 2002

Approved: July 1, 2002

Effective date: January 1, 2002

Amendment 3 - This amendment updated the plan to specify the States compliance with the final CHIP regulation.

Submitted: October 3, 2002

Approved: December 19, 2002

Effective date: July 1, 2002

Amendment 4 - This amendment allows CHIP coverage for unborn children of women up to 185% of the Federal poverty level who are not eligible for Medicaid.

Submitted: June 25, 2003

Approved: September 22, 2003

Effective date: November 12, 2002

Amendment 5 - This amendment changed the eligibility review period from 12 months of continuous coverage to 6 months of non-continuous coverage.

Submitted: January 22, 2004

Approved: June 1, 2004

Effective date: December 31, 2003

Amendment 6 - This amendment increased the premium amount from \$10/mo. per child; \$30/mo. maximum per family to \$15/mo. per child; \$45/mo. maximum per family. The time allowed for non-payment of premiums was decreased from 4-months to 3-months; the waiting period after disenrollment for non-payment was decreased from 4-months to 3-months.

Submitted: August 16, 2004

Approved: November 5, 2004

Effective date: July 1, 2004

Amendment 7 - This amendment restored the certification period back to 12 months

continuous coverage; it also updated the State plan to reflect the name and organizational changes that occurred within the agency that administers CHIP.

Submitted: May 2, 2006

Approved: August 1, 2006

Effective date: July 1, 2005

Amendment 8 - This amendment proposed a change in rates and payment methods

and a requirement for a SSN for children.

Submitted: November 27, 2006

Withdrawn: December 27, 2006

Amendment 9 - This amendment proposed funding for additional outreach activities. **Submitted: January 23, 2007**

Withdrawn: February 3, 2008

Amendment 10 - This amendment increased funding from CHIP for additional outreach activities as a part of the passage of Cover All Kids legislation.

Submitted: April 3, 2008

Approved: December 17, 2008

Effective date: July 1, 2007

Amendment 11 - This amendment proposes increasing the income limit to 300% FPL and creating a two-tiered premium structure for CHIP. The premium amount will also be increased. Good cause for dropping employer sponsored insurance is also amended from a cost of \$50 to a cost of 2.5% household income.

Submitted: April 14, 2008

Approved: April 3, 2009

Effective date: January 1, 2009

Amendment 12 - This amendment expanded the delivery of mental health services. **Submitted: May 14, 2008**

Approved: January 16, 2009

Effective date: July 1, 2008

Amendment 13 – This amendment is to provide federal funding for the Washington Poison Center (WAPC) under a health services initiative; expand CHIP coverage to lawfully residing alien children under age 19; require verification of citizenship; describe the CHIP dental coverage package; reference FQHC/RHC reimbursement methodology; and eliminate the 3-month sanction for failing to pay required premiums.

Submitted date: June 29, 2010

Approved date: December 9, 2010

Effective date: **July 1, 2009** for WAPC funding and lawfully residing alien children. **October 1, 2009** for dental coverage and FQHC/RHC descriptions. **January 1, 2010** for citizenship verification requirement.
April 1, 2010 for elimination of 3-month sanction penalty.

Amendment 14-0001, 14-0002, 14-0003, 14-0004: **See Appendix 1 & Table below**

Amendment 15-001: Hospital Presumptive Eligibility: **See Appendix 2 & Table below**

Amendment 16-0001: This amendment is to comply with federal regulation in the implementation of the Affordable Care Act (ACA) including conversion of the current CHIP effective income limit to a MAGI equivalent and technical corrections to reflect approved CHIP SPA templates referenced in the table below.

Submitted date: April 18, 2016

Approved date: June 1, 2016

Effective date: July 1, 2015.

Amendment 18-0001: This amendment documents compliance of Washington's child health plan with the Mental Health Parity and Addiction Equity Act (MHPAEA)

Submitted date: June 28, 2019

Approved date: March 18, 2021

Effective date: October 2, 2017

Amendment 19-0001: Record compliance with Managed Care final rule provisions within the CHIP state plan.

Submitted date: June 4, 2019

Approved date: June 18, 2019

Effective date: July 1, 2018

Amendment 20-0001: CHIP Disaster Relief State Plan Amendment

To implement provisions for temporary adjustments to enrollment and redetermination policies, cost sharing, premium requirements for children in families, changes in circumstances, reasonable opportunity period, waiting periods, and dental services during the Federal COVID-19 public health emergency.

Submitted date: April 29, 2020

Approved date: July 15, 2020

Effective date: March 1, 2020

Implementation Dates:

- March 18, 2020 for all flexibilities except waiving premiums
- May 1, 2020, for waiving premiums

Amendment 20-0002: CHIP Public Employees State Plan Amendment

To expand CHIP coverage to include eligible children of public employees as allowed under Section 10203(b)(2)(D) of the Affordable Care Act. Public employees are enrolled in Public Employees Benefits (PEB) and School Employees Benefits (SEB). **See Appendix 3**

Submitted date: June 24, 2020

Approved Date: August 28, 2020

Effective Date: January 1, 2020

Amendment 20-0003: CHIP SUPPORT Act State Plan Amendment

Requires that child health and pregnancy-related assistance “include coverage of mental health services (including behavioral health) necessary to prevent, diagnose, and treat a broad range of mental health symptoms and disorders, including substance use disorders.” It applies to all CHIP eligible populations regardless of the type of coverage (e.g., benchmark coverage) elected by the state under a separate CHIP under section 2103 of the Act.”

Submitted date: June 30, 2020

Approved Date:

Effective Date: October 24, 2019

1.4- TC Tribal Consultation (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

Washington's tribes were notified via email, with hard copy letters to the Tribal Chairpersons, on April 20, 2020. Washington has a standard tribal mailing list of email and physical mailing addresses.

Superseding Pages of MAGI CHIP State Plan Material State: Washington

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
WA-14-0001 Effective/ Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS7	Eligibility – Targeted Low-Income Children	Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3 Supersedes the current section Age 4.1.2.1 Incorporate within a separate subsection
		CS9	Eligibility – Coverage from Conception to Birth	
		CS15	MAGI-Based Income Methodologies	
WA-14-0002 Effective/ Implementation Date: January 1,	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within a separate subsection under section 4.1
WA-14-0004 Effective/ Implementation Date: October 1,	Eligibility Processing	CS24	Eligibility Process	Supersedes the current sections 4.3 and 4.4
WA-14-0003 Effective/ Implementation Date: January 1, 2014	Non- Financial Eligibility	CS17	Non-Financial Eligibility – Residency Non-	Supersedes the current section 4.1.5 Supersedes the current sections 4.1.9.1 Supersedes the current section 4.1.9.2 Supersedes the current section 4.4.4 Supersedes the current section 8.7.1 Supersedes the current section 4.1.8
		CS18	Financial – Citizenship	
		CS19	Non-Financial – Social Security Number	
		CS20	Substitution of Coverage	
		CS21	Non-Payment of Premiums	
CS27	Continuous Eligibility			
WA-15 - 0001		CS28	Hospital presumptive eligibility	See Appendix 2

Section 2. General Background and Description of Approach to Children’s Health Insurance Coverage and Coordination

Guidance: The demographic information requested in 2.1. can be used for State planning and will be used strictly for informational purposes. THESE NUMBERS WILL NOT BE USED AS A BASIS FOR THE ALLOTMENT.

Factors that the State may consider in the provision of this information are age breakouts, income brackets, definitions of insurability, and geographic location, as well as race and ethnicity. The State should describe its information sources and the assumptions it uses for

the development of its description.

- Population
- Number of uninsured
- Race demographics
- Age Demographics
- Info per region/Geographic information

2.1. Describe the extent to which, and manner in which, children in the State (including targeted low-income children and other groups of children specified) identified, by income level and other relevant factors, such as race, ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, distinguish between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (Section 2102(a)(1)); (42 CFR 457.80(a))

Based on the 2008 Washington State Population Survey (WSPS), 95.4% of all children in Washington had health care coverage in April/May 2008. This represents a 2.4% increase in healthcare coverage since the year 2000. 95.3% of children between 200% and 300% of the federal poverty level (FPL) had healthcare coverage. Approximately 13,000 children in this income range remained without healthcare coverage and are the target population for outreach under Washington's CHIP.

92.7% of children under 200% FPL had coverage at the time of the 2008 WSPS. Approximately 48,000 children in this income range were without healthcare coverage and are included in the target population for outreach as described in 42 CFR 457.90. 97.7% of children above 300% FPL had coverage at the time of the 2008 WSPS. Consistent with national trends, employer-based coverage was the principal source of coverage for higher income children. The rate of employer-sponsored coverage of children above 300% FPL was 85.1%, whereas the rate of employer-sponsored coverage of children below 200% FPL was only 18.8%.

Guidance: Section 2.2 allows states to request to use the funds available under the 10 percent limit on

administrative expenditures in order to fund services not otherwise allowable. The health services initiatives must meet the requirements of 42 CFR 457.10.

- 2.2. Health Services Initiatives-** Describe if the State will use the health services initiative option as allowed at 42 CFR 457.10. If so, describe what services or programs the State is proposing to cover with administrative funds, including the cost of each program, and how it is currently funded (if applicable), also update the budget accordingly. (Section 2105(a)(1)(D)(ii)); (42 CFR 457.10)

HCA funds poison treatment advice and prevention for children in Washington State under a health services initiative option as described in 42 CFR 457.10 through a contract with the Washington Poison Center (WAPC). The WAPC provides emergency telephone treatment advice, referral assistance, and information to manage exposure to poisonous and hazardous substances. The WAPC answers poisoning emergency calls from the general public 24 hours a day, 365 days each year at no charge. At all times, a Specialist in Poison Information (SPI) is available to manage cases and Certified Specialists in Poison Information (CSPI) are available to manage cases and direct Poison Information Providers. The service is provided via a toll-free phone number to all communities throughout Washington, including under-served, low-income, and indigent populations. Interpreters are available in over 150 languages and via telecommunications devices for the deaf and hearing-impaired (TTY).

WAPC public education programs direct attention and resources to at-risk populations living in poverty, including minority and immigrant communities. Consumer-based educational materials have been developed that are culturally relevant, taking into consideration health literacy levels and clearly illustrating and describing WAPC services. In addition to English, materials are available in Spanish, Korean, Vietnamese, Laotian, Chinese, Russian, and Somali.

The WAPC promotes poison awareness through community forums. WAPC's mascot "Mr. Yuk" is a familiar face at presentations in schools, community health fairs, and other local events and gatherings. The WAPC works closely with other community health programs such as Washington State's Safe Kids Program and

Safe Kids Coalition groups.

The WAPC advertises their public toll-free number and toll-free TTY number in the white pages and consumer guides of all Washington state telephone directories, as well as on billboards across the state. Advertisements and billboards are in Spanish and English.

The WAPC receives approximately 66,000 calls annually involving a poison or hazardous substance exposure. 63% of all calls received are regarding exposure of child under the age of 19. Over 35% of the total calls relate to exposure of a child in a family whose annual household income is no more than 300% FPL.¹

WAPC intervention resulted in over 94% these exposures calls being handled in the home so that the child did not have to use an Emergency Department or need a 911 call and response. Each call to the WAPC significantly reduces costs in other medical spending. Cost savings in 1996 dollars were estimated at \$175 per call.²

The current annual contract is approximately \$1.8 million dollars and is based on the WAPC's annual operating budget multiplied by the percentage of phone calls received on behalf of children. The expenditure is within the 10% administrative cap for the CHIP program.

¹ The percentage of calls attributed to children in families with incomes no greater than 300% FPL is based on WAPC records for 2009. 66,083 total exposure calls were answered statewide. 41,827 exposure calls were for children ages 0 – 18. 2008 Washington State Population Survey (<http://wa-state-ofm.us/SPSOnline/>) estimates 55.5% of Washington children are living in households with incomes no more than 300%FPL. This represents 23,214 calls, or 35.1% of the total volume of calls.

2.3-TC Tribal Consultation Requirements- (Sections 1902(a)(73) and 2107(e)(1)(C)); (ARRA #2, CHIPRA #3, issued May 28, 2009) Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCA). Section 2107(e)(1)(C) of the Act was also amended to apply these requirements to the Children’s Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Describe the process the State uses to seek advice on a regular, ongoing basis from federally recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Include information about the frequency, inclusiveness, and process for seeking such advice.

The Health Care Authority (HCA) has an extensive tribal consultation and communication policy that promotes a collaborative process between HCA, federally recognized Tribal governments, the Indian Health Service, Urban Indian Health Programs (UIHP), and the American Indian Health Commission for Washington State (AIHC). This process is set forth in Washington’s Medicaid State Plan section 1.4 with additional information available on the Tribal Affairs home page at <https://www.hca.wa.gov/about-hca/tribal-affairs>.

Section 3. Methods of Delivery and Utilization Controls

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 (Eligibility Standards and Methodology).

Guidance: In Section 3.1, describe all delivery methods the State will use to provide services to enrollees, including: (1) contracts with managed care organizations (MCO), prepaid inpatient health plans (PIHP), prepaid ambulatory health plans (PAHP), primary care case management entities (PCCM entities), and primary care case managers (PCCM); (2) contracts with indemnity health insurance plans; (3) fee-for-service (FFS) paid by the State to health care providers; and (4) any other arrangements for health care delivery. The State should describe any variations based upon geography and by population (including the conception to birth population). States must submit the managed care contract(s) to CMS' Regional Office for review.

3.1. Delivery Systems (Section 2102(a)(4)) (42 CFR 457.490; Part 457, Subpart L)
Washington's CHIP program reimburses Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) using the same alternative payment methodology (APM) as the State's Medicaid program. There is no difference between the CHIP rates and the Medicaid rates for reimbursing FQHCs and RHCs.

FQHCs/RHCs have a choice of reimbursement under the Prospective Payment System (PPS) as outlined in the Benefits Improvement and Protection Act of 2000 (BIPA) statutory language, or an Alternative Payment Methodology (APM).

Prospective Payment System

The facility-specific encounter rates were established in 2002, and they are considered the providers' base encounter rates. The base rates were calculated using cost report data from 1999 and 2000, and in some cases, 2001. The corresponding enhancement rates were also established at that this time. Pursuant to the requirements of the PPS, both FFS encounter rates and managed care enhancement rates for each provider have been increased annually by the percentage change in the MEI.

Alternative Payment Methodology

The APM encounter rates were established by starting with each provider's base

Effective Date: October 24, 2019

Approval Date:

PPS rate, and trending forward to 2009 using the APM index. The APM index is a Washington specific health care index developed by IHS Global Insight. Rates established under the APM will be inflated each year by the Washington State specific health care index. Annual reconciliation is a part of the APM. Rates determined under the APM will be periodically rebased.

Supplemental Payments for Managed Care Clients

For clients enrolled with a managed care contractor, the Agency will pay the FQHC/RHC a supplemental payment (called enhancement) in addition to the amount paid by the managed care contractor. These enhancements will pay monthly on a per-member-per-month basis. To ensure that the appropriate amounts are being paid to each FQHC/RHC, the Agency will perform an annual reconciliation and verify that the enhancement payments made in the previous year were in compliance with Section 1902(bb)(5)(A) of the Social Security Act.

An additional description of this methodology can be found on page 3 (RHC) and page 33(FQHC) of Attachment 4.19-B of the Title XIX state plan, as approved by CMS on June 26th, 2009.

3.1.1 Choice of Delivery System

3.1.1.1 Does the State use a managed care delivery system for its CHIP populations? Managed care entities include MCOs, PIHPs, PAHPs, PCCM entities and PCCMs as defined in 42 CFR 457.10. Please check the box and answer the questions below that apply to your State.

No, the State does not use a managed care delivery system for any CHIP populations.

Yes, the State uses a managed care delivery system for all CHIP populations.

- Yes, the State uses a managed care delivery system; however, only some of the CHIP population is included in the managed care delivery system and some of the CHIP population is included in a fee-for-service system.

If the State uses a managed care delivery system for only some of its CHIP populations and a fee-for-service system for some of its CHIP populations, please describe which populations are, and which are not, included in the State's managed care delivery system for CHIP. States will be asked to specify which managed care entities are used by the State in its managed care delivery system below in Section 3.1.2.

Children birth through eighteen are enrolled in the managed care delivery system. Children who are AI/AN may opt into managed care, PCCM, or remain fee for service. Unborn children are only covered under the fee-for-service network at this time.

Guidance: Utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package.

Examples of utilization control systems include but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42 CFR 457.490(b))

If the State does not use a managed care delivery system for any or some of its CHIP populations, describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of:

- The methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102(a)(4); 42 CFR 457.490(a))
- The utilization control systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102(a)(4); 42 CFR 457.490(b))

Washington provides comprehensive healthcare coverage for the unborn population through our fee-for-service network for medical services. Behavioral health services, including substance use disorder treatment is provided through managed care organizations under a behavioral health services only (BHSO) contract; or through regionally based Behavioral Health Organizations (BHOs). BHOs will be phased out by Jan. 1, 2020.

Guidance: Only States that use a managed care delivery system for all or some CHIP populations need to answer the remaining questions under Section 3 (starting with 3.1.1.2). If the State uses a managed care delivery system for only some of its CHIP population, the State's responses to the following questions will only apply to those populations.

3.1.1.2 Do any of your CHIP populations that receive services through a managed care delivery system receive any services outside of a managed care delivery system?

No

Yes

If yes, please describe which services are carved out of your managed care delivery system and how the State provides these services to an enrollee, such as through fee-for-service. Examples of carved out services may include transportation and dental, among others.

The following Covered Services are provided by the state and are NOT included in the MC delivery system:

- School-based Health Care Services for Children in Special Education with an Individualized Education Plan or Individualized Family Service Plan who have a disability, developmental delay, or are diagnosed with a physical or mental condition;
- Eyeglass frames, lenses, and fabrication services covered under HCA's selective contract for these services for children under age twenty-one (21), and associated fitting and dispensing services. The Contractor is encouraged to inform eye practitioners of the availability of Airway Heights Correctional Center to access glasses for adult clients age

twenty-one (21) and over if not offered by the Contractor as a value added benefit;

- Voluntary Termination of Pregnancy;
- Court-ordered transportation services, including ambulance services;
- Transportation Services other than ambulance, including but not limited to: taxi, cabulance, voluntary transportation, public transportation, and common carriers;
- Ambulance services, including air and ground ambulance transportation services with dates of service after December 31, 2017;
- Services provided by dentists and oral surgeons for dental diagnoses; anesthesia for dental care; prescriptions written by a dentist or oral surgeon for a dental diagnosis.
- Orthodontics;
- Maternity Support Services (MSS), consistent with the Marketing and Information, Subcontracts, and Care Coordination provisions of this Contract;
- Sterilizations for Enrollees under age twenty-one (21), or those that do not meet other federal requirements (42 C.F.R. § 441 Subpart F);
- Services provided by a health department when a Enrollee self-refers for care if the health department is not contracted with the Contractor;
- HIV Case Management;
- Prenatal Genetic Counseling;
- Hemophiliac Products – Blood factors VII, VIII, and IX, anti-inhibitor, and all FDA approved products labeled with an indication for use in treatment of hemophilia and von Willebrand disease when distributed for administration in the Enrollee’s home or other outpatient setting;
- Immune modulators and anti-viral medications to treat Hepatitis C. This exclusion does not apply to any other contracted service related to the diagnosis or treatment of Hepatitis C;
- The following drugs
 - axicabtagene ciloleucel, as marketed under the brand name Yescarta®;

- burosumab-twza, as marketed under the brand name Crysvisa®;
 - cerliponase alfa, as marketed under the brand name Brineura™;
 - edaravone, as marketed under the brand name Radicava™;
 - eteplirsen, as marketed under the brand name Exondys 51™;
 - nusinersen, as marketed under the brand name Spinraza®;
 - pegvaliase-pqpz, as marketed under the brand name Palynziq™;
 - tisagenlecleucel-t, as marketed under the brand name Kymriah™
; and
 - voretigene neparvovec-rzyl, as marketed under the brand name Luxturna™.
- Sexual reassignment surgery as described in WAC 182-531-1675(6)(d) and (e) as well as hospitalizations, physician, and Ancillary Services required to treat postoperative complications of these procedures; and
 - Chemical-Using Pregnant (CUP) Women program as described in WAC 182-533-0730 when provided by an HCA-approved CUP provider.
 - Inpatient psychiatric services, including psychiatric consultations when the inpatient admission is approved by a BHO;
 - Substance use treatment services covered through the HCA, Division of Behavioral Health and Recovery. Drugs prescribed as Medication Assisted Treatment or maintenance therapy for substance use disorders are a separate course of treatment, not ancillary to other treatment services and are a contracted service under the Pharmaceutical Products provisions of this Contract.

The following services are covered by other state agencies and are not Contracted Services. The Contractor is responsible for coordinating and referring Enrollees to these services through all means possible, e.g., Adverse Benefit Determination notifications, call center communication or Contractor publications.

- Long-term private duty nursing for Enrollees ages 18 and over. These services are covered by DSHS, Aging and Long-Term Support Administration (ALTSA);
- Community-based services (e.g., COPES, CFC and Personal Care Services) covered through the ALTSA;

- Nursing facility stays that do not meet rehabilitative or skilled criteria are covered through the ALTSA;
- Mental health services separately purchased for all Medicaid clients by the HCA;
- Health care services covered through the DSHS, Developmental Disabilities Administration (DDA) for institutionalized clients;
- Infant formula for oral feeding provided by the Women, Infants and Children (WIC) program in the Department of Health; and
- Any service provided to an Enrollee while incarcerated with the Washington State Department of Corrections (DOC).

3.1.2 Use of a Managed Care Delivery System for All or Some of the State’s CHIP Populations

3.1.2.1 Check each of the types of entities below that the State will contract with under its managed care delivery system, and select and/or explain the method(s) of payment that the State will use:

Managed care organization (MCO) (42 CFR 457.10)

Capitation payment

Describe population served: Children birth through eighteen who do not have third party liability coverage.

Prepaid inpatient health plan (PIHP) (42 CFR 457.10)

Capitation payment

Other (please explain)

Describe population served: All CHIP enrollees.

Guidance: If the State uses prepaid ambulatory health plan(s) (PAHP) to exclusively provide non-emergency medical transportation (a NEMT PAHP), the State should not check the following box for that plan. Instead, complete section 3.1.3 for the NEMT PAHP.

Prepaid ambulatory health plan (PAHP) (42 CFR 457.10)

Capitation payment

Other (please explain)

Describe population served:

Primary care case manager (PCCM) (individual practitioners) (42 CFR 457.10)

Case management fee

Other (please explain)

Primary care case management entity (PCCM Entity) (42 CFR 457.10)

Case management fee

Shared savings, incentive payments, and/or other financial rewards for improved quality outcomes (see 42 CFR 457.1240(f))

Other (please explain)

If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as described in 42 CFR 457.10), in addition to PCCM services:

Provision of intensive telephonic case management

Provision of face-to-face case management

Operation of a nurse triage advice line

Development of enrollee care plans

Execution of contracts with fee-for-service (FFS) providers in the FFS program

Oversight responsibilities for the activities of FFS providers in the FFS program

Provision of payments to FFS providers on behalf of the State

Provision of enrollee outreach and education activities

Operation of a customer service call center

Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement

- Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers
- Coordination with behavioral health systems/providers
- Other (please describe)

3.1.2.2 The State assures that if its contract with an MCO, PAHP, or PIHP allows the entity to use a physician incentive plan, the contract stipulates that the entity must comply with the requirements set forth in 42 CFR 422.208 and 422.210. (42 CFR 457.1201(h), cross-referencing to 42 CFR 438.3(i))

3.1.3 Nonemergency Medical Transportation PAHPs

Guidance: Only complete Section 3.1.3 if the State uses a PAHP to exclusively provide non-emergency medical transportation (a NEMT PAHP). If a NEMT PAHP is the only managed care entity for CHIP in the State, please continue to Section 4 after checking the assurance below. If the State uses a PAHP that does not exclusively provide NEMT and/or uses other managed care entities beyond a NEMT PAHP, the State will need to complete the remaining sections within Section 3.

The State assures that it complies with all requirements applicable to NEMT PAHPs, and through its contracts with such entities, requires NEMT PAHPs to comply with all applicable requirements, including the following (from 42 CFR 457.1206(b)):

- All contract provisions in 42 CFR 457.1201 except those set forth in 42 CFR 457.1201(h) (related to physician incentive plans) and 42 CFR 457.1201(l) (related to mental health parity).
- The information requirements in 42 CFR 457.1207 (see Section 3.5 below for more details).
- The provision against provider discrimination in 42 CFR 457.1208.
- The State responsibility provisions in 42 CFR 457.1212 (about disenrollment), 42 CFR 457.1214 (about conflict-of-interest safeguards), and 42 CFR 438.62(a), as cross-referenced in 42 CFR

457.1216 (about continued services to enrollees).

- The provisions on enrollee rights and protections in 42 CFR 457.1220, 457.1222, 457.1224, and 457.1226.
- The PAHP standards in 42 CFR 438.206(b)(1), as cross-referenced by 42 CFR 457.1230(a) (about availability of services), 42 CFR 457.1230(d) (about coverage and authorization of services), and 42 CFR 457.1233(a), (b) and (d) (about structure and operation standards).
- An enrollee's right to a State review under subpart K of 42 CFR 457.
- Prohibitions against affiliations with individuals debarred or excluded by Federal agencies in 42 CFR 438.610, as cross referenced by 42 CFR 457.1285.
- Requirements relating to contracts involving Indians, Indian Health Care Providers, and Indian managed care entities in 42 CFR 457.1209.

3.2. General Managed Care Contract Provisions

3.2.1 The State assures that it provides for free and open competition, to the maximum extent practical, in the bidding of all procurement contracts for coverage or other services, including external quality review organizations, in accordance with the procurement requirements of 45 CFR part 75, as applicable. (42 CFR 457.940(b); 42 CFR 457.1250(a), cross referencing to 42 CFR 438.356(e))

3.2.2 The State assures that it will include provisions in all managed care contracts that define a sound and complete procurement contract, as required by 45 CFR part 75, as applicable. (42 CFR 457.940(c))

3.2.3 The State assures that each MCO, PIHP, PAHP, PCCM, and PCCM entity complies with any applicable Federal and State laws that pertain to enrollee rights and ensures that its employees and contract providers observe and protect those rights (42 CFR 457.1220, cross-referencing to 42 CFR 438.100). These Federal and State laws include:

Title VI of the Civil Rights Act of 1964 (45 CFR part 80), Age Discrimination Act of 1975 (45 CFR part 91), Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, Titles II and III of the Americans with Disabilities Act, and section 1557 of the Patient Protection and Affordable Care Act.

- 3.2.4 The State assures that it operates a Web site that provides the MCO, PIHP, PAHP, and PCCM entity contracts. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(3))

MCO contracts are posted. PCCM contracts are currently under revision and are not posted at this time.

3.3 Rate Development Standards and Medical Loss Ratio

- 3.3.1 The State assures that its payment rates are:
- Based on public or private payment rates for comparable services for comparable populations; and
 - Consistent with actuarially sound principles as defined in 42 CFR 457.10. (42 CFR 457.1203(a))

Guidance: States that checked both boxes under 3.3.1 above do not need to make the next assurance. If the state is unable to check both boxes under 3.1.1 above, the state must check the next assurance.

If the State is unable to meet the requirements under 42 CFR 457.1203(a), the State attests that it must establish higher rates because such rates are necessary to ensure sufficient provider participation or provider access or to enroll providers who demonstrate exceptional efficiency or quality in the provision of services. (42 CFR 457.1203(b))

- 3.3.2 The State assures that its rates are designed to reasonably achieve a medical loss ratio standard equal to at least 85 percent for the rate year and provide for reasonable administrative costs. (42 CFR 457.1203(c))

3.3.3 The State assures that it will provide to CMS, if requested by CMS, a description of the manner in which rates were developed in accordance with the requirements of 42 CFR 457.1203(a) through (c). (42 CFR 457.1203(d))

3.3.4 The State assures that it annually submits to CMS a summary description of the reports pertaining to the medical loss ratio received from the MCOs, PIHPs, and PAHPs. (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(a))

3.3.5 Does the State require an MCO, PIHP, or PAHP to pay remittances through the contract for not meeting the minimum MLR required by the State? (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(b)(1))

No, the State does not require any MCO, PIHP, or PAHP to pay remittances.

Yes, the State requires all MCOs, PIHPs, and PAHPs to pay remittances.

Yes, the State requires some, but not all, MCOs, PIHPs, and PAHPs to pay remittances.

If the State requests some, but not all, MCOs, PIHPs, and PAHPs to pay remittances through the contract for not meeting the minimum MLR required by the State, please describe which types of managed care entities are and are not required to pay remittances. For example, if a state requires a medical MCO to pay a remittance but not a dental PAHP, please include this information.

The state requires all contracted medical MCOs to pay a remittance if they fail to meet the minimum MLR required by the state. NEMT PAHPs are not required to pay remittances.

If the answer to the assurance above is yes for any or all managed care entities, please answer the next assurance:

The State assures that if a remittance is owed by an MCO, PIHP, or PAHP to the State, the State:

- Reimburses CMS for an amount equal to the Federal share of the remittance, taking into account applicable differences in the

Federal matching rate; and

- Submits a separate report describing the methodology used to determine the State and Federal share of the remittance with the annual report provided to CMS that summarizes the reports received from the MCOs, PIHPs, and PAHPs. (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(b))

3.3.6 The State assures that each MCO, PIHP, and PAHP calculates and reports the medical loss ratio in accordance with 42 CFR 438.8. (42 CFR 457.1203(f))

3.4 Enrollment

The State assures that its contracts with MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities provide that the MCO, PIHP, PAHP, PCCM or PCCM entity:

- Accepts individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under the contract (42 CFR 457.1201(d), cross-referencing to 42 CFR 438.3(d)(1));
- Will not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll (42 CFR 457.1201(d), cross-referencing to 42 CFR 438.3(d)(3)); and
- Will not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity or disability. (42 CFR 457.1201(d), cross-referencing to 438.3(d)(4))

3.4.1 Enrollment Process

3.4.1.1 The State assures that it provides informational notices to potential enrollees in an MCO, PIHP, PAHP, PCCM, or PCCM entity that includes the available managed care entities, explains

how to select an entity, explains the implications of making or not making an active choice of an entity, explains the length of the enrollment period as well as the disenrollment policies, and complies with the information requirements in 42 CFR 457.1207 and accessibility standards established under 42 CFR 457.340. (42 CFR 457.1210(c))

3.4.1.2 The State assures that its enrollment system gives beneficiaries already enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity priority to continue that enrollment if the MCO, PIHP, PAHP, PCCM, or PCCM entity does not have the capacity to accept all those seeking enrollment under the program. (42 CFR 457.1210(b))

3.4.1.3 Does the State use a default enrollment process to assign beneficiaries to an MCO, PIHP, PAHP, PCCM, or PCCM entity? (42 CFR 457.1210(a))

Yes

No

NOTE: While Washington does have a default process for enrollment in an MCO, enrollees are also given the option of selecting a plan at the time they are approved for CHIP coverage.

If the State uses a default enrollment process, please make the following assurances:

The State assigns beneficiaries only to qualified MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities that are not subject to the intermediate sanction of having suspension of all new enrollment (including default enrollment) under 42 CFR 438.702 and have capacity to enroll beneficiaries. (42 CFR 457.1210(a)(1)(i))

The State maximizes continuation of existing provider-beneficiary relationships under 42 CFR 457.1210(a)(1)(ii) or if that is not possible, distributes the beneficiaries equitably and does not arbitrarily exclude any MCO, PIHP, PAHP,

PCCM or PCCM entity from being considered. (42 CFR 457.1210(a)(1)(ii), 42 CFR 457.1210(a)(1)(iii))

3.4.2 Disenrollment

3.4.2.1 The State assures that the State will notify enrollees of their right to disenroll consistent with the requirements of 42 CFR 438.56 at least annually. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f)(2))

3.4.2.2 The State assures that the effective date of an approved disenrollment, regardless of the procedure followed to request the disenrollment, will be no later than the first day of the second month following the month in which the enrollee requests disenrollment or the MCO, PIHP, PAHP, PCCM or PCCM entity refers the request to the State. (42 CFR 457.1212, cross-referencing to 438.56(e)(1))

3.4.2.3 If a beneficiary disenrolls from an MCO, PIHP, PAHP, PCCM, or PCCM entity, the State assures that the beneficiary is provided the option to enroll in another plan or receive benefits from an alternative delivery system. (Section 2103(f)(3) of the Social Security Act, incorporating section 1932(a)(4); 42 CFR 457.1212, cross referencing to 42 CFR 438.56; State Health Official Letter #09-008)

3.4.2.4 **MCO, PIHP, PAHP, PCCM and PCCM Entity Requests for Disenrollment.**

The State assures that contracts with MCOs, PIHPs, PAHPs, PCCMs and PCCM entities describe the reasons for which an MCO, PIHP, PAHP, PCCM and PCCM entity may request disenrollment of an enrollee, if any. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(b))

Guidance: Reasons for disenrollment by the MCO, PIHP, PAHP, PCCM, and PCCM entity must be specified in the contract with the State. Reasons for disenrollment may not include an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO, PIHP, PAHP, PCCM or PCCM entity seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(b)(2))

3.4.2.5 Enrollee Requests for Disenrollment.

Guidance: The State may also choose to limit disenrollment from the MCO, PIHP, PAHP, PCCM, or PCCM entity, except for either: 1) for cause, at any time; or 2) without cause during the latter of the 90 days after the beneficiary's initial enrollment or the State sends the beneficiary notice of that enrollment, at least once every 12 months, upon reenrollment if the temporary loss of CHIP eligibility caused the beneficiary to miss the annual disenrollment opportunity, or when the State imposes the intermediate sanction specified in 42 CFR 438.702(a)(4). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c))

Does the State limit disenrollment from an MCO, PIHP, PAHP, PCCM and PCCM entity by an enrollee? (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c))

- Yes
 No

If the State limits disenrollment by the enrollee from an MCO, PIHP, PAHP, PCCM and PCCM entity, please make the following assurances (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)):

- The State assures that enrollees and their representatives are given written notice of disenrollment rights at least 60 days before the start of each enrollment period. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(f)(1))
- The State assures that beneficiary requests to disenroll for cause will be permitted at any time by the MCO, PIHP, PAHP, PCCM or

PCCM entity. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(1) and (d)(2))

The State assures that beneficiary requests for disenrollment without cause will be permitted by the MCO, PIHP, PAHP, PCCM or PCCM entity at the following times:

- During the 90 days following the date of the beneficiary's initial enrollment into the MCO, PIHP, PAHP, PCCM, or PCCM entity, or during the 90 days following the date the State sends the beneficiary notice of that enrollment, whichever is later;
- At least once every 12 months thereafter;
If the State plan provides for automatic reenrollment for an individual who loses CHIP eligibility for a period of 2 months or less and the temporary loss of CHIP eligibility has caused the beneficiary to miss the annual disenrollment opportunity; and
- When the State imposes the intermediate sanction on the MCO, PIHP, PAHP, PCCM or PCCM entity specified in 42 CFR 438.702(a)(4). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(2)).

3.4.2.6 The State assures that the State ensures timely access to a State review for any enrollee dissatisfied with a State agency determination that there is not good cause for disenrollment. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(f)(2))

3.5 Information Requirements for Enrollees and Potential Enrollees

3.5.1 The State assures that it provides, or ensures its contracted MCOs, PAHPs, PIHPs, PCCMs and PCCM entities provide, all enrollment notices, informational materials, and instructional materials related to enrollees and potential enrollees in accordance with the terms of 42 CFR 457.1207, cross-referencing to 42 CFR 438.10.

3.5.2 The State assures that all required information provided to enrollees and potential enrollees are in a manner and format that may be easily

understood and is readily accessible by such enrollees and potential enrollees. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(1))

3.5.3 The State assures that it operates a Web site that provides the content specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)-(i) either directly or by linking to individual MCO, PIHP, PAHP and PCCM entity Web sites.

3.5.4 The State assures that it has developed and requires each MCO, PIHP, PAHP and PCCM entity to use:

- Definitions for the terms specified under 42 CFR 438.10(c)(4)(i), and
Model enrollee handbooks, and model enrollee notices. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(4))

3.5.5 If the State, MCOs, PIHPs, PAHPs, PCCMs or PCCM entities provide the information required under 42 CFR 457.1207 electronically, check this box to confirm that the State assures that it meets the requirements under 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(6) for providing the material in an accessible manner.

Including that:

- The format is readily accessible;
- The information is placed in a location on the State, MCO's, PIHP's, PAHP's, or PCCM's, or PCCM entity's Web site that is prominent and readily accessible;
- The information is provided in an electronic form which can be electronically retained and printed;
- The information is consistent with the content and language requirements in 42 CFR 438.10; and
- The enrollee is informed that the information is available in paper form without charge upon request and is provided the information upon request within 5 business days.

3.5.6 ☒

The State assures that it meets the language and format requirements set forth in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(d), including but not limited to:

- Establishing a methodology that identifies the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State, and in each MCO, PIHP, PAHP, or PCCM entity service area;
- Making oral interpretation available in all languages and written translation available in each prevalent non-English language;
- Requiring each MCO, PIHP, PAHP, and PCCM entity to make its written materials that are critical to obtaining services available in the prevalent non-English languages in its particular service area;
- Making interpretation services available to each potential enrollee and requiring each MCO, PIHP, PAHP, and PCCM entity to make those services available free of charge to each enrollee; and
- Notifying potential enrollees, and requiring each MCO, PIHP, PAHP, and PCCM entity to notify its enrollees:
 - That oral interpretation is available for any language and written translation is available in prevalent languages;
 - That auxiliary aids and services are available upon request and at no cost for enrollees with disabilities; and
 - How to access the services in 42 CFR 457.1207, cross-referencing 42 CFR 438.10(d)(5)(i) and (ii).

3.5.7 ☒

The State assures that the State or its contracted representative provides the information specified in 42 CFR 457.1207, cross-referencing to 438.10(e)(2), and includes the information either in paper or electronic format, to all potential enrollees at the time the potential enrollee becomes eligible to enroll in a voluntary managed care program or is first required to enroll in a mandatory managed care program and within a timeframe that enables the potential enrollee to use the information to choose among the available MCOs, PIHPs, PAHPs, PCCMs and PCCM entities:

- Information about the potential enrollee's right to disenroll consistent with the requirements of 42 CFR 438.56 and which explains clearly the process for exercising this disenrollment right, as well as the alternatives available to the potential enrollee based on their specific circumstance;
- The basic features of managed care;
- Which populations are excluded from enrollment in managed care, subject to mandatory enrollment, or free to enroll voluntarily in the program;
The service area covered by each MCO, PIHP, PAHP, PCCM, or PCCM entity;
- Covered benefits including:
 - Which benefits are provided by the MCO, PIHP, or PAHP; and which, if any, benefits are provided directly by the State; and
 - For a counseling or referral service that the MCO, PIHP, or PAHP does not cover because of moral or religious objections, where and how to obtain the service;
- The provider directory and formulary information required in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h) and (i);
- Any cost-sharing for the enrollee that will be imposed by the MCO, PIHP, PAHP, PCCM, or PCCM entity consistent with those set forth in the State plan;
- The requirements for each MCO, PIHP or PAHP to provide adequate access to covered services, including the network adequacy standards established in 42 CFR 457.1218, cross-referencing 42 CFR 438.68;
- The MCO, PIHP, PAHP, PCCM and PCCM entity's responsibilities for coordination of enrollee care; and
- To the extent available, quality and performance indicators for each MCO, PIHP, PAHP and PCCM entity, including enrollee satisfaction.

3.5.8

The State assures that it will provide the information specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f) to all enrollees of

MCOs, PIHPs, PAHPs and PCCM entities, including that the State must notify all enrollees of their right to disenroll consistent with the requirements of 42 CFR 438.56 at least annually.

3.5.9

The State assures that each MCO, PIHP, PAHP and PCCM entity will provide the information specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f) to all enrollees of MCOs, PIHPs, PAHPs and PCCM entities, including that:

- The MCO, PIHP, PAHP and, when appropriate, the PCCM entity, must make a good faith effort to give written notice of termination of a contracted provider within the timeframe specified in 42 CFR 438.10(f), and
- The MCO, PIHP, PAHP and, when appropriate, the PCCM entity must make available, upon request, any physician incentive plans in place as set forth in 42 CFR 438.3(i).

3.5.10

The State assures that each MCO, PIHP, PAHP and PCCM entity will provide enrollees of that MCO, PIHP, PAHP or PCCM entity an enrollee handbook that meets the requirements as applicable to the MCO, PIHP, PAHP and PCCM entity, specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)(1)-(2), within a reasonable time after receiving notice of the beneficiary's enrollment, by a method consistent with 42 CFR 438.10(g)(3), and including the following items:

- Information that enables the enrollee to understand how to effectively use the managed care program, which, at a minimum, must include:
 - Benefits provided by the MCO, PIHP, PAHP or PCCM entity;
 - How and where to access any benefits provided by the State, including any cost sharing, and how transportation is provided; and
 - In the case of a counseling or referral service that the MCO, PIHP, PAHP, or PCCM entity does not cover because

of moral or religious objections, the MCO, PIHP, PAHP, or PCCM entity must inform enrollees that the service is not covered by the MCO, PIHP, PAHP, or PCCM entity and how they can obtain information from the State about how to access these services.

- The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled;
- Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider;
- The extent to which, and how, after-hours and emergency coverage are provided, including:
 - What constitutes an emergency medical condition and emergency services;
 - The fact that prior authorization is not required for emergency services; and
 - The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care.
- Any restrictions on the enrollee's freedom of choice among network providers;
- The extent to which, and how, enrollees may obtain benefits, including family planning services and supplies from out-of-network providers;
- Cost sharing, if any is imposed under the State plan;
- Enrollee rights and responsibilities, including the elements specified in 42 CFR § 438.100;
- The process of selecting and changing the enrollee's primary care provider;
- Grievance, appeal, and review procedures and timeframes, consistent with 42 CFR 457.1260, in a State-developed or

State-approved description, including:

- The right to file grievances and appeals;
- The requirements and timeframes for filing a grievance or appeal;
- The availability of assistance in the filing process; and
- The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee;
- How to access auxiliary aids and services, including additional information in alternative formats or languages;
- The toll-free telephone number for member services, medical management, and any other unit providing services directly to enrollees; and
- Information on how to report suspected fraud or abuse.

3.5.11 The State assures that each MCO, PIHP, PAHP and PCCM entity will give each enrollee notice of any change that the State defines as significant in the information specified in the enrollee handbook at least 30 days before the intended effective date of the change. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)(4))

3.5.12 The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will make available a provider directory for the MCO's, PIHP's, PAHP's or PCCM entity's network providers, including for physicians (including specialists), hospitals, pharmacies, and behavioral health providers, that includes information as specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h)(1)-(2) and (4).

3.5.13 The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will update any information included in a paper provider directory at least monthly and in an electronic provider directories as specified in 42 CFR 438.10(h)(3). (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h)(3))

- 3.5.14** The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will make available the MCO's, PIHP's, PAHP's, or PCCM entity's formulary that meets the requirements specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(i), including:
- Which medications are covered (both generic and name brand); and
 - What tier each medication is on.

- 3.5.15** The State assures that each MCO, PIHP, PAHP, PCCM and PCCM entity follows the requirements for marketing activities under 42 CFR 457.1224, cross-referencing to 42 CFR 438.104 (except 42 CFR 438.104(c)).

Guidance: Requirements for marketing activities include, but are not limited to, that the MCO, PIHP, PAHP, PCCM, or PCCM entity does not distribute any marketing materials without first obtaining State approval; distributes the materials to its entire service areas as indicated in the contract; does not seek to influence enrollment in conjunction with the sale or offering of any private insurance; and does not, directly or indirectly, engage in door-to-door, telephone, email, texting, or other cold-call marketing activities. (42 CFR 104(b))

Guidance: Only States with MCOs, PIHPs, or PAHPs need to answer the remaining assurances in Section 3.5 (3.5.16 through 3.5.18).

- 3.5.16** The State assures that each MCO, PIHP and PAHP protects communications between providers and enrollees under 42 CFR 457.1222, cross-referencing to 42 CFR 438.102.

- 3.5.17** The State assures that MCOs, PIHPs, and PAHPs have arrangements and procedures that prohibit the MCO, PIHP, and PAHP from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of the MCO, PAHP, or PIHP for the purpose of influencing the individual to enroll with the entity. (42 CFR 457.1280(b)(2))

Guidance: States should also complete Section 3.9, which includes additional provisions about the notice procedures for grievances and appeals.

- 3.5.18** The State assures that each contracted MCO, PIHP, and PAHP comply with the notice requirements specified for grievances and appeals in accordance with the terms of 42 CFR 438, Subpart F, except that the terms of 42 CFR 438.420 do not apply and that references to reviews should be read to refer to reviews as described in 42 CFR 457, Subpart K. (42 CFR 457.1260)

3.6 Benefits and Services

Guidance: The State should also complete Section 3.10 (Program Integrity).

- 3.6.1** The State assures that MCO, PIHP, PAHP, PCCM entity, and PCCM contracts involving Indians, Indian health care providers, and Indian managed care entities comply with the requirements of 42 CFR 438.14. (42 CFR 457.1209)
- 3.6.2** The State assures that all services covered under the State plan are available and accessible to enrollees. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)
- 3.6.3** The State assures that it:
- Publishes the State’s network adequacy standards developed in accordance with 42 CFR 457.1218, cross-referencing 42 CFR 438.68(b)(1) on the Web site required by 42 CFR 438.10;
 - Makes available, upon request, the State’s network adequacy standards at no cost to enrollees with disabilities in alternate formats or through the provision of auxiliary aids and services. (42 CFR 457.1218, cross-referencing 42 CFR 438.68(e))

Guidance: Only States with MCOs, PIHPs, or PAHPs need to complete the remaining assurances in Section 3.6 (3.6.4 through 3.6.20).

- 3.6.4** The State assures that each MCO, PAHP and PIHP meet the State’s network adequacy standards. (42 CFR 457.1218, cross-referencing 42 CFR 438.68; 42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)

- 3.6.5** The State assures that each MCO, PIHP, and PAHP includes within its network of credentialed providers:
- A sufficient number of providers to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities;
 - Women’s health specialists to provide direct access to covered care necessary to provide women’s routine and preventative health care services for female enrollees; and
 - Family planning providers to ensure timely access to covered services. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b))

- 3.6.6** The State assures that each contract under 42 CFR 457.1201 permits an enrollee to choose his or her network provider. (42 CFR 457.1201(j), cross-referencing 42 CFR 438.3(l))

- 3.6.7** The State assures that each MCO, PIHP, and PAHP provides for a second opinion from a network provider or arranges for the enrollee to obtain one outside the network, at no cost. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(3))

- 3.6.8** The State assures that each MCO, PIHP, and PAHP ensures that providers, in furnishing services to enrollees, provide timely access to care and services, including by:
- Requiring the contract to adequately and timely cover out-of-network services if the provider network is unable to provide necessary services covered under the contract to a particular enrollee and at a cost to the enrollee that is no greater than if the services were furnished within the network;
 - Requiring the MCO, PIHP and PAHP meet and its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services;

- Ensuring that the hours of operation for a network provider are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid or CHIP Fee-For-Service, if the provider serves only Medicaid or CHIP enrollees;
- Ensuring that the MCO, PIHP and PAHP makes available services include in the contract on a 24-hours a day, 7 days a week basis when medically necessary;
- Establishing mechanisms to ensure compliance by network providers;
- Monitoring network providers regularly to determine compliance;
- Taking corrective action if there is a failure to comply by a network provider. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(4) and (5) and (c))

3.6.9 The State assures that each MCO, PIHP, and PAHP has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care. (42 CFR 457.1230(b), cross-referencing to 42 CFR 438.207)

3.6.10 The State assures that each MCO, PIHP, and PAHP will be required to submit documentation to the State, at the time of entering into a contract with the State, on an annual basis, and at any time there has been a significant change to the MCO, PIHP, or PAHP's operations that would affect the adequacy of capacity and services, to demonstrate that each MCO, PIHP, and PAHP for the anticipated number of enrollees for the service area:

- Offers an appropriate range of preventative, primary care and specialty services; and
- Maintains a provider network that is sufficient in number, mix, and geographic distribution. (42 CFR 457.1230, cross-referencing to 42 CFR 438.207(b))

3.6.11 ☒ Except that 42 CFR 438.210(a)(5) does not apply to CHIP, the State assures that its contracts with each MCO, PIHP, or PAHP comply with the coverage of services requirements under 42 CFR 438.210, including:

- Identifying, defining, and specifying the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer; and
- Permitting an MCO, PIHP, or PAHP to place appropriate limits on a service. (42 CFR 457.1230(d), cross referencing to 42 CFR 438.210(a) except that 438.210(a)(5) does not apply to CHIP contracts)

3.6.12 ☒ Except that 438.210(b)(2)(iii) does not apply to CHIP, the State assures that its contracts with each MCO, PIHP, or PAHP comply with the authorization of services requirements under 42 CFR 438.210, including that:

- The MCO, PIHP, or PAHP and its subcontractors have in place and follow written policies and procedures;
- The MCO, PIHP, or PAHP have in place mechanisms to ensure consistent application of review criteria and consult with the requesting provider when appropriate; and
- Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual with appropriate expertise in addressing the enrollee's medical, or behavioral health needs. (42 CFR 457.1230(d), cross referencing to 42 CFR 438.210(b), except that 438.210(b)(2)(iii) does not apply to CHIP contracts)

3.6.13 ☒ The State assures that its contracts with each MCO, PIHP, or PAHP require each MCO, PIHP, or PAHP to notify the requesting provider and given written notice to the enrollee of any adverse benefit determination to deny a service authorization request, or to authorize a

service in an amount, duration, or scope that is less than requested. (42 CFR 457.1230(d), cross-referencing to 42 CFR 438.210(c))

- 3.6.14** The State assures that its contracts with each MCO, PIHP, or PAHP provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee. (42 CFR 457.1230(d), cross-referencing to 42 CFR 438.210(e))
- 3.6.15** The State assures that it has a transition of care policy that meets the requirements of 438.62(b)(1) and requires that each contracted MCO, PIHP, and PAHP implements the policy. (42 CFR 457.1216, cross-referencing to 42 CFR 438.62)
- 3.6.16** The State assures that each MCO, PIHP, and PAHP has implemented procedures to deliver care to and coordinate services for all enrollees in accordance with 42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208, including:
- Ensure that each enrollee has an ongoing source of care appropriate to his or her needs;
 - Ensure that each enrollee has a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee;
 - Provide the enrollee with information on how to contact their designated person or entity responsible for the enrollee's coordination of services;
 - Coordinate the services the MCO, PIHP, or PAHP furnishes to the enrollee between settings of care; with services from any other MCO, PIHP, or PAHP; with fee-for-service services; and with the services the enrollee receives from community and social support providers;
 - Make a best effort to conduct an initial screening of each enrollee's needs within 90 days of the effective date of

- enrollment for all new enrollees;
- Share with the State or other MCOs, PIHPs, or PAHPs serving the enrollee the results of any identification and assessment of the enrollee’s needs;
- Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards; and
- Ensure that each enrollee’s privacy is protected in the process of coordinating care is protected with the requirements of 45 CFR parts 160 and 164 subparts A and E. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(b)).

Guidance: For assurances 3.6.17 through 3.6.20, applicability to PIHPs and PAHPs is based a determination by the State in relation to the scope of the entity’s services and on the way the State has organized its delivery of managed care services, whether a particular PIHP or PAHP is required to implement the mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(a)(2))

3.6.17 The State assures that it has implemented mechanisms for identifying to MCOs, PIHPs, and PAHPs enrollees with special health care needs who are eligible for assessment and treatment services under 42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c) and included the mechanism in the State’s quality strategy.

3.6.18 The State assures that each applicable MCO, PIHP, and PAHP implements the mechanisms to comprehensively assess each enrollee identified by the state as having special health care needs. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(2))

3.6.19 The State assures that each MCO, PIHP, and PAHP will produce a treatment or service plan that meets the following requirements for enrollees identified with special health care needs:

- Is in accordance with applicable State quality assurance and

utilization review standards;

- Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(3)).

- 3.6.20** The State assures that each MCO, PIHP, and PAHP must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs for enrollees identified with special health care needs who need a course of treatment or regular care monitoring. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(4))

3.7 Operations

- 3.7.1** The State assures that it has established a uniform credentialing and recredentialing policy that addresses acute, primary, behavioral, and substance use disorders providers and requires each MCO, PIHP and PAHP to follow those policies. (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(b)(1))

Guidance: Only States with MCOs, PIHPs, or PAHPs need to answer the remaining assurances in Section 3.7 (3.7.2 through 3.7.9).

- 3.7.2** The State assures each contracted MCO, PIHP and PAHP will comply with the provider selection requirements in 42 CFR 457.1208 and 457.1233(a), cross-referencing 42 CFR 438.12 and 438.214, including that:

- Each MCO, PIHP, or PAHP implements written policies and procedures for selection and retention of network providers (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(a));
- MCO, PIHP, and PAHP network provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require

costly treatment (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(c));

- MCOs, PIHPs, and PAHPs do not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification, solely on the basis of that license or certification (42 CFR 457.1208, cross referencing 42 CFR 438.12(a));
- If an MCO, PIHP, or PAHP declines to include individual or groups of providers in the MCO, PIHP, or PAHP's provider network, the MCO, PIHP, and PAHP gives the affected providers written notice of the reason for the decision (42 CFR 457.1208, cross referencing 42 CFR 438.12(a)); and
- MCOs, PIHPs, and PAHPs do not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act. (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(d)).

3.7.3

The State assures that each contracted MCO, PIHP, and PAHP complies with the subcontractual relationships and delegation requirements in 42 CFR 457.1233(b), cross-referencing 42 CFR 438.230, including that:

- The MCO, PIHP, or PAHP maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State;
- All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor specify that all delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement, the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's, PIHP's, or PAHP's contract obligations, and the contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the MCO,

PIHP, or PAHP determine that the subcontractor has not performed satisfactorily;

All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor must specify that the subcontractor agrees to comply with all applicable CHIP laws, regulations, including applicable sub regulatory guidance and contract provisions; and

The subcontractor agrees to the audit provisions in 438.230(c)(3).

3.7.4 The State assures that each contracted MCO and, when applicable, each PIHP and PAHP, adopts and disseminates practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field; consider the needs of the MCO's, PIHP's, or PAHP's enrollees; are adopted in consultation with network providers; and are reviewed and updated periodically as appropriate. (42 CFR 457.1233(c), cross referencing 42 CFR 438.236(b) and (c)).

3.7.5 The State assures that each contracted MCO and, when applicable, each PIHP and PAHP makes decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the practice guidelines. (42 CFR 457.1233(c), cross referencing 42 CFR 438.236(d)).

3.7.6 The State assures that each contracted MCO, PIHP, and PAHP maintains a health information system that collects, analyzes, integrates, and reports data consistent with 42 CFR 438.242. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of CHIP eligibility. (42 CFR 457.1233(d), cross referencing 42 CFR 438.242).

3.7.7 The State assures that it reviews and validates the encounter data collected, maintained, and submitted to the State by the MCO, PIHP, or

PAHP to ensure it is a complete and accurate representation of the services provided to the enrollees under the contract between the State and the MCO, PIHP, or PAHP and meets the requirements 42 CFR 438.242 of this section. (42 CFR 457.1233(d), cross referencing 42 CFR 438.242).

3.7.8 The State assures that it will submit to CMS all encounter data collected, maintained, submitted to the State by the MCO, PIHP, and PAHP once the State has reviewed and validated the data based on the requirements of 42 CFR 438.242. (CMS State Medicaid Director Letter #13-004).

3.7.9 The State assures that each contracted MCO, PIHP and PAHP complies with the privacy protections under 42 CFR 457.1110. (42 CFR 457.1233(e)).

3.8 Beneficiary Protections

3.8.1 The State assures that each MCO, PIHP, PAHP, PCCM and PCCM entity has written policies regarding the enrollee rights specified in 42 CFR 438.100. (42 CFR 457.1220, cross-referencing to 42 CFR 438.100(a)(1)).

3.8.2 The State assures that its contracts with an MCO, PIHP, PAHP, PCCM, or PCCM entity include a guarantee that the MCO, PIHP, PAHP, PCCM, or PCCM entity will not avoid costs for services covered in its contract by referring enrollees to publicly supported health care resources. (42 CFR 457.1201(p)).

3.8.3 The State assures that MCOs, PIHPs, and PAHPs do not hold the enrollee liable for the following:

- The MCO's, PIHP's or PAHP's debts, in the event of the entity's solvency. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(a))

- Covered services provided to the enrollee for which the State does not pay the MCO, PIHP or PAHP or for which the State, MCO, PIHP, or PAHP does not pay the individual or the health care provider that furnished the services under a contractual, referral or other arrangement. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(b))
- Payments for covered services furnished under a contract, referral or other arrangement that are in excess of the amount the enrollee would owe if the MCO, PIHP or PAHP covered the services directly. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(c))

3.9 Grievances and Appeals

Guidance: Only States with MCOs, PIHPs, or PAHPs need to complete Section 3.9. States with PCCMs and/or PCCM entities should be adhering to the State's review process for benefits.

3.9.1 The State assures that each MCO, PIHP, and PAHP has a grievance and appeal system in place that allows enrollees to file a grievance and request an appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c))

3.9.2 The State assures that each MCO, PIHP, and PAHP has only one level of appeal for enrollees. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(b))

3.9.3 The State assures that an enrollee may request a State review after receiving notice that the adverse benefit determination is upheld, or after an MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in 42 CFR 438.408. (42 CFR 457.1260, cross-referencing to 438.402(c))

3.9.4. Does the state offer and arrange for an external medical review?

Yes

No

Guidance: Only states that answered yes to assurance 3.9.4 need to complete the next assurance (3.9.5).

- 3.9.5 The State assures that the external medical review is:
- At the enrollee's option and not required before or used as a deterrent to proceeding to the State review;
 - Independent of both the State and MCO, PIHP, or PAHP;
 - Offered without any cost to the enrollee; and
 - Not extending any of the timeframes specified in 42 CFR 438.408. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(1)(i))
- 3.9.6 The State assures that an enrollee may file a grievance with the MCO, PIHP, or PAHP at any time. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(i))
- 3.9.7 The State assures that an enrollee has 60 calendar days from the date on an adverse benefit determination notice to file a request for an appeal to the MCO, PIHP, or PAHP. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(ii))
- 3.9.8 The State assures that an enrollee may file a grievance and request an appeal either orally or in writing. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(3)(i)).
- 3.9.9 The State assures that each MCO, PIHP, and PAHP gives enrollees timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below in Section 3.9.10 and in 42 CFR 438.10.
- 3.9.10 The State assures that the notice of an adverse benefit determination explains:
- The adverse benefit determination.
 - The reasons for the adverse benefit determination, including the

right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.

- The enrollee's right to request an appeal of the MCO's, PIHP's, or PAHP's adverse benefit determination, including information on exhausting the MCO's, PIHP's, or PAHP's one level of appeal and the right to request a State review.
- The procedures for exercising the rights specified above under this assurance.
- The circumstances under which an appeal process can be expedited and how to request it. (42 CFR 457.1260, cross-referencing to 42 CFR 438.404(b))

3.9.11 The State assures that the notice of an adverse benefit determination is provided in a timely manner in accordance with 42 CFR 457.1260. (42 CFR 457.1260, cross-referencing to 42 CFR 438.404(c)).

3.9.12 The State assures that MCOs, PIHPs, and PAHPs give enrollees reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(a))

3.9.13 The state makes the following assurances related to MCO, PIHP, and PAHP processes for handling enrollee grievances and appeals:

- Individuals who make decisions on grievances and appeals were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.

- Individuals who make decisions on grievances and appeals, if deciding any of the following, are individuals who have the appropriate clinical expertise in treating the enrollee's condition or disease:
 - An appeal of a denial that is based on lack of medical necessity.
 - A grievance regarding denial of expedited resolution of an appeal.
 - A grievance or appeal that involves clinical issues.
- All comments, documents, records, and other information submitted by the enrollee or their representative will be taken into account, without regard to whether such information was submitted or considered in the initial adverse benefit determination.
- Enrollees have a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.
- Enrollees are provided the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.
- The enrollee and his or her representative or the legal representative of a deceased enrollee's estate are included as parties to the appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(b))

3.9.14 The State assures that standard grievances are resolved (including notice to the affected parties) within 90 calendar days from the day the MCO, PIHP, or PAHP receives the grievance. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b))

3.9.15 The State assures that standard appeals are resolved (including notice to the affected parties) within 30 calendar days from the day the MCO, PIHP, or PAHP receives the appeal. The MCO, PIHP, or PAHP may extend the timeframe by up to 14 calendar days if the enrollee requests the extension or the MCO, PIHP, or PAHP shows that there is need for additional information and that the delay is in the enrollee's interest. (42 CFR 457.1260, cross-referencing to 42 CFR 42 CFR 438.408(b) and (c))

3.9.16 The State assures that each MCO, PIHP, and PAHP establishes and maintains an expedited review process for appeals that is no longer than 72 hours after the MCO, PIHP, or PAHP receives the appeal. The expedited review process applies when the MCO, PIHP, or PAHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b) and (c), and 42 CFR 438.410(a))

3.9.17 The State assures that if an MCO, PIHP, or PAHP denies a request for expedited resolution of an appeal, it transfers the appeal within the timeframe for standard resolution in accordance with 42 CFR 438.408(b)(2). (42 CFR 457.1260, cross-referencing to 42 CFR 438.410(c)(1))

3.9.18 The State assures that if the MCO, PIHP, or PAHP extends the timeframes for an appeal not at the request of the enrollee or it denies a request for an expedited resolution of an appeal, it completes all of the following:

- Make reasonable efforts to give the enrollee prompt oral notice of the delay.
- Within 2 calendar days give the enrollee written notice of the reason

for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.

- Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c) and 42 CFR 438.410(c))

3.9.19 The State assures that if an MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process and the enrollee may initiate a State review. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c)(3))

3.9.20 The State assures that has established a method that an MCO, PIHP, and PAHP will use to notify an enrollee of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at 42 CFR 438.10. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(1))

3.9.21 For all appeals, the State assures that each contracted MCO, PIHP, and PAHP provides written notice of resolution in a format and language that, at a minimum, meet the standards described at 42 CFR 438.10. The notice of resolution includes at least the following items:

- The results of the resolution process and the date it was completed; and
- For appeals not resolved wholly in favor of the enrollees:
 - The right to request a State review, and how to do so.
 - The right to request and receive benefits while the hearing is pending, and how to make the request.
 - That the enrollee may, consistent with State policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(i) and (e))

- 3.9.22** For notice of an expedited resolution, the State assures that each contracted MCO, PIHP, or PAHP makes reasonable efforts to provide oral notice, in addition to the written notice of resolution. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(ii))
- 3.9.23** The State assures that if it offers an external medical review:
- The review is at the enrollee's option and is not required before or used as a deterrent to proceeding to the State review;
 - The review is independent of both the State and MCO, PIHP, or PAHP; and
 - The review is offered without any cost to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(f))
- 3.9.24** The State assures that MCOs, PIHPs, and PAHPs do not take punitive action against providers who request an expedited resolution or support an enrollee's appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.410(b))
- 3.9.25** The State assures that MCOs, PIHPs, or PAHPs must provide information specified in 42 CFR 438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract. This includes:
- The right to file grievances and appeals;
 - The requirements and timeframes for filing a grievance or appeal;
 - The availability of assistance in the filing process;
 - The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee; and
 - The fact that, when requested by the enrollee, benefits that the MCO, PIHP, or PAHP seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State review within the timeframes specified for filing, and that the enrollee may, consistent with State policy, be required to pay the cost of services furnished

while the appeal or State review is pending if the final decision is adverse to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.414)

3.9.26 The State assures that it requires MCOs, PIHPs, and PAHPs to maintain records of grievances and appeals and reviews the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy. The record must be accurately maintained in a manner accessible to the state and available upon request to CMS. (42 CFR 457.1260, cross-referencing to 42 CFR 438.416)

3.9.27 The State assures that if the MCO, PIHP, or PAHP, or the State review officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO, PIHP, or PAHP must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. (42 CFR 457.1260, cross-referencing to 42 CFR 438.424(a))

3.10 Program Integrity

Guidance: The State should complete Section 11 (Program Integrity) in addition to Section 3.10.

Guidance: Only States with MCOs, PIHPs, or PAHPs need to answer the first seven assurances (3.10.1 through 3.10.7).

3.10.1 The State assures that any entity seeking to contract as an MCO, PIHP, or PAHP under a separate child health program has administrative and management arrangements or procedures designed to safeguard against fraud and abuse, including:

Enforcing MCO, PIHP, and PAHP compliance with all applicable Federal and State statutes, regulations, and standards;

Prohibiting MCOs, PIHPs, or PAHPs from conducting any unsolicited personal contact with a potential enrollee by an

employee or agent of the MCO, PAHP, or PIHP for the purpose of influencing the individual to enroll with the entity; and

- Including a mechanism for MCOs, PIHPs, and PAHPs to report to the State, to CMS, or to the Office of Inspector General (OIG) as appropriate, information on violations of law by subcontractors, providers, or enrollees of an MCO, PIHP, or PAHP and other individuals. (42 CFR 457.1280).

3.10.2 The State assures that it has in effect safeguards against conflict of interest on the part of State and local officers and employees and agents of the State who have responsibilities relating to the MCO, PIHP, or PAHP contracts or enrollment processes described in 42 CFR 457.1210(a). (42 CFR 457.1214, cross referencing 42 CFR 438.58)

3.10.3 The State assures that it periodically, but no less frequently than once every 3 years, conducts, or contracts for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each MCO, PIHP or PAHP. (42 CFR 457.1285, cross referencing 42 CFR 438.602(e))

3.10.4 The State assures that it requires MCOs, PIHPs, PAHP, and or subcontractors (only to the extent that the subcontractor is delegated responsibility by the MCO, PIHP, or PAHP for coverage of services and payment of claims) implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include the following:

- A compliance program that includes all of the elements described in 42 CFR 438.608(a)(1);
- Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State;
- Provision for prompt notification to the State when it receives information about changes in an enrollee's circumstances that may

- affect the enrollee's eligibility;
- Provision for notification to the State when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCO, PIHP or PAHP;
- Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis;
- In the case of MCOs, PIHPs, or PAHPs that make or receive annual payments under the contract of at least \$5,000,000, provision for written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers;
- Provision for the prompt referral of any potential fraud, waste, or abuse that the MCO, PIHP, or PAHP identifies to the State Medicaid/CHIP program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit; and
- Provision for the MCO's, PIHP's, or PAHP's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with 42 CFR 455.23. (42 CFR 457.1285, cross referencing 42 CFR 438.608(a))

3.10.5 The State assures that each MCO, PIHP, or PAHP requires and has a mechanism for a network provider to report to the MCO, PIHP or PAHP when it has received an overpayment, to return the overpayment to the MCO, PIHP or PAHP within 60 calendar days after the date on which the overpayment was identified, and to notify the MCO, PIHP or PAHP in writing of the reason for the overpayment. (42 CFR 457.1285, cross referencing 42 CFR 438.608(d)(2))

- 3.10.6** The State assures that each MCO, PIHP, or PAHP reports annually to the State on their recoveries of overpayments. (42 CFR 457.1285, cross referencing 42 CFR 438.608(d)(3))
- 3.10.7** The State assures that it screens and enrolls, and periodically revalidates, all network providers of MCOs, PIHPs, and PAHPs, in accordance with the requirements of part 455, subparts B and E. This requirement also extends to PCCMs and PCCM entities to the extent that the primary care case manager is not otherwise enrolled with the State to provide services to fee-for-service beneficiaries. (42 CFR 457.1285, cross referencing 42 CFR 438.602(b)(1) and 438.608(b))
- 3.10.8** The State assures that it reviews the ownership and control disclosures submitted by the MCO, PIHP, PAHP, PCCM or PCCM entity, and any subcontractors. (42 CFR 457.1285, cross referencing 42 CFR 438.602(c))
- 3.10.9** The State assures that it confirms the identity and determines the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases. If the State finds a party that is excluded, the State promptly notifies the MCO, PIHP, PAHP, PCCM, or PCCM entity and takes action consistent with 42 CFR 438.610(c). (42 CFR 457.1285, cross referencing 42 CFR 438.602(d))
- 3.10.10** The State assures that it receives and investigates information from whistleblowers relating to the integrity of the MCO, PIHP, PAHP, PCCM, or PCCM entity, subcontractors, or network providers receiving Federal funds under this part. (42 CFR 457.1285, cross referencing 42 CFR 438.602(f))
- 3.10.11** The State assures that MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities with which the State contracts are not located outside of the

United States and that no claims paid by an MCO, PIHP, or PAHP to a network provider, out-of-network provider, subcontractor or financial institution located outside of the U.S. are considered in the development of actuarially sound capitation rates. (42 CFR 457.1285, cross referencing to 42 CFR 438.602(i); Section 1902(a)(80) of the Social Security Act)

3.10.12

The State assures that MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities submit to the State the following data, documentation, and information:

- Encounter data in the form and manner described in 42 CFR 438.818.
- Data on the basis of which the State determines the compliance of the MCO, PIHP, or PAHP with the medical loss ratio requirement described in 42 CFR 438.8.
- Data on the basis of which the State determines that the MCO, PIHP or PAHP has made adequate provision against the risk of insolvency as required under 42 CFR 438.116.
- Documentation described in 42 CFR 438.207(b) on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in 42 CFR 438.206.
- Information on ownership and control described in 42 CFR 455.104 of this chapter from MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors as governed by 42 CFR 438.230.
- The annual report of overpayment recoveries as required in 42 CFR 438.608(d)(3). (42 CFR 457.1285, cross referencing 42 CFR 438.604(a))

3.10.13

The State assures that:

- It requires that the data, documentation, or information submitted in accordance with 42 CFR 457.1285, cross referencing 42 CFR 438.604(a), is certified in a manner that the MCO's, PIHP's, PAHP's, PCCM's, or PCCM entity's Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. (42 CFR 457.1285, cross referencing 42 CFR 438.606(a))
- It requires that the certification includes an attestation that, based on best information, knowledge, and belief, the data, documentation, and information specified in 42 CFR 438.604 are accurate, complete, and truthful. (42 CFR 457.1285, cross referencing 42 CFR 438.606(b)); and
- It requires the MCO, PIHP, PAHP, PCCM, or PCCM entity to submit the certification concurrently with the submission of the data, documentation, or information required in 42 CFR 438.604(a) and (b). (42 CFR 457.1285, cross referencing 42 CFR 438.604(c))

3.10.14 The State assures that each MCO, PIHP, PAHP, PCCM, PCCM entity, and any subcontractors provides: written disclosure of any prohibited affiliation under 42 CFR 438.610, written disclosure of and information on ownership and control required under 42 CFR 455.104, and reports to the State within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract. (42 CFR 457.1285, cross referencing 42 CFR 438.608(c))

3.10.15 The State assures that services are provided in an effective and efficient manner. (Section 2101(a))

3.10.16 The State assures that it operates a Web site that provides:

- The documentation on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services;

- Information on ownership and control of MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors; and
- The results of any audits conducted under 42 CFR 438.602(e). (42 CFR 457.1285, cross-referencing to 42 CFR 438.602(g)).

3.11 Sanctions

Guidance: Only States with MCOs need to answer the next three assurances (3.11.1 through 3.11.3). Intermediate sanctions are defined at 42 CFR 438.702(a)(4) as: (1) Civil money penalties; (2) Appointment of temporary management (for an MCO); (3) Granting enrollees the right to terminate enrollment without cause; (4) Suspension of all new enrollment; and (5) Suspension of payment for beneficiaries.

3.11.1 The State assures that it has established intermediate sanctions that it may impose if it makes the determination that an MCO has acted or failed to act in a manner specified in 438.700(b)-(d). (42 CFR 457.1270, cross referencing 42 CFR 438.700)

3.11.2 The State assures that it will impose temporary management if it finds that an MCO has repeatedly failed to meet substantive requirements of part 457 subpart L. (42 CFR 457.1270, cross referencing 42 CFR 438.706(b))

3.11.3 The State assures that if it imposes temporary management on an MCO, the State allows enrollees the right to terminate enrollment without cause and notifies the affected enrollees of their right to terminate enrollment. (42 CFR 457.1270, cross referencing 42 CFR 438.706(b))

Guidance: Only states with PCCMs, or PCCM entities need to answer the next assurance (3.11.4).

3.11.4 Does the State establish intermediate sanctions for PCCMs or PCCM entities?

Yes

No

Guidance: Only states with MCOs and states that answered yes to assurance 3.11.4 need to complete the next three assurances (3.11.5 through 3.11.7).

3.11.5 The State assures that before it imposes intermediate sanctions, it gives the affected entity timely written notice. (42 CFR 457.1270, cross referencing 42 CFR 438.710(a))

3.11.6 The State assures that if it intends to terminate an MCO, PCCM, or PCCM entity, it provides a pre-termination hearing and written notice of the decision as specified in 42 CFR 438.710(b). If the decision to terminate is affirmed, the State assures that it gives enrollees of the MCO, PCCM or PCCM entity notice of the termination and information, consistent with 42 CFR 438.10, on their options for receiving CHIP services following the effective date of termination. (42 CFR 457.1270, cross referencing 42 CFR 438.710(b))

3.11.7 The State assures that it will give CMS written notice that complies with 42 CFR 438.724 whenever it imposes or lifts a sanction for one of the violations listed in 42 CFR 438.700. (42 CFR 457.1270, cross referencing 42 CFR 438.724)

3.12 Quality Measurement and Improvement; External Quality Review

Guidance: The State should complete Sections 7 (Quality and Appropriateness of Care) and 9 (Strategic Objectives and Performance Goals and Plan Administration) in addition to Section 3.12.

Guidance: States with MCO(s), PIHP(s), PAHP(s), or certain PCCM entity/ies (PCCM entities whose contract with the State provides for shared savings, incentive payments or other financial reward for improved quality outcomes - see 42 CFR 457.1240(f)) - should complete the applicable sub-sections for each entity type in this section, regarding 42 CFR 457.1240 and 1250.

3.12.1 Quality Strategy

Guidance: All states with MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities need to complete section 3.12.1.

- 3.12.1.1** The State assures that it will draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished CHIP enrollees as described in 42 CFR 438.340(a). The quality strategy must include the following items:
- The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by 42 CFR 438.68 and 438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with 42 CFR 438.236;
 - A description of:
 - The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP with which the State contracts, including but not limited to, the performance measures reported in accordance with 42 CFR 438.330(c); and
 - The performance improvement projects to be implemented in accordance with 42 CFR 438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP, or PAHP.
 - Arrangements for annual, external independent reviews, in accordance with 42 CFR 438.350, of the quality outcomes and timeliness of, and access to, the services covered under each contract;
 - A description of the State's transition of care policy required under 42 CFR 438.62(b)(3);
 - The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, and primary language;
 - For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of 42 CFR Part

438;

- A description of how the State will assess the performance and quality outcomes achieved by each PCCM entity;
- The mechanisms implemented by the State to comply with 42 CFR 438.208(c)(1) (relating to the identification of persons with special health care needs);
Identification of the external quality review (EQR)-related activities for which the State has exercised the option under 42 CFR 438.360 (relating to nonduplication of EQR-related activities), and explain the rationale for the State's determination
that the private accreditation activity is comparable to such EQR-related activities;
- Identification of which quality measures and performance outcomes the State will publish at least annually on the Web site required under 42 CFR 438.10(c)(3); and
- The State's definition of a “significant change” for the purposes of updating the quality strategy under 42 CFR 438.340(c)(3)(ii). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b))

3.12.1.2 The State assures that the goals and objectives for continuous quality improvement in the quality strategy are measurable and take into consideration the health status of all populations in the State served by the MCO, PIHP, and PAHP. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b)(2))

3.12.1.3 The State assures that for purposes of the quality strategy, the State provides the demographic information for each CHIP enrollee to the MCO, PIHP or PAHP at the time of enrollment. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b)(6))

- 3.12.1.4** The State assures that it will review and update the quality strategy as needed, but no less than once every 3 years. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2))
- 3.12.1.5** The State assures that its review and updates to the quality strategy will include an evaluation of the effectiveness of the quality strategy conducted within the previous 3 years and the recommendations provided pursuant to 42 CFR 438.364(a)(4). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2)(i) and (iii).
- 3.12.1.6** The State assures that it will submit to CMS:
- A copy of the initial quality strategy for CMS comment and feedback prior to adopting it in final; and
 - A copy of the revised strategy whenever significant changes are made to the document, or whenever significant changes occur within the State's CHIP program, including after the review and update required every 3 years. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(3))
- 3.12.1.7** Before submitting the strategy to CMS for review, the State assures
- that when it drafts or revises the State's quality strategy it will:
- Make the strategy available for public comment; and
 - If the State enrolls Indians in the MCO, PIHP, or PAHP, consult with Tribes in accordance with the State's Tribal consultation policy. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(1))
- 3.12.1.8** The State assures that it makes the results of the review of the quality strategy (including the effectiveness evaluation) and the final quality strategy available on the Web site required under 42 CFR 438.10(c)(3). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2)(ii) and (d))

3.12.2 Quality Assessment and Performance Improvement Program

3.12.2.1 Quality Assessment and Performance Improvement Program: Measures and Projects

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete the next two assurances (3.12.2.1.1 and 3.12.2.1.2).

- 3.12.2.1.1** The State assures that it requires that each MCO, PIHP, and PAHP establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees as provided in 42 CFR 438.330, except that the terms of 42 CFR 438.330(d)(4) (related to dual eligibles) do not apply.

The elements of the assessment and program include at least:

- Standard performance measures specified by the un
- Any measures and programs required by CMS (42 CFR 438.330(a)(2);
- Performance improvement projects that focus on clinical and non-clinical areas, as specified in 42 CFR 438.330(d);
- Collection and submission of performance measurement data in accordance with 42 CFR 438.330(c);
- Mechanisms to detect both underutilization and overutilization of services; and
- Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs, as defined by the State in the quality strategy under 42 CFR 457.1240(e) and Section 3.12.1 of this template). (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(b) and (c)(1)).

Guidance: A State may request an exemption from including the performance measures or performance improvement programs established by CMS under 42 CFR 438.330(a)(2), by submitting a written request to CMS explaining the basis for such request.

- 3.12.2.1.2** The State assures that each MCO, PIHP, and PAHP's performance improvement projects are designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. The performance improvement projects include at least the following elements:
- Measurement of performance using objective quality indicators;
 - Implementation of interventions to achieve improvement in the access to and quality of care;
 - Evaluation of the effectiveness of the interventions based on the performance measures specified in 42 CFR 438.330(d)(2)(i); and
 - Planning and initiation of activities for increasing or sustaining improvement. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(d)(2))

Guidance: Only states with a PCCM entity whose contract with the State provides for shared savings, incentive payments or other financial reward for improved quality outcomes need to, complete the next assurance (3.12.2.1.3).

- 3.12.2.1.3** The State assures that it requires that each PCCM entity establishes and implements an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees as provided in 42 CFR 438.330, except that the terms of 42 CFR 438.330(d)(4) (related to dual eligibles) do not apply. The assessment and program must include:
- Standard performance measures specified by the State;
 - Mechanisms to detect both underutilization and overutilization of services; and
 - Collection and submission of performance

measurement data in accordance with 42 CFR 438.330(c). (42 CFR 457.1240(a) and (b), cross referencing to 42 CFR 438.330(b)(3) and (c))

3.12.2.2 Quality Assessment and Performance Improvement Program: Reporting and Effectiveness

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete Section 3.12.2.2.

3.12.2.2.1 The State assures that each MCO, PIHP, and PAHP reports on the status and results of each performance improvement project conducted by the MCO, PIHP, and PAHP to the State as required by the State, but not less than once per year. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(d)(3))

3.12.2.2.2 The State assures that it annually requires each MCO, PIHP, and PAHP to:

- 1) Measure and report to the State on its performance using the standard measures required by the State;
- 2) Submit to the State data specified by the State to calculate the MCO's, PIHP's, or PAHP's performance using the standard measures identified by the State; or
- 3) Perform a combination of options (1) and (2) of this assurance. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(c)(2))

3.12.2.2.3 The State assures that the State reviews, at least annually, the impact and effectiveness of the quality assessment and performance improvement program of each MCO, PIHP, PAHP and PCCM entity. The State's review must include:

- The MCO's, PIHP's, PAHP's, and PCCM entity's performance on the measures on which it is required to report; and

- The outcomes and trended results of each MCO's, PIHP's, and PAHP's performance improvement projects. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(e)(1))

3.12.3 Accreditation

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete Section 3.12.3.

3.12.3.1 The State assures that it requires each MCO, PIHP, and PAHP to inform the state whether it has been accredited by a private independent accrediting entity, and, if the MCO, PIHP, or PAHP has received accreditation by a private independent accrediting agency, that the MCO, PIHP, and PAHP authorizes the private independent accrediting entity to provide the State a copy of its recent accreditation review that includes the MCO, PIHP, and PAHP's accreditation status, survey type, and level (as applicable); accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and expiration date of the accreditation. (42 CFR 457.1240(c), cross referencing to 42 CFR 438.332(a) and (b))

3.12.3.2 The State assures that it will make the accreditation status for each contracted MCO, PIHP, and PAHP available on the Web site required under 42 CFR 438.10(c)(3), including whether each MCO, PIHP, and PAHP has been accredited and, if applicable, the name of the accrediting entity, accreditation program, and accreditation level; and update this information at least annually. (42 CFR 457.1240(c), cross referencing to 42 CFR 438.332(c))

3.12.4 Quality Rating

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete Section 3.12.4.

The State assures that it will implement and operate a quality rating system that

issues an annual quality rating for each MCO, PIHP, and PAHP, which the State will prominently display on the Web site required under 42 CFR 438.10(c)(3), in accordance with the requirements set forth in 42 CFR 438.334. (42 CFR 457.1240(d))

Guidance: States will be required to comply with this assurance within 3 years after CMS, in consultation with States and other Stakeholders and after providing public notice and opportunity for comment, has identified performance measures and a methodology for a Medicaid and CHIP managed care quality rating system in the Federal Register.

3.12.5 Quality Review

Guidance: All states with MCOs, PIHPs, PAHPs, PCCMs or PCCM entities need to complete Sections 3.12.5 and 3.12.5.1.

The State assures that each contract with a MCO, PIHP, PAHP, or PCCM entity requires that a qualified EQRO performs an annual external quality review (EQR) for each contracting MCO, PIHP, PAHP or PCCM entity, except as provided in 42 CFR 438.362. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(a))

3.12.5.1 External Quality Review Organization

3.12.5.1.1 The State assures that it contracts with at least one external quality review organization (EQRO) to conduct either EQR alone or EQR and other EQR-related activities. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.356(a))

3.12.5.1.2 The State assures that any EQRO used by the State to comply with 42 CFR 457.1250 must meet the competence and independence requirements of 42 CFR 438.354 and, if the EQRO uses subcontractors, that the EQRO is accountable for and oversees all subcontractor functions. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.354 and 42 CFR 438.356(b) through (d))

3.12.5.2 External Quality Review-Related Activities

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete the next three assurances (3.12.5.2.1 through 3.12.5.2.3). Under 42 CFR 457.1250(a), the State, or its agent or EQRO, must conduct the EQR-related activity under 42 CFR 438.358(b)(1)(iv) regarding validation of the MCO, PIHP, or PAHP's network adequacy during the preceding 12 months; however, the State may permit its contracted MCO, PIHP, and PAHPs to use information from a private accreditation review in lieu of any or all the EQR-related activities under 42 CFR 438.358(b)(1)(i) through (iii) (relating to the validation of performance improvement projects, validation of performance measures, and compliance review).

3.12.5.2.1 The State assures that the mandatory EQR-related activities described in 42 CFR 438.358(b)(1)(i) through (iv) (relating to the validation of performance improvement projects, validation of performance measures, compliance review, and validation of network adequacy) will be conducted on all MCOs, PIHPs, or PAHPs. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.358(b)(1))

3.12.5.2.2 The State assures that if it elects to use nonduplication for any or all of the three mandatory EQR-related activities described at 42 CFR 438.358(b)(1)(i) – (iii), the State will document the use of nonduplication in the State's quality strategy. (42 CFR 457.1250(a), cross referencing 438.360, 438.358(b)(1)(i) through (b)(1)(iii), and 438.340)

3.12.5.2.3 The State assures that if the State elects to use nonduplication for any or all of the three mandatory EQR-related activities described at 42 CFR 438.358(b)(1)(i) – (iii), the State will ensure that all information from a Medicare or private accreditation review for an MCO, PIHP, or PAHP will be furnished to the EQRO for analysis and inclusion in the EQR technical report described in 42

CFR 438.364. ((42 CFR 457.1250(a), cross referencing to 42 CFR 438.360(b))

Guidance: Only states with PCCM entities need to complete the next assurance (3.12.5.2.4).

- 3.12.5.2.4** The State assures that the mandatory EQR-related activities described in 42 CFR 438.358(b)(2) (cross-referencing 42 CFR 438.358(b)(1)(ii) and (b)(1)(iii)) will be conducted on all PCCM entities, which include:
- Validation of PCCM entity performance measures required in accordance with 42 CFR 438.330(b)(2) or PCCM entity performance measures calculated by the State during the preceding 12 months; and
 - A review, conducted within the previous 3-year period, to determine the PCCM entity’s compliance with the standards set forth in subpart D of 42 CFR part 438 and the quality assessment and performance improvement requirements described in 42 CFR 438.330. (42 CFR 457.1250(a), cross referencing to 438.358(b)(2))

3.12.5.3 External Quality Review Report

Guidance: All states with MCOs, PIHPs, PAHPs, PCCMs or PCCM entities need to complete Sections 3.12.5.3.

- 3.12.5.3.1** The State assures that data obtained from the mandatory and optional, if applicable, EQR-related activities in 42 CFR 438.358 is used for the annual EQR to comply with 42 CFR 438.350 and must include, at a minimum, the elements in § 438.364(a)(2)(i) through (iv). (42 CFR 457.1250(a), cross referencing to 42 CFR 438.358(a)(2))

- 3.12.5.3.2** The State assures that only a qualified EQRO will

Approval Date:

produce the EQR technical report (42 CFR 438.364(c)(1)).

- 3.12.5.3.3** The State assures that in order for the qualified EQRO to perform an annual EQR for each contracting MCO, PIHP, PAHP or PCCM entity under 42 CFR 438.350(a) that the following conditions are met:
- The EQRO has sufficient information to use in performing the review;
 - The information used to carry out the review must be obtained from the EQR-related activities described in 42 CFR 438.358 and, if applicable, from a private accreditation review as described in 42 CFR 438.360;
 - For each EQR-related activity (mandatory or optional), the information gathered for use in the EQR must include the elements described in 42 CFR 438.364(a)(2)(i) through (iv); and
 - The information provided to the EQRO in accordance with 42 CFR 438.350(b) is obtained through methods consistent with the protocols established by the Secretary in accordance with 42 CFR 438.352. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(b) through (e))

- 3.12.5.3.4** The State assures that the results of the reviews performed by a qualified EQRO of each contracting MCO, PIHP, PAHP, and PCCM entity are made available as specified in 42 CFR 438.364 in an annual detailed technical report that summarizes findings on access and quality of care. The report includes at least the following items:
- A description of the manner in which the data from all activities conducted in accordance with 42 CFR 438.358⁸³ were aggregated and analyzed, and

Approval Date:

conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR 438.310(c)(2));

- For each EQR-related activity (mandatory or optional) conducted in accordance with 42 CFR 438.358:
 - Objectives;
 - Technical methods of data collection and analysis;
 - Description of data obtained, including validated performance measurement data for each activity conducted in accordance with 42 CFR 438.358(b)(1)(i) and (ii); and
 - Conclusions drawn from the data.
- An assessment of each MCO's, PIHP's, PAHP's, or PCCM entity's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to CHIP beneficiaries;
- Recommendations for improving the quality of health care services furnished by each MCO, PIHP, PAHP, or

PCCM entity, including how the State can target goals and objectives in the quality strategy, under 42 CFR 438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to CHIP beneficiaries;

- Methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities, consistent with guidance included in the EQR protocols issued in accordance with 42 CFR 438.352(e); and
- An assessment of the degree to which each MCO, PIHP,

PAHP, or PCCM entity has addressed effectively the recommendations for quality improvement made by the

EQRO during the previous year's EQR. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(f) and 438.364(a))

3.12.5.3.5 The State assures that it does not substantively revise the content of the final EQR technical report without evidence of error or omission. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(b))

3.12.5.3.6 The State assures that it finalizes the annual EQR technical report by April 30th of each year. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(1))

3.12.5.3.7 The State assures that it posts the most recent copy of the annual EQR technical report on the Web site required under 42 CFR 438.10(c)(3) by April 30th of each year. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(i))

3.12.5.3.8 The State assures that it provides printed or electronic

copies of the information specified in 42 CFR 438.364(a) for the annual EQR technical report, upon request, to interested parties such as participating health care providers, enrollees, and potential enrollees of the MCO, PIHP, PAHP, or PCCM, beneficiary advocacy groups, and members of the general public. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(ii))

3.12.5.3.9 The State assures that it makes the information specified in 42 CFR 438.364(a) for the annual EQR technical report available in alternative formats for persons with disabilities, when requested. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(3))

3.12.5.3.10 The State assures that information released under 42 CFR 438.364 for the annual EQR technical report does not disclose the identity or other protected health information of any patient. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(d))

Section 4. Eligibility Standards and Methodology

Guidance: States electing to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan or combination plan should check the appropriate box and provide the ages and income level for each eligibility group.
If the State is electing to take up the option to expand Medicaid eligibility as allowed under section 214 of CHIPRA regarding lawfully residing, complete section 4.1-LR as well as update the budget to reflect the additional costs if the state will claim title XXI match for these children until and if the time comes that the children are eligible for Medicaid.

4.0. **Medicaid Expansion**

4.0.1. Ages of each eligibility group and the income standard for that group:

4.1. **Separate Program** Check all standards that will apply to the State plan. (42CFR 457.305(a) and 457.320(a))

4.1.0 Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option.

The state uses the federal hub and the SSA verification option. In instances where citizenship is not verified by these means the client is approved for coverage based on their attestation and given a reasonable opportunity to provide verification.

4.1.1 Geographic area served by the Plan if less than Statewide:

4.1.2 Ages of each eligibility group, including unborn children and pregnant women (if applicable) and the income standard for that group: Birth through eighteen. **SEE CS7**

4.1.2.1-PC Age: conception through birth (SHO #02-004, issued November 12, 2002). **SEE CS9**

4.1.3 Income of each separate eligibility group (if applicable):
Birth through Eighteen – **312%FPL**

4.1.3.1-PC 0% of the FPL (and not eligible for Medicaid) through 193% of the FPL (SHO #02-004, issued November 12, 2002)
SEE CS7, CS9, and CS15.

4.1.4 Resources of each separate eligibility group (including any standards relating to spend downs and disposition of resources):
There is no resource limit.

4.1.5 Residency (so long as residency requirement is not based on length of time in state): **SEE CS17**

4.1.6 Disability Status (so long as any standard relating to disability status does not restrict eligibility):

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.” **SEE CS10**

4.1.8 Duration of eligibility, not to exceed 12 months: **SEE CS27**

4.1.9 Other Standards- Identify and describe other standards for or affecting eligibility, including those standards in 457.310 and 457.320 that are not addressed above. For instance:
Citizenship and immigration status. **SEE CS18.**

Guidance: States may only require the SSN of the child who is applying for coverage. If SSNs are required and the State covers unborn children, indicate that the unborn children are exempt from providing a SSN. Other standards include, but are not limited to presumptive eligibility and deemed newborns.

4.1.9.1 States should specify whether Social Security Numbers (SSN) are required.

SSNs are required for children birth through eighteen. **SEE CS19.**

Guidance: States should describe their continuous eligibility process and populations that can be continuously eligible.

4.1.9.2 Continuous eligibility
SEE CS27.

4.1-PW **Pregnant Women Option** (section 2112)- The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. Describe the population of pregnant women that the State proposes to cover in this section. Include all eligibility criteria, such as those described in the above categories (for instance, income and resources) that will be applied to this population. Use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option.

Guidance: States have the option to cover groups of “lawfully residing” children and/or pregnant women. States may elect to cover (1) “lawfully residing” children described at section 2107(e)(1)(J) of the Act; (2) “lawfully residing” pregnant women described at section 2107(e)(1)(J) of the Act; or (3) both. A state electing to cover children and/or pregnant women who are considered lawfully residing in the U.S. must offer coverage to all such individuals who meet the definition of lawfully residing, and may not cover a subgroup or only certain groups. In addition, states may not cover these new groups only in CHIP, but must also extend the coverage option to Medicaid. States will need to update their budget to reflect the additional costs for coverage of these children. If a State has been covering these children with State only funds, it is helpful to indicate that so CMS understands the basis for the enrollment estimates and the projected cost of providing coverage. Please remember to update section 9.10 when electing this option.

4.1- LR **Lawfully Residing Option** (Sections 2107(e)(1)(J) and 1903(v)(4)(A); (CHIPRA # 17, SHO # 10-006 issued July 1, 2010) Check if the State is electing the option under section 214 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding lawfully residing to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

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

- (1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. § 1641);
- (2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;
- (3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. § 1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;
- (4) An alien who belongs to one of the following classes:
 - (i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. § § 1160 or 1255a, respectively);
 - (ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. § 1254a), and pending applicants for TPS who have been granted employment authorization;
 - (iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
 - (iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;
 - (v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
 - (vi) Aliens currently in deferred action status; or
 - (vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;
- (5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention

- Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;
- (6) An alien who has been granted withholding of removal under the Convention Against Torture;
 - (7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J));
 - (8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or
 - (9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.
- Elected for pregnant women.
- Elected for children under age **19. SEE CS18**

4.1.1-LR The State provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA Lawfully Residing option, it has verified, at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act. **SEE CS18.**

4.1-DS **Supplemental Dental** (Section 2103(c)(5) - A child who is eligible to enroll in dental-only supplemental coverage, effective January 1, 2009. Eligibility is limited to only targeted low-income children who are otherwise eligible for CHIP but for the fact that they are enrolled in a group health plan or health insurance offered through an employer. The State's CHIP plan income eligibility level is at least the highest income eligibility standard under its approved State child health plan (or under a waiver) as of January 1, 2009. All

who meet the eligibility standards and apply for dental-only supplemental coverage shall be provided benefits. States choosing this option must report these children separately in SEDS. Please update sections 1.1-DS, 4.2-DS, and 9.10 when electing this option.

4.2. Assurances The State assures by checking the box below that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

4.2.1. These standards do not discriminate on the basis of diagnosis.

4.2.2. Within a defined group of covered targeted low-income children, these

standards do not cover children of higher income families without covering children with a lower family income. This applies to pregnant women included in the State plan as well as targeted low-income children.

4.2.3. These standards do not deny eligibility based on a child having a pre-existing medical condition. This applies to pregnant women as well as targeted low-income children.

4.2-DS Supplemental Dental - Please update sections 1.1-DS, 4.1-DS, and 9.10 when electing this option. For dental-only supplemental coverage, the State assures that it has made the following findings with standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

4.2.1-DS These standards do not discriminate on the basis of diagnosis.

4.2.2-DS 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-DS These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Methodology. Describe the methods of establishing and continuing eligibility and enrollment. The description should address the procedures for applying the eligibility standards, the organization and infrastructure responsible for

making and reviewing eligibility determinations, and the process for enrollment of individuals receiving covered services, and whether the State uses the same application form for Medicaid and/or other public benefit programs. (Section 2102)(b)(2)) (42CFR, 457.350)

State delay in processing applications: The requirements related to timely processing of applications may be temporarily waived for CHIP applicants during the Federal COVID-19 public health emergency. State delay in processing renewals and extension of renewals deadlines for families. The requirements related to timely processing of renewals and/or deadlines for families to respond to renewal requests may be temporarily waived for CHIP beneficiaries during the federal COVID-19 public health emergency.

Extend the reasonable opportunity period: The state may provide for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period during the federal COVID-19 public health emergency.

Suspend processing of some changes in circumstance: The state will temporarily delay acting on certain changes in circumstances for CHIP beneficiaries whom the state determines are impacted by a federally-declared disaster area such that processing the change in a timely manner is not feasible. The state will continue to act on the changes in circumstance described in 42 CFR 457.342(a), which cross-reference 435.926(d).

Families now apply and renew their coverage through Washington states' Health Benefit Exchange at www.wahealthplanfinder.org. They may also use a streamlined paper application submitted to the Exchange for data entry of the information on the application.

Ex Parte renewals are completed using electronic data-matching with the federal

hub. If the electronic match confirms eligibility, then CHIP coverage is continued without the need for any further information or forms. If the electronic data match fails, then the family is sent a letter advising them to go to the www.wahealthplanfinder.org to renew their coverage. They also receive a paper renewal form that they may complete and return to the state's Health Benefit Exchange to have renewal data entered into the system.

Data entered into the www.wahealthplanfinder.org web application is transferred to the Automated Client Eligibility System (ACES). ACES transfers eligibility information to the state's Medical Management Information System (MMIS) "ProviderOne". MMIS information is used to enroll clients into managed care.

The application requires the citizenship status and Social Security Number (SSN) of only those children for whom the family is seeking benefits. Adults, and other children listed on the application for whom the family is not applying, are not required to declare their citizenship status or provide an SSN.

When the family applies via www.wahealthplanfinder.org (HPF) web portal, data such as the SSN is transmitted to other available state and federal data exchanges. The information from these exchanges may then be used as electronic proof of eligibility requirements. One such system is the SVES data match with the Social Security Administration (SSA). SSN information is entered into the HPF system during the application process and transmitted to the federal hub in real time. Verification of citizenship and enumeration is federally verified and transmitted back to the HPF system and the application is processed in real time. For continuing enrollment, the Agency will employ an ex parte renewal process that notifies families of their ongoing eligibility every twelve months when the family's circumstances are electronically verified. The renewal letter is generated and mailed to the head of household approximately six weeks prior to the end of the client's 12-month certification period. The family is directed to update their information in the HPF system; call the Agency on a statewide 800#, or complete and return the paper

renewal form with current information such as household members, income, and health insurance status. The information is input into the HPF and eligibility is automatically reviewed first for Medicaid, and then reviewed for CHIP eligibility if the recipient is not Medicaid eligible.

CHIP applicants have the same appeal rights as Medicaid applicants. Applicants who are denied eligibility are sent a letter with information on their rights for an Administrative Hearing. Clients may call the Office of Administrative Hearings (OAH) to set up a hearing. OAH notifies the client and the agency's Administrative Hearing Coordinator. The Coordinator prepares the case and sets up a pre-hearing conference as a way to settle the dispute or collect information. Cases that are not resolved in the pre-hearing conference proceed to an Administrative Hearing. At the Administrative Hearing, an Administrative Law Judge gathers information from the client and agency staff. Hearings can be conducted via telephone or in person. The Judge's decision is mailed to the client and the Administrative Hearings Coordinator. Either party may appeal the decision for additional review and if need be, to the courts.

Guidance: The box below should be checked as related to children and pregnant women. Please note: A State providing dental-only supplemental coverage may not have a waiting list or limit eligibility in any way.

4.3.1. Limitation on Enrollment Describe the processes, if any, that a State will use for instituting enrollment caps, establishing waiting lists, and deciding which children will be given priority for enrollment. If this section does not apply to your state, check the box below. (Section 2102(b)(2)) (42CFR, 457.305(b))

Check here if this section does not apply to your State.

Guidance: Note that for purposes of presumptive eligibility, States do not need to verify the citizenship status of the child. States electing this option should indicate so in the State plan. (42 CFR 457.355)

4.3.2. Check if the State elects to provide presumptive eligibility for children that meets the requirements of section 1920A of the Act. (Section

2107(e)(1)(L)); (42 CFR 457.355) **SEE CS28.**

Guidance: Describe how the State intends to implement the Express Lane option. Include information on the identified Express Lane agency or agencies, and whether the State will be using the Express Lane eligibility option for the initial eligibility determinations, redeterminations, or both.

4.3.3-EL Express Lane Eligibility Check here if the state elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of CHIP eligibility. The state agrees to comply with the requirements of sections 2107(e)(1)(E) and 1902(e)(13) of the Act for this option. Please update sections 4.4-EL, 5.2-EL, 9.10, and 12.1 when electing this option. This authority may not apply to eligibility determinations made before February 4, 2009, or after September 30, 2013. (Section 2107(e)(1)(E))

4.3.3.1-EL Also indicate whether the Express Lane option is applied to (1) initial eligibility determination, (2) redetermination, or (3) both.

4.3.3.2-EL List the public agencies approved by the State as Express Lane agencies.

4.3.3.3-EL List the components/components of CHIP eligibility that are determined under the Express Lane. In this section, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between CHIP eligibility determinations for such children and the determination under the Express Lane option.

4.3.3.3-EL List the component/components of CHIP eligibility that are determined under the Express Lane.

4.3.3.4-EL Describe the option used to satisfy the screen and enrollment requirements before a child may be enrolled under title XXI.

Guidance: States should describe the process they use to screen and enroll children required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 457.80(c). Describe the screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a

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Approval Date:

minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by an Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL and provide an explanation of how this was calculated. Describe whether the State is temporarily enrolling children in CHIP, based on the income finding from an Express Lane agency, pending the completion of the screen and enroll process.

In this section, states should describe their eligibility screening process in a way that addresses the five assurances specified below. The State should consider including important definitions, the relationship with affected Federal, State, and local agencies, and other applicable criteria that will describe the State's ability to make assurances. (Sections 2102(b)(3)(A) and 2110(b)(2)(B)), (42 CFR 457.310(b)(2), 42CFR 457.350(a)(1) and 457.80(c)(3))

4.4. Eligibility screening and coordination with other health coverage programs

States must describe how they will assure that:

- 4.4.1.** only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance (including access to a State health benefits plan) are furnished child health assistance under the plan. (Sections 2102(b)(3)(A), 2110(b)(2)(B)) (42 CFR 457.310(b), 42 CFR 457.350(a)(1) and 42 CFR 457.80(c)(3)) Confirm that the State does not apply a waiting period for pregnant women. **SEE CS10**

The state does not apply a waiting period for pregnant women.

- 4.4.2.** children found through the screening process to be potentially eligible for medical assistance under the State Medicaid plan are enrolled for assistance under such plan. (Section 2102(b)(3)(B)) (42CFR 457.350(a)(2))

4.4.3. children found through the screening process to be ineligible for Medicaid are enrolled in CHIP. (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

4.4.4. the insurance provided under the State child health plan does not substitute for coverage under group health plans. (Section 2102(b)(3)(C)) (42CFR, 457.805)
Suspend waiting periods: The waiting period policy will be temporarily suspended for CHIP applicants during the Federal COVID-19 public health emergency. **See CS20**

4.4.4.1. (formerly 4.4.4.4) If the State provides coverage under a premium assistance program, describe: 1) the minimum period without coverage under a group health plan. This should include any allowable exceptions to the waiting period; 2) the expected minimum level of contribution employers will make; and 3) how cost-effectiveness is determined. (42CFR 457.810(a)-(c))

4.4.5. Child health assistance is provided to targeted low-income children in the State who are American Indian and Alaska Native. (Section 2102(b)(3)(D)) (42 CFR 457.125(a))

Guidance: When the State is using an income finding from an Express Lane agency, the State must still comply with screen and enroll requirements before enrolling children in CHIP. The State may either continue its current screen and enroll process or elect one of two new options to fulfill these requirements.

4.4-EL The State should designate the option it will be using to carry out screen and enroll requirements:

- The State will continue to use the screen and enroll procedures required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 42 CFR 457.80(c). Describe this process.
- The State is establishing a screening threshold set as a percentage of the Federal poverty level⁹⁷ (FPL) that exceeds the highest Medicaid

income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by the Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL and provide an explanation of how this was calculated.

- The State is temporarily enrolling children in CHIP, based on the income finding from the Express Lane agency, pending the completion of the screen and enroll process.

Section 5. Outreach and Coordination

- 5.1.** (formerly 2.2) Describe the current State efforts to provide or obtain creditable health coverage for uninsured children by addressing sections 5.1.1 and 5.1.2. (Section 2102)(a)(2) (42CFR 457.80(b))

Guidance: The information below may include whether the state elects express lane eligibility a description of the State's outreach efforts through Medicaid and state-only programs.

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

Washington operates several programs to provide healthcare coverage to low income children. The largest of these programs is Medicaid, which provides coverage to approximately 800,000 U.S. citizen and legal alien children annually, in households with incomes up to 210% FPL³. Washington's CHIP program began in 2001 and currently provides coverage to approximately 42,000 U.S. citizen and legal alien children annually in households with incomes between 210% - 312% FPL.

Washington's CHIP coverage also provides coverage for over 11,000 low-income unborn children annually whose mothers do not qualify for Medicaid but have household income below 193% FPL. In 2006, Washington reinstated its entirely state funded Children's

Health program for low- income children who do not qualify for Medicaid or CHIP based on their citizenship status. Currently the program provides coverage to over 18,000 low-income children annually. The Children’s Health program mirrors Medicaid and CHIP in its construction. As in the CHIP program, children in households with income between 210% and 312% FPL are required to pay a premium.

To facilitate the success of these programs, Washington has engaged in a number of enrollment and retention strategies to ensure a high penetration rate into Medicaid and CHIP eligible populations. Among our best practices are:

- Continuous Eligibility – Once a child is found eligible for medical assistance, the child remains continuously eligible for a full twelve months, regardless of changes in the household income.
- No asset test - There is no resource test applied to eligibility for children’s medical programs.
- No interview requirement – Families do not need a face- to- face interview. Application can be made through the mail, by phone, or by electronic submission through www.wahealthplanfinder.org.
- Simplified Application –Families may apply for healthcare coverage including CHIP, through our state-based exchange using a single application. This application may be submitted as a paper application, or by calling the Exchange, or electronically at www.wahealthplanfinder.org
- Joint Application – Applications for medical assistance are automatically considered for Medicaid, CHIP, and state-funded programs.
- Application Assisters –Our state-based Exchange has contracted with 10 lead organizations who subcontract with various community-based organizations to serve as in-person assisters directly assisting families with completion of an electronic application at www.wahealthplanfinder.org, or the streamlined paper application.
- Premium Payment Program – Parents may be reimbursed for the cost of employer-sponsored insurance to cover their Medicaid eligible child.
- Renewal contacts – The Agency provides the renewal dates to managed care organizations (MCO) who have volunteered to assist their enrollees with the renewal process. MCO staff contact the families by phone and assist them with completing the annual renewal form electronically.

Guidance: The State may address the coordination between the public-private outreach and the public health programs that is occurring statewide. This section will provide a historic record of the steps the State is taking to identify and enroll all uninsured children from the time the State's plan was initially approved. States do not have to rewrite his section but may instead update this section as appropriate.

5.1.2. (formerly 2.2.2.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in health insurance programs that involve a public-private partnership:

Washington State continues to participate in the national Healthy Kids Now! (HKN!) toll-free 800#. This number provides information on Medicaid and CHIP eligibility for those clients who might qualify for services. Washington also funds a toll-free 800# through WithinReach providing information, application assistance, and referral services. Washington's CHIP eligibility is determined within the structure of our state-based Health Benefit Exchange, www.wahealthplanfinder.org. We continue to work closely with community partner agencies, medical providers, schools, and civic organizations to publicize and promote the Washington Apple Health for Kids program.

(Guidance: The State should describe below how its Title XXI program will closely coordinate the enrollment with Medicaid because under Title XXI, children identified as Medicaid-eligible are required to be enrolled in Medicaid. Specific information related to Medicaid screen and enroll procedures is requested in Section 4.4. (42CFR 457.80(c))

5.2. (formerly 2.3) Describe how CHIP coordinates with other public and private health insurance programs, other sources of health benefits coverage for children, other relevant child health programs, (such as title V), that provide health care services for low-income children to increase the number of children with creditable health coverage. (Section 2102(a)(3), 2102(b)(3)(E) and 2102(c)(2)) (42CFR 457.80(c)). This item requires a brief overview of how Title XXI efforts – particularly new enrollment outreach efforts – will be coordinated with and improve upon existing State efforts.

As of October 1, 2013 Washington employs an electronic application process that will allow families to apply online, over-the-phone, or in-person and receive a “real-time” eligibility decision on their application through our state-based exchange

www.wahealthplanfinder.org. Families may also apply by mailing or faxing in a streamlined paper application, but the determination is not made in “real time” when a paper application is used. The Washington Healthplanfinder system has dramatically improved the delivery of affordable health care by speeding up the process of receiving an eligibility decision and reducing the number of administrative barriers. Not only are families able to apply on-line, but the system conducts electronic verifications of identity, citizenship status, enumeration, and income. Self-attestation is allowed in the determination of eligibility, and previously required verifications are followed up on as needed in post-eligibility. When a family applies for coverage, eligibility is determined across the spectrum of Medicaid, CHIP, state-funded, and premium tax-credit programs.

5.2-EL The State should include a description of its election of the Express Lane eligibility option to provide a simplified eligibility determination process and expedited enrollment of eligible children into Medicaid or CHIP.

Guidance: Outreach strategies may include, but are not limited to, community outreach workers, outstationed eligibility workers, translation and transportation services, assistance with enrollment forms, case management and other targeting activities to inform families of low-income children of the availability of the health insurance program under the plan or other private or public health coverage.

The description should include information on how the State will inform the target of the availability of the programs, including American Indians and Alaska Natives, and assist them in enrolling in the appropriate program.

5.3. Strategies: Describe the procedures used by the State to accomplish outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program. (Section 2102(c)(1)) (42CFR 457.90)

The state has an ongoing publicity campaign to promote Washington Apple Health coverage. The campaign targets back to school and open enrollment time periods. Representatives of the Health Care Authority also participate in health fairs and local community outreach events.

Section 6. Coverage Requirements for Children's Health Insurance

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 proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

6.1. The State elects to provide the following forms of coverage to children:
(Check all that apply.) (Section 2103(c)); (42CFR 457.410(a))

Guidance: Benchmark coverage is substantially equal to the benefits coverage in a benchmark benefit package (FEHBP-equivalent coverage, State employee coverage, and/or the HMO coverage plan that has the largest insured commercial, non-Medicaid enrollment in the state). If box below is checked, either 6.1.1.1., 6.1.1.2., or 6.1.1.3. must also be checked. (Section 2103(a)(1))

6.1.1. Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

Guidance: Check box below if the benchmark benefit package to be offered by the State is the standard Blue Cross/Blue Shield preferred provider option service benefit plan, as described in and offered under Section 8903(1) of Title 5, United States Code. (Section 2103(b)(1) (42 CFR 457.420(b))

6.1.1.1. FEHBP-equivalent coverage; (Section 2103(b)(1) (42 CFR 457.420(a)) (If checked, attach copy of the plan.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is State employee coverage, meaning a coverage plan that is offered and generally available to State employees in the state. (Section 2103(b)(2))

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

Guidance: Check box below if the benchmark benefit package to be offered by the State is offered by a health maintenance organization (as defined in Section 2791(b)(3) of the Public Health Services Act) and has the largest insured commercial, non-Medicaid enrollment of covered lives ~~103~~ such coverage plans offered by an HMO in the state.

(Section 2103(b)(3) (42 CFR 457.420(c)))

- 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.)

Guidance: States choosing Benchmark-equivalent coverage must check the box below and ensure that the coverage meets the following requirements:

- the coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:
 - dental services
 - inpatient and outpatient hospital services
 - physicians' services
 - surgical and medical services
 - laboratory and x-ray services
 - well-baby and well-child care, including age-appropriate immunizations
 - emergency services
- the coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages (FEHBP-equivalent coverage, State employee coverage, or coverage offered through an HMO coverage plan that has the largest insured commercial enrollment in the state); and
- the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the additional categories in such package, if offered, as described in 42 CFR 457.430:
 - coverage of prescription drugs
 - mental health services
 - vision services
 - hearing services

If 6.1.2. is checked, a signed actuarial memorandum must be attached. The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3) and (b)(4) of 42 CFR 457.431. The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State results.

The actuarial report must be prepared by an individual who is a member of the American Academy of Actuaries. This report must be prepared in accordance with the principles

and standards of the American Academy of Actuaries. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a

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standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan, apply the same principles and factors in comparing the value of different coverage (or categories of services), without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used, and take into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage. (Section 2103(a)(2))

- 6.1.2.** Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope, and duration of each service, as well as any exclusions or limitations. Attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431.

Guidance: A State approved under the provision below, may modify its program from time to time so long as it continues to provide coverage at least equal to the lower of the actuarial value of the coverage under the program as of August 5, 1997, or one of the benchmark programs. If “existing comprehensive state-based coverage” is modified, an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997, or one of the benchmark plans must be attached. Also, the fiscal year 1996 State expenditures for “existing comprehensive state-based coverage” must be described in the space provided for all states. (Section 2103(a)(3))

- 6.1.3.** Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

Guidance: Secretary-approved coverage does not refer to any other health benefits coverage deemed

appropriate and acceptable by the Secretary upon application by a state. (Section 2103(a)(4)) (42 CFR 457.250)

6.1.4. Secretary-approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

Guidance: Section 1905(r) of the Act defines EPSDT to require coverage of (1) any medically necessary screening, and diagnostic services, including vision, hearing, and dental screening and diagnostic services, consistent with a periodicity schedule based on current and reasonable medical practice standards or the health needs of an individual child to determine if a suspected condition or illness exists; and (2) all services listed in section 1905(a) of the Act that are necessary to correct or ameliorate any defects and mental and physical illnesses or conditions discovered by the screening services, whether or not those services are covered under the Medicaid state plan. Section 1902(a)(43) of the Act requires that the State (1) provide and arrange for all necessary services, including supportive services, such as transportation, needed to receive medical care included within the scope of the EPSDT benefit and (2) inform eligible beneficiaries about the services available under the EPSDT benefit.

If the coverage provided does not meet all of the statutory requirements for EPSDT contained in sections 1902(a)(43) and 1905(r) of the Act, do not check this box.

6.1.4.1. Coverage of all benefits that are provided to children under the same as Medicaid State plan, including Early Periodic Screening Diagnosis and Treatment (EPSDT)

Washington's CHIP will provide the same scope of coverage as provided under its Medicaid program. The chart below lists the general categories of medically necessary services available to children eligible for Categorically Needy (CN) Medicaid under Title XIX of the Social Security Act (SSA) and CHIP under Title XXI of the SSA.

6.1.4.2. Comprehensive coverage for children under a Medicaid Section 1115 demonstration waiver

6.1.4.3. Coverage that the State has extended to the entire Medicaid population

Guidance: Check below if the coverage offered includes benchmark coverage, as specified in 42 CFR 457.420, plus additional coverage. Under this option, the State

must as added clearly demonstrate that the coverage it provides includes the same coverage the benchmark package, and also describes the services that are being to the benchmark package.

6.1.4.4. Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. Coverage that is the same as defined by existing comprehensive state-based coverage applicable only New York, Pennsylvania, or Florida (under 457.440)

Guidance: Check below if the State is purchasing coverage through a group health plan, and intends to demonstrate that the group health plan is substantially equivalent to or greater than to coverage under one of the benchmark plans specified in 457.420, through use of a benefit-by-benefit comparison of the coverage. Provide a sample of the comparison format that will be used. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in 457.431 to determine actuarial equivalence.

6.1.4.6. Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit-by-benefit comparison (Provide a sample of how the comparison will be done)

Guidance: Check below if the State elects to provide a source of coverage that is not described above. Describe the coverage that will be offered, including any benefit limitations or exclusions.

6.1.4.7. Other (Describe)

SERVICE	MEDICAID CN	CHIP
Advanced RN Practitioner Services	Yes	Yes
Ambulance/Ground and Air	Yes	Yes
Anesthesia Services	Yes	Yes
Audiology	Yes	Yes
Blood/Blood Administration	Yes	Yes

Case Management – Maternity	L	L
Chiropractic Care	Yes	Yes
Clinic Services	Yes	Yes
Community Mental Health Centers	Yes	Yes
Dental Services	Yes	Yes
Dentures Only	Yes	Yes
Detox (3 days)	Yes	Yes
Drugs and Pharmaceutical Supplies	Yes	Yes
Elective Surgery	Yes	Yes
Emergency Room Services	Yes	Yes
Emergency Surgery	Yes	Yes
Eyeglasses and Exams	Yes	Yes
Family Planning Services	Yes	Yes
Healthy Kids (EPSDT)	Yes	Yes
Hearing Aid	Yes	Yes
Hospice	Yes	Yes
Home Health Services	Yes	Yes
Indian Health Clinics	Yes	Yes
Inpatient Hospital Care	Yes	Yes
Intermediate Care Facility/Services for MR	Yes	Yes
Involuntary Commitment	Yes	Yes
Maternity Support Services	Yes	Yes
Medical Equipment, Durable (DME)	Yes	Yes
Mental Health (Outpatient Services)	Yes	Yes
Midwife Services	Yes	Yes
Neuromuscular Centers	Yes	Yes
Nursing Facility Services	Yes	Yes
Nutrition Therapy	Yes	Yes
Optometry	Yes	Yes
Organ Transplants	Yes	Yes
Out-of-State Care	Yes	Yes
Outpatient Hospital Care	Yes	Yes
Oxygen/Respiratory Therapy	Yes	Yes
Pain Management (Chronic)	Yes	Yes
Personal Care Services	Yes	Yes
Physical/Occupational/Speech Therapy	Yes	Yes
Physical Medicine and Rehabilitation	Yes	Yes
Physician	Yes	Yes

Podiatry	Yes	Yes
Private Duty Nursing	L	L
Prosthetic Devices/Mobility Aids	Yes	Yes
Psychiatric Services	Yes	Yes
Psychological Evaluation	L	L
Rural Health Services & FQHC	Yes	Yes
Substance Abuse/Outpatient	Yes	Yes
Surgical Appliances	Yes	Yes
Total Enteral/Parenteral Nutrition	Yes	Yes
Transportation Other than Ambulance	Yes	Yes
X-Ray and Lab Services	Yes	Yes
Key: Yes: Service is covered (may require prior approval or have other requirements).		
L: Limited coverage		

Guidance: All forms of coverage that the State elects to provide to children in its plan must be checked. The State should also describe the scope, amount and duration of services covered under its plan, as well as any exclusions or limitations. States that choose to cover unborn children under the State plan should include a separate section 6.2 that specifies benefits for the unborn child population. (Section 2110(a)) (42CFR, 457.490)

If the state elects to cover the new option of targeted low income pregnant women, but chooses to provide a different benefit package for these pregnant women under the CHIP plan, the state must include a separate section 6.2 describing the benefit package for pregnant women. (Section 2112)

6.2. The State elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)

- 6.2.1.** Inpatient services (Section 2110(a)(1))
- 6.2.2.** Outpatient services (Section 2110(a)(2))
- 6.2.3.** Physician services (Section 2110(a)(3))
- 6.2.4.** Surgical services (Section 2110(a)(4))
- 6.2.5.** Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
- 6.2.6.** Prescription drugs (Section 2110(a)(6))

- 6.2.7. Over-the-counter medications (Section 2110(a)(7))
- 6.2.8. Laboratory and radiological services (Section 2110(a)(8))
- 6.2.9. Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))
- 6.2.10. 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))
- 6.2.11. Disposable medical supplies (Section 2110(a)(13))

Guidance: Home and community-based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.

- 6.2.12. Home and community-based health care services (Section 2110(a)(14))

Guidance: Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school, or other setting.

- 6.2.13. Nursing care services (Section 2110(a)(15))
- 6.2.14. 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))
- 6.2.15. Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)
- 6.2.16. Vision screenings and services (Section 2110(a)(24))
- 6.2.17. Hearing screenings and services (Section 2110(a)(24))
- 6.2.18. Case management services (Section 2110(a)(20))
- 6.2.19. Care coordination services (Section 2110(a)(21))
- 6.2.20. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 6.2.21. Hospice care (Section 2110(a)(23))

Guidance: See guidance for section 6.1.4.1 for a guidance on the statutory requirements for

Approval Date:

EPSDT under sections 1905(r) and 1902(a)(43) of the Act. If the benefit being provided does not meet the EPSDT statutory requirements, do not check this box.

6.2.22. EPSDT consistent with requirements of sections 1905(r) and 1902(a)(43) of the Act

6.2.22.1 The state assures that any limitations applied to the amount, duration, and scope of benefits described in Sections 6.2 and 6.3- BH of the CHIP state plan can be exceeded as medically necessary.

Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

6.2.25. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))

6.2.26. Premiums for private health care insurance coverage (Section 2110(a)(25))

6.2.27. Medical transportation (Section 2110(a)(26))

Guidance: Enabling services, such as transportation, translation, and outreach services, may be offered only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

6.2.28. Enabling services (such as transportation, translation, and outreach services) (Section 2110(a)(27))

6.2.29. Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28))

6.2-DC Dental Coverage (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) The State will provide dental coverage to children through one of the following. Please update Sections 9.10 and 10.3-DC when electing this option. Dental

Effective Date: October 24, 2019

Approval Date:

services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

The state adopted the Washington Medicaid dental benefit package for CHIP. This includes EPSDT coverage. The state assures dental services represented by the following categories of common dental terminology (CDT) codes are included in the dental benefit. A comprehensive description of covered services and schedules can be found at: <https://www.hca.wa.gov/assets/billers-and-providers/Dental-related-serv-bg.pdf>.

6.2.1-DC State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT*) codes are included in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)

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4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

6.2.1.1-DC Periodicity Schedule. The State has adopted the following periodicity schedule:

- State-developed Medicaid-specific
- American Academy of Pediatric Dentistry
- Other Nationally recognized periodicity schedule
- Other (description attached)

Dental services: D9992-care coordination allowed specifically for phone triage during the Federal COVID-19 pandemic. This is a temporary code and is not considered tele-dentistry. *Not to be used for normal operations such as appointment scheduling (20-001).

EPSDT

6.2.2-DC Benchmark coverage; (Section 2103(c)(5), 42 CFR 457.410, and 42 CFR 457.420)

6.2.2.1-DC FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT* codes)

6.2.2.2-DC State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services,

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also attach a description of the services and applicable CDT codes)

6.2.2.3-DC HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2-DS **Supplemental Dental Coverage-** The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children (Section 2110(b)(5)(C)(ii)). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

Guidance: Under Title XXI, pre-existing condition exclusions are not allowed, with the only exception

Effective Date: October 24, 2019

Approval Date:

being in relation to another law in existence (HIPAA/ERISA). Indicate that the plan adheres to this requirement by checking the applicable description.

In the event that the State provides benefits through a group health plan or group health coverage, or provides family coverage through a group health plan under a waiver (see Section 6.4.2.), pre-existing condition limits are allowed to the extent permitted by HIPAA/ERISA. If the State is contracting with a group health plan or provides benefits through group health coverage, describe briefly any limitations on pre-existing conditions. (Formerly 8.6.)

6.2- MHPAEA Section 2103(c)(6)(A) of the Social Security Act requires that, to the extent that it provides both medical/surgical benefits and mental health or substance use disorder benefits, a State child health plan ensures that financial requirements and treatment limitations applicable to mental health and substance use disorder benefits comply with the mental health parity requirements of section 2705(a) of the Public Health Service Act in the same manner that such requirements apply to a group health plan. If the state child health plan provides for delivery of services through a managed care arrangement, this requirement applies to both the state and managed care plans. These requirements are also applicable to any additional benefits provided voluntarily to the child health plan population by managed care entities and will be considered as part of CMS’s contract review process at 457.1201(l).

6.2.1- MHPAEA Before completing a parity analysis, the State must determine whether each covered benefit is a medical/surgical, mental health, or substance use disorder benefit based on a standard that is consistent with state and federal law and generally recognized independent standards of medical practice (§ 457.496(f)(1)(i)).

6.2.1.1- MHPAEA Please choose the standard(s) the state uses to determine whether a covered benefit is a medical/surgical benefit, mental health benefit, or substance use disorder benefit. The most current version of the standard elected must be used. If different standards are used for the different benefit types, please specify the benefit type(s) to which each standard is applied. If “Other” is selected, please provide a description of that standard.

International Classification of Disease (ICD)

Diagnostic and Statistical Manual of Mental Disorders (DSM)

State guidelines

Other (Describe:)

6.2.1.2- MHPAEA Does the State provide mental health and/or substance use disorder benefits?

Yes

No

Guidance: If the State does not provide any mental health or substance use disorder benefits, the mental health parity requirements do not apply ((§ 457.496(f)(1)). Continue on to Section 6.3.

6.2.2- MHPAEA Section 2103(c)(6)(B) of the Act provides that to the extent a State child health plan includes coverage of early and periodic screening, diagnostic, and treatment services (EPSDT) defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the plan shall be deemed to satisfy the parity requirements of section 2103(c)(6)(A) of the Act.

6.2.2.1- MHPAEA Does the State child health plan provide coverage of EPSDT? The State must provide for coverage of EPSDT benefits, consistent with Medicaid statutory requirements, as indicated in section 6.2.26 of the State child health plan in order to answer “yes.”

Yes

No

Guidance: If the State child health plan *does not* provide EPSDT consistent with Medicaid statutory requirements at sections 1902(a)(43) and 1905(r) of the Act, please go to Section 6.2.3- MHPAEA to complete the required parity analysis of the State child health plan.

If the state *does* provide EPSDT benefits consistent with Medicaid requirements, please continue this section to demonstrate compliance with the statutory requirements of section 2103(c)(6)(B) of the Act and the mental health parity regulations of § 457.496(b) related to deemed compliance.

6.2.2.2- MHPAEA EPSDT benefits are provided to the following:

Effective Date: October 24, 2019

Approval Date:

All children covered under the State child health plan

A subset of children covered under the State child health plan.

Please describe the different populations (if applicable) covered under the State child health plan that are provided EPSDT benefits consistent with Medicaid statutory requirements.

Children birth to age 19

Guidance: If only a subset of children are provided EPSDT benefits under the State child health plan, § 457.496(b)(3) limits deemed compliance to those children only and you must complete Section 6.2.3- MHPAEA to complete the required parity analysis for the other children.

6.2.2.3- MHPAEA To be deemed compliant with the MHPAEA parity requirements, States must provide EPSDT in accordance with sections 1902(a)(43) and 1905(r) of the Act (§ 457.496(b)(2)). The State assures each of the following for children eligible for EPSDT under the separate State child health plan:

All screening services, including screenings for mental health and substance use disorder conditions, are provided at intervals that align with a periodicity schedule that meets reasonable standards of medical or dental practice as well as when medically necessary to determine the existence of suspected illness or conditions (Section 1905(r)).

All diagnostic services described in 1905(a) of the Act are provided as needed to diagnose suspected conditions or illnesses discovered through screening services, whether or not those services are covered under the Medicaid state plan (Section 1905(r)).

All items and services described in section 1905(a) of the Act are provided when needed to correct or ameliorate a defect or any physical or mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan (Section 1905(r)(5)).

Treatment limitations applied to services provided under the EPSDT benefit are not limited based on a monetary cap or budgetary constraints and

may be exceeded as medically necessary to correct or ameliorate a medical or physical condition or illness (Section 1905(r)(5)).

Non-quantitative treatment limitations, such as definitions of medical necessity or criteria for medical necessity, are applied in an individualized manner that does not preclude coverage of any items or services necessary to correct or ameliorate any medical or physical condition or illness (Section 1905(r)(5)).

EPSDT benefits are not excluded on the basis of any condition, disorder, or diagnosis (Section 1905(r)(5)).

The provision of all requested EPSDT screening services, as well as any corrective treatments needed based on those screening services, are provided or arranged for as necessary (Section 1902(a)(43)).

All families with children eligible for the EPSDT benefit under the separate State child health plan are provided information and informed about the full range of services available to them (Section 1902(a)(43)(A)).

Guidance: For states seeking deemed compliance for their entire State child health plan population, please continue to Section 6.3. If not all of the covered populations are offered EPSDT, the State must conduct a parity analysis of the benefit packages provided to those populations. Please continue to 6.2.3- MHPAEA.

Mental Health Parity Analysis Requirements for States Not Providing EPSDT to All Covered Populations

Guidance: The State must complete a parity analysis for each population under the State child health plan that is not provided the EPSDT benefit consistent with the requirements § 457.496(b). If the State provides benefits or limitations that vary within the child or pregnant woman populations, states should perform a parity analysis for each of the benefit packages. For example, if different financial requirements are applied according to a beneficiary's income, a separate parity analysis is needed for the benefit package provided at each income level.

6.2.3- MHPAEA In order to conduct the parity analysis, the State must place all medical/surgical and mental health and substance use disorder benefits covered under the

State child health plan into one of four classifications: Inpatient, outpatient, emergency care, and prescription drugs (§ § 457.496(d)(2)(ii); 457.496(d)(3)(ii)(B)).

6.2.3.1 MHPAEA Please describe below the standard(s) used to place covered benefits into one of the four classifications.

The state classified services in the four categories based on the approach described in the CMS Parity Compliance Toolkit and guidance provide through the CMS/SAMHSA technical assistance process and the CMS parity academy.

Washington State’s Parity Analysis States: Federal parity regulations allow states some latitude in placement of benefits within each of these categories. Washington State developed a preliminary list of benefits in each category based on current state plan services. The state then consulted with MCOs and BHOs to ensure the list was accurate and complete. Before sending out parity questionnaires, the state created a list of services covered under each category. This helped ensure consistency among MCOs and BHOs when answering questions about each benefit category. The definitions for each category are:

- Outpatient: Routine services that occur in an outpatient setting and are not included in the emergency category.
- Inpatient: Any non-emergency service that involves the individual staying overnight at a facility. This includes inpatient MH and SUD treatment and crisis stabilization services occurring in a facility.
- Emergency: Services or items delivered in an emergency department (ED) setting or emergency/crisis stabilization services, not requiring an overnight stay, which are not delivered in an inpatient setting.
- Pharmacy: Covered medications, drugs and associated supplies requiring a prescription.

6.2.3.1.1 MHPAEA The state assures that:

The State has classified all benefits covered under the State plan into one of the four classifications.

The same reasonable standards are used for determining the classification for a mental health or substance use disorder benefit as are used for determining the classification of medical/surgical benefits.

6.2.3.1.2- MHPAEA Does the state use sub-classifications to distinguish between office visits and other outpatient services?

Yes

No

6.2.3.1.2.1- MHPAEA If the State uses sub-classifications to distinguish between outpatient office visits and other outpatient services, the State assures the following:

The sub-classifications are only used to distinguish office visits from other outpatient items and services and are not used to distinguish between similar services on other bases (ex: generalist vs. specialist visits).

Guidance: For purposes of this section, any reference to “classification(s)” includes sub-classification(s) in states using sub-classifications to distinguish between outpatient office visits from other outpatient services.

6.2.3.2 MHPAEA The State assures that:

Mental health/ substance use disorder benefits are provided in all classifications in which medical/surgical benefits are provided under the State child health plan.

Guidance: States are not required to cover mental health or substance use disorder benefits. However, if a state does provide any mental health or substance use disorders, those mental health or substance use disorder benefits must be provided in all the same classifications in which medical/surgical benefits are covered under the State child health plan.

Annual and Aggregate Lifetime Limits

6.2.4- MHPAEA A State that provides both medical/surgical benefits and mental health and/or substance use disorder benefits must comply with parity requirements related to annual and aggregate lifetime dollar limits for benefits covered under the State child health plan (§ 457.496(c)).

6.2.4.1- MHPAEA Please indicate whether the State applies an aggregate lifetime dollar limit and/or an annual dollar limit on any mental health or substance abuse disorder benefits covered under the State child health plan.

Aggregate lifetime dollar limit is applied

Aggregate annual dollar limit is applied

No dollar limit is applied

Guidance: If there are no aggregate lifetime or annual dollar limit on any mental health or substance use disorder benefits, please go to section 6.2.5- MHPAEA.

6.2.4.2- MHPAEA Are there any medical/surgical benefits covered under the State child health plan that have either an aggregate lifetime dollar limit or an annual dollar limit? If yes, please specify what type of limits apply.

Yes (Type(s) of limit: _____)

No

Guidance: If no aggregate lifetime dollar limit is applied to medical/ surgical benefits, the State may not impose an aggregate lifetime dollar limit on *any* mental health or substance use disorder benefits. If no aggregate annual dollar limit is applied to medical/surgical benefits, the State may not impose an aggregate annual dollar limit on *any* mental health or substance use disorder benefits (§ 457.496(c)(1)).

6.2.4.3 – MHPAEA. States applying an aggregate lifetime or annual dollar limit on medical/surgical benefits and mental health or substance use disorder benefits must determine whether the portion of the medical/surgical benefits to which the limit applies is less than one-third, at least one-third but less than two-thirds, or at least two-thirds of all medical/surgical benefits covered under the State plan (457.496(c)).

The portion of medical/surgical benefits subject to the limit is based on the dollar amount expected to be paid for all medical/surgical benefits under the State plan for the State plan year or portion of the plan year after a change in benefits that affects the applicability of the aggregate lifetime or annual dollar limits (457.496(c)(3)).

The State assures that it has developed a reasonable methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable.

Guidance: Please include the state's methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable, as an attachment to the State child health plan.

6.2.4.3.1- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to a lifetime dollar limit:

- Less than 1/3
- At least 1/3 and less than 2/3
- At least 2/3

6.2.4.3.2- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to an annual dollar limit:

- Less than 1/3
- At least 1/3 and less than 2/3
- At least 2/3

Guidance: If an aggregate lifetime limit is applied to less than one-third of all medical/surgical benefits, the State may not impose an aggregate lifetime limit on *any* mental health or substance use disorder benefits. If an annual dollar limit is applied to less than one-third of all medical surgical benefits, the State may not impose an annual dollar limit on *any* mental health or substance use disorder benefits (§ 457.496(c)(1)). Skip to section 6.2.5-MHPAEA.

If the State applies an aggregate lifetime or annual dollar limit to at least one-third of all medical/surgical benefits, please continue below to provide the assurances related to the determination of the portion of total costs for medical/surgical benefits that are subject to either an annual or lifetime limit.

6.2.4.3.2.1- MHPAEA ¹²⁰ If the State applies an aggregate lifetime
Approval Date:

or annual dollar limit to at least 1/3 and less than 2/3 of all medical/surgical benefits, the State assures the following (§ § 457.496(c)(4)(i)(B); 457.496(c)(4)(ii)):

The State applies an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits.

Guidance: The state's methodology for calculating the average limit for medical/surgical benefits must be consistent with § § 457.496(c)(4)(i)(B) and 457.496(c)(4)(ii). Please include the state's methodology as an attachment to the State child health plan.

6.2.4.3.2.2- MHPAEA If at least 2/3 of all medical/surgical benefits are subject to an annual or lifetime limit, the State assures either of the following (§ 457.496(c)(2)(i); (§ 457.496(c)(2)(ii)):

The aggregate lifetime or annual dollar limit is applied to both medical/surgical benefits and mental health and substance use disorder benefits in a manner that does not distinguish between medical/surgical benefits and mental health and substance use disorder benefits; or

The aggregate lifetime or annual dollar limit placed on mental health and substance use disorder benefits is no more restrictive than the aggregate lifetime or annual dollar limit on medical/surgical benefits.

Quantitative Treatment Limitations

6.2.5- MHPAEA Does the State apply quantitative treatment limitations (QTLs) on any mental health or substance use disorder benefits in any classification of benefits? If yes, specify the classification(s) of benefits in which the State applies one or more QTLs on any mental health or substance use disorder benefits.

Yes (Specify:)

No

Guidance: If the state does not apply any type of QTLs on any mental health or substance use disorder benefits in any classification, the state meets parity requirements for QTLs and should continue to Section 6.2.6 - MHPAEA. If the state does apply financial requirements to any mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue.

6.2.5.1- MHPAEA Does the State apply any type of QTL on any medical/surgical benefits?

Yes

No

Guidance: If the State does not apply QTLs on any medical/surgical benefits, the State may not impose quantitative treatment limitations on mental health or substance use disorder benefits, please go to Section 6.2.6- MHPAEA related to non-quantitative treatment limitations.

6.2.5.2- MHPAEA Within each classification of benefits in which the State applies a type of QTL on any mental health or substance use disorder benefits, the State must determine the proportion of medical and surgical benefits in the class which are subject to the limitation. More specifically, the State must determine the ratio of (a) the dollar amount of all payments expected to be paid under the State plan for medical and surgical benefits within a classification which are subject to the type quantitative treatment limitation for the plan year (or portion of the plan year after a mid-year change affecting the applicability of a type of quantitative treatment limitation to any medical/surgical benefits in the class) to (b) the dollar amount expected to be paid for all medical and surgical benefits within the classification for the plan year. For purposes of this paragraph all payments expected to be paid under the State plan includes payments expected to be made directly by the State and payments which are expected to be made by MCEs contracting with the State. (§ 457.496(d)(3)(i)(C))

The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above for each classification within which the State applies QTLs to mental health or substance use disorder benefits. (§ 457.496(d)(3)(i)(E))

Guidance: Please include the state’s methodology as an attachment to the State child health plan.

6.2.5.3- MHPAEA For each type of QTL applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of QTL to “substantially all” (defined as at least two-thirds) of the medical/surgical benefits within the same classification? (§ 457.496(d)(3)(i)(A))

Yes

No

Guidance: If the State does not apply a type of QTL to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose that type of QTL on mental health or substance use disorder benefits in that classification.

(§ 457.496(d)(3)(i)(A))

6.2.5.3.1- MHPAEA For each type of QTL applied to mental health or substance use disorder benefits, the State must determine the predominant level of that type which is applied to medical/surgical benefits in the classification. The “predominant level” of a type of QTL in a classification is the level (or least restrictive of a combination of levels) that applies to more than one-half of the medical/surgical benefits in that classification, as described in § § 457.496(d)(3)(i)(B). The portion of medical/surgical benefits in a classification to which a given level of a QTL type is applied is based on the dollar amount of payments expected to be paid for medical/surgical benefits subject to that level as compared to all medical/surgical benefits in the classification, as described in § 457.496(d)(3)(i)(C). For each type of quantitative treatment limitation applied to mental health or substance use

disorder benefits, the State assures:

The same reasonable methodology applied in determining the dollar amounts used to determine whether substantially all medical/surgical benefits within a classification are subject to a type of quantitative treatment limitation also is applied in determining the dollar amounts used to determine the predominant level of a type of quantitative treatment limitation applied to medical/surgical benefits within a classification. (§ 457.496(d)(3)(i)(E))

The level of each type of quantitative treatment limitation applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominate level of that type which is applied by the State to medical/surgical benefits within the same classification. (§ 457.496(d)(2)(i))

Guidance: If there is no single level of a type of QTL that exceeds the one-half threshold, the State may combine levels within a type of QTL such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominate level is the least restrictive level of the levels combined to meet the one-half threshold (§ 457.496(d)(3)(i)(B)(2)).

Non-Quantitative Treatment Limitations

6.2.6- MHPAEA The State may utilize non-quantitative treatment limitations (NQTLs) for mental health or substance use disorder benefits, but the State must ensure that those NQTLs comply with all the mental health parity requirements (§ § 457.496(d)(4); 457.496(d)(5)).

6.2.6.1 – MHPAEA If the State imposes any NQTLs, complete this subsection. If the State does not impose NQTLs, please go to Section 6.2.7-MHPAEA.

The State assures that the processes, strategies, evidentiary standards or other factors used in the application of any NQTL to mental health or substance use disorder benefits are no more stringent than the processes,

strategies, evidentiary standards or other factors used in the application of NQTLs to medical/surgical benefits within the same classification.

Guidance: Examples of NQTLs include medical management standards to limit or exclude benefits based on medical necessity, restrictions based on geographic location, provider specialty, or other criteria to limit the scope or duration of benefits, provider reimbursement rates and provider network design (ex: preferred providers vs. participating providers).

Additional examples of possible NQTLs are provided in § 457.496(d)(4)(ii).

6.2.6.2 – MHPAEA The State or MCE contracting with the State must comply with parity if they provide coverage of medical or surgical benefits furnished by out-of-network providers.

6.2.6.2.1- MHPAEA Does the state or MCE contracting with the State provide coverage of services provided by out of network providers?

Yes

No

6.2.6.2.2- MHPAEA If yes, please assure the following:

The State attests that when determining access to out-of-network providers within a benefit classification, the processes, strategies, evidentiary standards, or other factors used to determine access to those providers for mental health/ substance use disorder benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used to determine access for out- of-network providers for medical/surgical benefits.

Availability of Plan Information

6.2.7- MHPAEA The State must provide beneficiaries, potential enrollees, and providers with information related to medical necessity criteria and denials of payment or reimbursement for mental health or substance use disorder services.

6.2.7.1- MHPAEA Medical necessity criteria determinations must be made available to any current or potential enrollee or contracting provider, upon request.

The state attests that the following entities provide this information:

125

Approval Date:

Effective Date: October 24, 2019

State

Managed Care entities

Both

6.2.7.2- MHPAEA Reason for any denial for reimbursement or payment for mental health or substance use disorder benefits must be made available to the enrollee by the health plan or the State. The state attests that the following entities provide denial information:

State

Managed Care entities

Both

6.2-BH Behavioral Health Coverage Section 2103(c)(5) requires that states provide coverage to prevent, diagnose, and treat a broad range of mental health and substance use disorders in a culturally and linguistically appropriate manner for all CHIP enrollees, including pregnant women and unborn children.

Guidance: Please attach a copy of the state's periodicity schedule. For pregnancy-related coverage, please describe the recommendations being followed for those services.

6.2.1- BH Periodicity Schedule The state has adopted the following periodicity schedule for behavioral health screenings and assessments. Please specify any differences between any covered CHIP populations:

State-developed schedule

American Academy of Pediatrics/ Bright Futures

Other Nationally recognized periodicity schedule (please specify:)

Other (please describe:)

6.3- BH Covered Benefits Please check off the behavioral health services that are provided to the state's CHIP populations, and provide a description of the amount, duration, and scope of each benefit. For each benefit, please also indicate whether the benefit is

available for mental health and/or substance use disorders. If there are differences in benefits based on the population or type of condition being treated, please specify those differences.

If EPSDT is provided, as described at Section 6.2.22 and 6.2.22.1, the state should only check off the applicable benefits. It does not have to provide additional information regarding the amount, duration, and scope of each covered behavioral health benefit.

Guidance: Please include a description of the services provided in addition to the behavioral health screenings and assessments described in the assurance below at 6.3.1.1-BH.

6.3.1- BH Behavioral health screenings and assessments. (Section 2103(c)(6)(A))

The state provides coverage of all of the developmental and behavioral health related screenings and assessments as recommended by AAP/Bright Futures, as well as those with a grade of an A or B by USPSTF.

6.3.1.1- BH The state assures that all developmental and behavioral health recommendations outlined in the AAP Bright Futures periodicity schedule and United States Public Preventive Services Task Force (USPSTF) recommendations graded as A and B are covered as a part of the CHIP benefit package, as appropriate for the covered populations.

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools in primary care practice, providing education, training, and technical resources, and covering the costs of administering or purchasing the tools.

6.3.1.2- BH The state assures that it will implement a strategy to facilitate the use of age-appropriate validated behavioral health screening tools in primary care settings. Please describe how the state will facilitate the use of validated screening tools.

The EPSDT Billing guide¹²⁷ provided by the Agency includes

recommendations for screening periodicity for each child. Included within the billing guide are tools designed to be used for screening including reference indicators (pg. 33-46).

<https://www.hca.wa.gov/assets/billers-and-providers/EPSTD-bi-20200701.pdf>. The Washington State Health Care Authority website provides program-specific resources. Updates are provided through email notifications and these updates are archived in a provider alert section of the website.

6.3.2- BH Outpatient services (Sections 2110(a)(11) and 2110(a)(19))

Guidance: Psychosocial treatment includes services such as psychotherapy, group therapy, family therapy and other types of counseling services.

6.3.2.1- BH Psychosocial treatment

Provided for: Mental Health Substance Use Disorder

- One psychiatric diagnostic interview examination per provider in a calendar year unless an additional evaluation is medically necessary.
- Medically necessary individual or family/group psychotherapy visit, with or without the client
- One psychiatric medication management service per day in an outpatient setting unless more is medically necessary

6.3.2.2- BH Tobacco cessation

Provided for: Substance Use Disorder

Only pregnant women to have access to in-person counseling for tobacco cessation. Pregnant women are permitted to access two tobacco/nicotine cessation counseling attempts every twelve months. An attempt is defined as up to four tobacco/nicotine cessation counseling sessions. HCA covers one face-to-face tobacco/nicotine cessation counseling session per client, per day. All medications are covered regardless of pregnancy status. Non-pregnant patients in need of tobacco cessation services may receive limited

counseling and referral by a primary care practitioner. Referral services may include:

- Referral to the toll-free Washington State Tobacco Quitline for telephone counseling and follow-up support calls for clients age 13 and older. When a client is receiving counseling from the Quitline, the Quitline may recommend a tobacco/nicotine cessation prescription for the client.
- Enrollment in a tobacco cessation program through the Quitline provides the enrollee access to inbound calls to the Quitline with 24/7 access to a Quit Coach.
- Nicotine replacement products and prescription drugs to promote tobacco/nicotine cessation with a prescription, prescribed by a provider with prescriptive authority, when submitted to a pharmacy.
- All FDA approved medications for tobacco cessation are available, however non-preferred medications require prior authorization. In addition to its Quitline, the state provides tobacco cessation in-person to children through Early Periodic Screening, Diagnostic, and Treatment (EPSDT) when medically necessary.

Guidance: In order to provide a benefit package consistent with section 2103(c)(5) of the Act, MAT benefits are required for the treatment of opioid use disorders. However, if the state provides MAT for other SUD conditions, please include a description of those benefits below at section 6.3.2.3- BH.

6.3.2.3- BH Medication Assisted Treatment

Provided for: Substance Use Disorder

- All FDA-approved MAT medications are available.

6.3.2.3.1- BH Opioid Use Disorder

- Must be provided by a practitioner who is waived by the Drug Addiction Treatment Act of 2000 (DATA) to write prescriptions

for buprenorphine or other FDA-approved products under this waiver;

- Includes opioid counseling; and
- Must not duplicate addiction services provided and reimbursed through other payment methodologies.

6.3.2.3.2- BH Alcohol Use Disorder

HCA covers alcohol and substance misuse counseling through screening, brief interventions, and referral to treatment (SBIRT) services when provided by, or under the supervision of, a certified physician or other certified licensed health care professional within the scope of their practice.

6.3.2.3.3- BH Other

6.3.2.4- BH Peer Support

Provided for: Mental Health Substance Use Disorder

- Peer Support: Services provided by peer counselors to enrolled individuals under the consultation, facilitation, or supervision of a CDP who understands rehabilitation and recovery. This service provides scheduled activities that promote recovery, self-advocacy, development of natural supports, and maintenance of community living skills.
- Services provided by peer counselors to the individual are noted in the individuals' Individualized Service Plan which delineates specific goals that are flexible, tailored to the individual, and attempt to utilize community and natural supports. Progress notes document individual progress relative to goals identified in the Individualized Service Plan and indicates where treatment goals have not yet been achieved.
- Peer counselors work with their peers (adults and youth) and the parents of children receiving or who have received behavioral health services. They draw upon their experiences to help peers

find hope and make progress toward recovery. Peer counselors assist individuals and families in developing their own recovery goals. They provide individual or group peer support, a peer counselor may work in a treatment setting or meet peers where they are at in the community. Peer counselors model skills in recovery and self-management to help individuals meet their rehabilitative goals. Peer counselors assist in a wide range of services to facilitate meeting the recovery goals on treatment plans to help individuals regain control and achieve success in their own lives, such as developing supportive relationships and self-advocacy

6.3.2.5- BH Caregiver Support

Provided for: Mental Health Substance Use Disorder

Therapeutic Psychoeducation: Psychological counseling provided for the direct benefit of an enrolled individual. Service is provided with family members and/or other relevant persons in attendance as active participants.

- Informational and experiential services designed to aid enrolled individuals, their family members (e.g., spouse, parents, siblings) and other individuals identified by the individual as a primary natural support, in the management of psychiatric conditions, increased knowledge of mental illnesses and understanding the importance of their individual plan of care.

6.3.2.6- BH Respite Care

Provided for: Mental Health Substance Use Disorder

6.3.2.7- BH Intensive in-home services

Provided for: Mental Health Substance Use Disorder

Services are provided to enrolled individuals who are

experiencing a mental health crisis and/or are in need of SUD services. These services are to be provided in the person's own home, or another home-like setting, or a setting which provides safety for the individual and the mental health professional. Stabilization services shall include short-term (less than two weeks per episode) face-to-face assistance with life skills training and understanding of medication effects. This service includes: a) follow up to crisis services; and b) other individuals determined by a mental health professional to need additional stabilization services. Stabilization services may be provided prior to an intake evaluation for mental health services.

Youth who have been determined eligible for Wrap-around intensive services (WISe), have access to crisis services, including face-to-face interventions any time of day, 365 days a year. These direct services are available in the amount, duration, and scope necessary to address the medically necessary identified needs.

6.3.2.8- BH Intensive outpatient

Provided for: Mental Health Substance Use Disorder

Intensive levels of service otherwise furnished under this state plan amendment that is provided to enrolled individuals who require a multi-disciplinary treatment team in the community that is available upon demand based on the individual's need. Twenty-four hours per day, seven days per week, access is required if necessary. Goals for High Intensity Treatment include the reinforcement of safety, the promotion of stability and independence of the individual in the community, and the restoration to a higher level of functioning. These services are designed to rehabilitate individuals who are experiencing severe symptoms in the community and

thereby avoid more restrictive levels of care such as psychiatric inpatient hospitalization or residential placement.

6.3.2.9- BH Psychosocial rehabilitation

Provided for: Mental Health Substance Use Disorder

Therapeutic child-care to treat psychosocial disorders in children under 21 years of age based on medical necessity. Services Include: developmental assessment using recognized, standardized instruments play therapy; behavior modification; individual counseling; self-esteem building; and family intervention to modify parenting behavior and/or the child's environment to eliminate/prevent the child's dysfunctional behavior.

Guidance: If the state considers day treatment and partial hospitalization to be the same benefit, please indicate that in the benefit description. If there are differences between these benefits, such as the staffing or intensity of the setting, please specify those in the description of the benefit's amount, duration, and scope.

6.3.3- BH Day Treatment

Provided for: Mental Health Substance Use Disorder

MH: An intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) for enrollees to promote improved functioning or a restoration to a previous higher level of functioning. The program is designed to assist the individual in the acquisition of skills, retention of current functioning or improvement in the current level of functioning, appropriate socialization, and adaptive coping skills. This service is available 5 hours per day, 5 days per week.

SUD: Both youth and eligible mothers of unborn, over the age 18, have access to intensive outpatient program (IOP) which provides more frequent individual and group counseling sessions to support recovery.

This program offers services that are comparable to partial hospitalization (day treatment.)

6.3.3.1- BH Partial Hospitalization
Provided for: Mental Health Substance Use Disorder

The state considers day treatment and partial hospitalization (PHP) to be the same benefit.

6.3.4- BH Inpatient services, including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Sections 2110(a)(10) and 2110(a)(18))
Provided for: Mental Health Substance Use Disorder

Inpatient psychiatric care for all Apple Health clients, including managed care enrollees (i.e., those on Medicaid and state programs), must be all of the following:

- Medically necessary (as defined in WAC 182-500-0070)
- For a principal covered diagnosis
- Approved (ordered) by the professional in charge of the hospital or hospital unit

Guidance: If applicable, please clarify any differences within the residential treatment benefit (e.g. intensity of services, provider types, or settings in which the residential treatment services are provided).

6.3.4.1- BH Residential Treatment
Provided for: Mental Health Substance Use Disorder

A specialized form of rehabilitation service (non hospital/non IMD) that offers a sub-acute psychiatric management environment. Enrolled individuals receiving this service present with severe impairment in psychosocial

functioning or has apparent mental illness symptoms with an unclear etiology due to their mental illness and treatment cannot be safely provided in a less restrictive environment and do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster housing, SRO apartments) for extended hours to provide direct mental health care to an enrollee. Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment.

Individuals who are pregnant, covered through Washington Apple Health, and have a substance use history may be eligible to receive CUP Women services provided by a CUP Women provider.

- The CUP Women Program is an inpatient, up to 26-day, hospital-based program for adult or adolescent individuals who are:
 - Pregnant.
 - Have a medical need.
 - Have a substance use history and are screened "at risk."
 - Have a current ProviderOne Services Card (or have a pending application for one).

The purpose of the CUP Women program is to:

- Reduce harm to a birthing parent and their unborn baby who need medical stabilization for complications often present in chemically-dependent pregnant individual.
- Provide all of the following services in a hospital setting to improve the health of the pregnant individual and the unborn baby:
 - Immediate access to care.

- Medical detoxification and stabilization.
- Medical treatment.
- Substance use treatment and referral.

6.3.4.2- BH Detoxification
 Provided for: Substance Use Disorder

Clinically managed residential facilities are considered sub-acute detox.

- Limited medical coverage by staff and counselors who monitor patients.
- Generally, any treatment medications are self-administered. DOH regulates both the facility and the program.

Medically monitored inpatient programs are considered acute detox.

- Medical coverage by nurses with physician’s on-call 24/7 for consultation. They have “standing orders” and available medications to help with withdrawal symptoms.
- Licensed as Residential Treatment Facilities (RTF), not hospitals.
- Required to have formal referral relationships with higher levels of care. DOH regulates both the facility and the program.

Medically managed Intensive Inpatient services are considered acute hospital detox.

- Have medical services provided 24/7 by registered nurses (RNs) and doctors. There is full access to medical acute care including ICU, if needed. Doctors, nurses, and counselors work as a part of an interdisciplinary team who medically manage the care of the patient.

Guidance: Crisis intervention and stabilization could include services such as mobile crisis, or short term residential or other facility-based services in order to avoid inpatient hospitalization.

6.3.5- BH Emergency services
Provided for: Mental Health Substance Use Disorder

Covered services related to an emergency medical condition that are provided after an enrollee is stabilized to maintain the stabilized condition, or, to improve or resolve the patient's condition. For the purposes of the mental health program, emergency services end when patient is ready to discharge from the emergency room and either be released or admitted to an inpatient psychiatric facility.

6.3.5.1- BH Crisis Intervention and Stabilization
Provided for: Mental Health Substance Use Disorder

Crisis mental health services are provided upon request, 24-hours a day, seven days a week, and are available to anyone who needs them regardless of ability to pay.

Crisis services provided for Apple Health clients who are not enrolled in an integrated managed care plan are eligible for FFS billing when the provider meets the above qualifications.

Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Services are provided by or under the supervision of a mental health professional.

Screening

- With just a few questions on a questionnaire or in an interview, practitioners can identify patients who have alcohol or other drug (substance) use problems and determine how severe those

problems already are. Three of the most widely used screening tools are the Alcohol Use Disorders Identification Test (AUDIT), the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) and the Drug Abuse Screening Test (DAST).

Brief intervention

- If screening results indicate at risk behavior, individuals receive brief interventions. The intervention educates them about their substance use, alerts them to possible consequences and motivates them to change their behavior.

Referral to treatment

- Individuals whose screening indicates a severe problem or dependence should be referred to a licensed and certified behavioral health agency for assessment and treatment of a substance use disorder (SUD).

6.3.6- BH Continuing care services
Provided for: Mental Health Substance Use Disorder

A range of activities, facilitated by the outpatient community mental health agency's liaison conducted in or with a facility for the direct benefit of a enrolled individual in the public mental health system.

6.3.7- BH Care Coordination
Provided for: Mental Health Substance Use Disorder

Eligible youth and families have access to a wide array of services and supports to address their specifically identified needs and is intended to draw in resources through teaming with formal, informal, and natural supports and programs that are offered in a variety of settings (home, community, school, etc.). A Care Coordinator is a formal member of the WISe team who is specially trained to coordinate and facilitate the WISe process for an individual youth and family and provide advanced care coordination activities within the phases and activities of WISe. The Care Coordinator is typically the

facilitator of the Child & Family Team (CFT), and ultimately responsible for leading the team through the phases and activities of WISe both during and outside of the meetings. The Care Coordinator contributes knowledge and skills related to making sure that the team process honors each member's role, responsibility and perspective.

6.3.7.1- BH Intensive wraparound

Provided for: Mental Health Substance Use Disorder

Wraparound with Intensive Services (WISe) provides a range of services for clients age 20 or younger with mental disorders causing severe disruptions in behavior and requiring:

- Coordinating services and support across multiple domains (i.e., mental health system, juvenile justice, child protection/welfare, special education, developmental disabilities).
- Intensive care collaboration.
- Ongoing intervention to stabilize the child and family to prevent more restrictive or institutional placement.

6.3.7.2- BH Care transition services

Provided for: Mental Health Substance Use Disorder

Formal transition plan is developed when appropriate. The transition plan includes input from formal providers, natural supports, family and youth CFTs use the CANS to monitor for an increase of strengths and a reduction of needs.

The CFT, using clinical judgment and supervision, will determine the beginning of the transition window, and prepare for the youth and family to transition. Up to six months of transition services are allowed.

6.3.8- BH Case Management

Provided for: Mental Health Substance Use Disorder

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Effective Date: October 24, 2019

When applicable, Case Management Services are provided to eligible individuals in need, to ensure timely and appropriate treatment and care coordination. Activities include assessment for discharge or admission community to mental health care, integrated mental health treatment planning, resource identification and linkage to mental health rehabilitative services, and collaborative development of individualized services that promote continuity of mental health care.

6.3.9- BH Other
Provided for: Mental Health Substance Use Disorder

6.4- BH Assessment Tools

6.4.1- BH Please specify or describe all of the tool(s) required by the state and/or each managed care entity:

Behavioral health screenings must be done using standardized screening tools or through an interview. If the screening tool indicates further treatment is needed, providers should give treatment and/or make a referral to a behavioral health provider for further assessment and treatment recommendations.

ASAM Criteria (American Society Addiction Medicine)
 Mental Health Substance Use Disorders

InterQual
 Mental Health Substance Use Disorders

MCG Care Guidelines
 Mental Health Substance Use Disorders

CALOCUS/LOCUS (Child and Adolescent Level of Care Utilization)

System)

- Mental Health Substance Use Disorders
- CASII (Child and Adolescent Service Intensity Instrument)
 Mental Health Substance Use Disorders
- CANS (Child and Adolescent Needs and Strengths)
 Mental Health Substance Use Disorders
- State-specific criteria (e.g. state law or policies) (please describe)
 Mental Health Substance Use Disorders
- Plan-specific criteria (please describe)
 Mental Health Substance Use Disorders
- Other (please describe)
 Mental Health Substance Use Disorders
- No specific criteria or tools are required
 Mental Health Substance Use Disorders

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools to determine possible treatments or plans of care, providing education, training, and technical resources, and covering the costs of administering or purchasing the assessment tools.

6.4.2- BH Please describe the state's strategy to facilitate the use of validated assessment tools for the treatment of behavioral health conditions.

The state employs a comprehensive assessment strategy to facilitate the use of validated assessment tools for the treatment of behavioral health conditions. Assessment services will be facilitated by the managed care organizations, or the BHSO in the event an individual is enrolled in fee-for-service. The state provides a list of recommended assessment and screening tools, as well as ¹⁴¹maintains a website that provides information

Effective Date: October 24, 2019

Approval Date:

and resources for providers. Resources are provided via program-specific content on our Billers, Providers and Partners webpage. Additionally, the state facilitates a provider alert system which provides email notifications regarding program, authorization, or billing related changes to specific programs. All alerts are archived on the Provider Alerts website.

6.2.5- BH Covered Benefits The State assures the following related to the provision of behavioral health benefits in CHIP:

All behavioral health benefits are provided in a culturally and linguistically appropriate manner consistent with the requirements of section 2103(c)(6), regardless of delivery system.

The state will provide all behavioral health benefits consistent with 42 CFR 457.495 to ensure there are procedures in place to access covered services as well as appropriate and timely treatment and monitoring of children with chronic, complex or serious conditions.

6.2- MHPAEA Section 2103(c)(6)(A) of the Social Security Act requires that, to the extent that it provides both medical/surgical benefits and mental health or substance use disorder benefits, a State child health plan ensures that financial requirements and treatment limitations applicable to mental health and substance use disorder benefits comply with the mental health parity requirements of section 2705(a) of the Public Health Service Act in the same manner

that such requirements apply to a group health plan. If the state child health plan provides for delivery of services through a managed care arrangement, this requirement applies to both the state and managed care plans. These requirements are also applicable to any additional benefits provided voluntarily to the child health plan population by managed care entities and will be considered as part of CMS's contract review process at 457.1201(l).

6.2.1- MHPAEA Before completing a parity analysis, the State must determine whether each covered benefit is a medical/surgical, mental health, or substance use disorder benefit based on a standard that is consistent with state and federal law and generally recognized independent standards of medical practice (§ 457.496(f)(1)(i)).

6.2.1.1- MHPAEA Please choose the standard(s) the state uses to determine whether a covered benefit is a medical/surgical benefit, mental health benefit, or substance use disorder benefit. The most current version of the standard elected must be used. If different standards are used for the different benefit types, please specify the benefit type(s) to which each standard is applied. If “Other” is selected, please provide a description of that standard.

- International Classification of Disease (ICD)
- Diagnostic and Statistical Manual of Mental Disorders (DSM)
- State guidelines
- Other (Describe:)

6.2.1.2- MHPAEA Does the State provide mental health and/or substance use disorder benefits?

- Yes
- No

Guidance: If the State does not provide any mental health or substance use disorder benefits, the mental health parity requirements do not apply ((§ 457.496(f)(1)). Continue on to Section 6.3.

6.2.2- MHPAEA Section 2103(c)(6)(B) of the Act provides that to the extent a State child health plan includes coverage of early and periodic screening, diagnostic, and treatment services (EPSDT) defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the plan shall be deemed to satisfy the parity requirements of section 2103(c)(6)(A) of the Act.

6.2.2.1- MHPAEA Does the State child health plan provide coverage of EPSDT? The State must provide for coverage of EPSDT benefits, consistent with Medicaid

statutory requirements, as indicated in section 6.2.26 of the State child health plan in order to answer “yes.”

Yes

No

Guidance: If the State child health plan *does not* provide EPSDT consistent with Medicaid statutory requirements at sections 1902(a)(43) and 1905(r) of the Act, please go to Section 6.2.3- MHPAEA to complete the required parity analysis of the State child health plan.

If the state *does* provide EPSDT benefits consistent with Medicaid requirements, please continue this section to demonstrate compliance with the statutory requirements of section 2103(c)(6)(B) of the Act and the mental health parity regulations of § 457.496(b) related to deemed compliance.

6.2.2.2- MHPAEA EPSDT benefits are provided to the following:

All children covered under the State child health plan

A subset of children covered under the State child health plan.

Please describe the different populations (if applicable) covered under the State child health plan that are provided EPSDT benefits consistent with Medicaid statutory requirements.

Guidance: If only a subset of children is provided EPSDT benefits under the State child health plan, § 457.496(b)(3) limits deemed compliance to those children only and you must complete Section 6.2.3- MHPAEA to complete the required parity analysis for the other children.

6.2.2.3- MHPAEA To be deemed compliant with the MHPAEA parity requirements, States must provide EPSDT in accordance with sections 1902(a)(43) and 1905(r) of the Act (§ 457.496(b)(2)). The State assures each of the following for children eligible for EPSDT under the separate State child health plan:

All screening services, including screenings for mental health and substance use disorder conditions, are provided at intervals that align with a periodicity schedule that meets reasonable standards of medical or dental practice as well as when medically necessary to determine the existence of

suspected illness or conditions (Section 1905(r)).

All diagnostic services described in 1905(a) of the Act are provided as needed to diagnose suspected conditions or illnesses discovered through screening services, whether or not those services are covered under the Medicaid state plan (Section 1905(r)).

All items and services described in section 1905(a) of the Act are provided when needed to correct or ameliorate a defect or any physical or mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan (Section 1905(r)(5)).

Treatment limitations applied to services provided under the EPSDT benefit are not limited based on a monetary cap or budgetary constraints and may be exceeded as medically necessary to correct or ameliorate a medical or physical condition or illness (Section 1905(r)(5)).

Non-quantitative treatment limitations, such as definitions of medical necessity or criteria for medical necessity, are applied in an individualized manner that does not preclude coverage of any items or services necessary to correct or ameliorate any medical or physical condition or illness (Section 1905(r)(5)).

EPSDT benefits are not excluded on the basis of any condition, disorder, or diagnosis (Section 1905(r)(5)).

The provision of all requested EPSDT screening services, as well as any corrective treatments needed based on those screening services, are provided or arranged for as necessary (Section 1902(a)(43)).

All families with children eligible for the EPSDT benefit under the separate State child health plan are provided information and informed about the full range of services available to them (Section 1902(a)(43)(A)).

Guidance: For states seeking deemed compliance for their entire State child health plan population, please continue to Section 6.3. If not all of the covered populations are offered EPSDT, the State

must conduct a parity analysis of the benefit packages provided to those populations. Please continue to 6.2.3- MHPAEA.

Mental Health Parity Analysis Requirements for States Not Providing EPSDT to All Covered Populations

Guidance: The State must complete a parity analysis for each population under the State child health plan that is not provided the EPSDT benefit consistent with the requirements § 457.496(b). If the State provides benefits or limitations that vary within the child or pregnant woman populations, states should perform a parity analysis for each of the benefit packages. For example, if different financial requirements are applied according to a beneficiary's income, a separate parity analysis is needed for the benefit package provided at each income level.

6.2.3- MHPAEA In order to conduct the parity analysis, the State must place all medical/surgical and mental health and substance use disorder benefits covered under the State child health plan into one of four classifications: Inpatient, outpatient, emergency care, and prescription drugs (§ § 457.496(d)(2)(ii); 457.496(d)(3)(ii)(B)).

6.2.3.1 MHPAEA Please describe below the standard(s) used to place covered benefits into one of the four classifications.

6.2.3.1.1 MHPAEA The state assures that:

The State has classified all benefits covered under the State plan into one of the four classifications.

The same reasonable standards are used for determining the classification for a mental health or substance use disorder benefit as are used for determining the classification of medical/surgical benefits.

6.2.3.1.2- MHPAEA Does the state use sub-classifications to distinguish between office visits and other outpatient services?

Yes

No

6.2.3.1.2.1- MHPAEA If the State uses sub-classifications to

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distinguish between outpatient office visits and other outpatient services, the State assures the following:

- The sub-classifications are only used to distinguish office visits from other outpatient items and services, and are not used to distinguish between similar services on other bases (ex: generalist vs. specialist visits).

Guidance: For purposes of this section, any reference to “classification(s)” includes sub-classification(s) in states using sub-classifications to distinguish between outpatient office visits from other outpatient services.

6.2.3.2 MHPAEA The State assures that:

- Mental health/ substance use disorder benefits are provided in all classifications in which medical/surgical benefits are provided under the State child health plan.

Guidance: States are not required to cover mental health or substance use disorder benefits. However if a state does provide any mental health or substance use disorders, those mental health or substance use disorder benefits must be provided in all the same classifications in which medical/surgical benefits are covered under the State child health plan.

Annual and Aggregate Lifetime Limits

6.2.4- MHPAEA A State that provides both medical/surgical benefits and mental health and/or substance use disorder benefits must comply with parity requirements related to annual

and aggregate lifetime dollar limits for benefits covered under the State child health plan (§ 457.496(c)).

6.2.4.1- MHPAEA Please indicate whether the State applies an aggregate lifetime dollar limit and/or an annual dollar limit on any mental health or substance abuse disorder benefits covered under the State child health plan.

Aggregate lifetime dollar limit is applied

Aggregate annual dollar limit is applied

No dollar limit is applied

Guidance: If there are no aggregate lifetime or annual dollar limit on any mental health or substance use disorder benefits, please go to section 6.2.5- MHPAEA.

6.2.4.2- MHPAEA Are there any medical/surgical benefits covered under the State child health plan that have either an aggregate lifetime dollar limit or an annual dollar limit? If yes, please specify what type of limits apply.

Yes (Type(s) of limit: _____)

No

Guidance: If no aggregate lifetime dollar limit is applied to medical/ surgical benefits, the State may not impose an aggregate lifetime dollar limit on *any* mental health or substance use disorder benefits. If no aggregate annual dollar limit is applied to medical/surgical benefits, the State may not impose an aggregate annual dollar limit on *any* mental health or substance use disorder benefits (§ 457.496(c)(1)).

6.2.4.3 – MHPAEA. States applying an aggregate lifetime or annual dollar limit on medical/surgical benefits and mental health or substance use disorder benefits must determine whether the portion of the medical/surgical benefits to which the limit applies is less than one-third, at least one-third but less than two-thirds, or at least two-thirds of all medical/surgical benefits covered under the State plan (457.496(c)).

The portion of medical/surgical benefits subject to the limit is based on the dollar amount expected to be paid for all medical/surgical benefits under the State plan for the

State plan year or portion of the plan year after a change in benefits that affects the applicability of the aggregate lifetime or annual dollar limits (457.496(c)(3)).

The State assures that it has developed a reasonable methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable.

Guidance: Please include the state's methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable, as an attachment to the State child health plan.

6.2.4.3.1- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to a lifetime dollar limit:

- Less than 1/3
- At least 1/3 and less than 2/3
- At least 2/3

6.2.4.3.2- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to an annual dollar limit:

- Less than 1/3
- At least 1/3 and less than 2/3
- At least 2/3

Guidance: If an aggregate lifetime limit is applied to less than one-third of all medical/surgical benefits, the State may not impose an aggregate lifetime limit on *any* mental health or substance use disorder benefits. If an annual dollar limit is applied to less than one-third of all medical surgical benefits, the State may not impose an annual dollar limit on *any* mental health or substance use disorder benefits (§ 457.496(c)(1)). Skip to section 6.2.5-MHPAEA.

If the State applies an aggregate lifetime or annual dollar limit to at least one-third of all medical/surgical benefits, please continue below to provide the assurances related to the determination of the portion of

total costs for medical/surgical benefits that are subject to either an annual or lifetime limit.

6.2.4.3.2.1- MHPAEA If the State applies an aggregate lifetime or annual dollar limit to at least 1/3 and less than 2/3 of all medical/surgical benefits, the State assures the following (§ § 457.496(c)(4)(i)(B); 457.496(c)(4)(ii)):

- The State applies an aggregate lifetime or annual dollar limit on mental health or substance use disorder

benefits that is no more restrictive than an average limit calculated for medical/surgical benefits.

Guidance: The state's methodology for calculating the average limit for medical/surgical benefits must be consistent with § 457.496(c)(4)(i)(B) and 457.496(c)(4)(ii). Please include the state's methodology as an attachment to the State child health plan.

6.2.4.3.2.2- MHPAEA If at least 2/3 of all medical/surgical benefits are subject to an annual or lifetime limit, the State assures either of the following (§ 457.496(c)(2)(i); (§ 457.496(c)(2)(ii)):

The aggregate lifetime or annual dollar limit is applied to both medical/surgical benefits and mental health and substance use disorder benefits in a manner that does not distinguish between medical/surgical benefits and mental health and substance use disorder benefits; or

The aggregate lifetime or annual dollar limit placed on mental health and substance use disorder benefits is no more restrictive than the aggregate lifetime or annual dollar limit on medical/surgical benefits.

Quantitative Treatment Limitations

6.2.5- MHPAEA Does the State apply quantitative treatment limitations (QTLs) on any mental health or substance use disorder benefits in any classification of benefits? If yes, specify the classification(s) of benefits in which the State applies one or more QTLs on any mental health or substance use disorder benefits.

Yes (Specify:)

No

Guidance: If the state does not apply any type of QTLs on any mental health or substance use disorder benefits in any classification, the state meets parity requirements for QTLs and should continue to Section 6.2.6 - MHPAEA. If the state does apply financial requirements to any mental health or substance use

disorder benefits, the state must conduct a parity analysis. Please continue.

6.2.5.1- MHPAEA Does the State apply any type of QTL on any medical/surgical benefits?

Yes

No

Guidance: If the State does not apply QTLs on any medical/surgical benefits, the State may not impose quantitative treatment limitations on mental health or substance use disorder benefits, please go to Section 6.2.6- MHPAEA related to non-quantitative treatment limitations.

6.2.5.2- MHPAEA Within each classification of benefits in which the State applies a type of QTL on any mental health or substance use disorder benefits, the State must determine the proportion of medical and surgical benefits in the class which are subject to the limitation. More specifically, the State must determine the ratio of (a) the dollar amount of all payments expected to be paid under the State plan for medical and surgical benefits within a classification which are subject to the type quantitative treatment limitation for the plan year (or portion of the plan year after a mid-year change affecting the applicability of a type of quantitative treatment limitation to any medical/surgical benefits in the class) to (b) the dollar amount expected to be paid for all medical and surgical benefits within the classification for the plan year. For purposes of

this paragraph all payments expected to be paid under the State plan includes payments expected to be made directly by the State and payments which are expected to be made by MCEs contracting with the State. (§ 457.496(d)(3)(i)(C))

The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above for each classification within which the State applies QTLs to mental health or substance use disorder benefits. (§ 457.496(d)(3)(i)(E))

Effective Date: October 24, 2019

Approval Date:

Guidance: Please include the state’s methodology as an attachment to the State child health plan.

6.2.5.3- MHPAEA For each type of QTL applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of QTL to “substantially all” (defined as at least two-thirds) of the medical/surgical benefits within the same classification? (§ 457.496(d)(3)(i)(A))

Yes

No

Guidance: If the State does not apply a type of QTL to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose that type of QTL on mental health or substance use disorder benefits in that classification.

(§ 457.496(d)(3)(i)(A))

6.2.5.3.1- MHPAEA For each type of QTL applied to mental health or substance use disorder benefits, the State must determine the predominant level of that type which is applied to medical/surgical benefits in the classification. The “predominant level” of a type of QTL in a classification is the level (or least restrictive of a combination of levels) that applies to more than one-half of the medical/surgical benefits in that classification, as described in § § 457.496(d)(3)(i)(B). The portion of medical/surgical benefits in a classification to which a given level of a QTL type is applied is based on the dollar amount of

payments expected to be paid for medical/surgical benefits subject to that level as compared to all medical/surgical benefits in the classification, as described in § 457.496(d)(3)(i)(C). For each type of quantitative treatment limitation applied to mental health or substance use disorder benefits, the State assures:

The same reasonable methodology applied in determining the dollar amounts used to determine whether substantially all

medical/surgical benefits within a classification are subject to a type of quantitative treatment limitation also is applied in determining the dollar amounts used to determine the predominant level of a type of quantitative treatment limitation applied to medical/surgical benefits within a classification. (§ 457.496(d)(3)(i)(E))

The level of each type of quantitative treatment limitation applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominate level of that type which is applied by the State to medical/surgical benefits within the same classification. (§ 457.496(d)(2)(i))

Guidance: If there is no single level of a type of QTL that exceeds the one-half threshold, the State may combine levels within a type of QTL such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominate level is the least restrictive level of the levels combined to meet the one-half threshold (§ 457.496(d)(3)(i)(B)(2)).

Non-Quantitative Treatment Limitations

6.2.6- MHPAEA The State may utilize non-quantitative treatment limitations (NQTLs) for mental health or substance use disorder benefits, but the State must ensure that those NQTLs comply with all the mental health parity requirements (§ § 457.496(d)(4); 457.496(d)(5)).

6.2.6.1 – MHPAEA If the State imposes any NQTLs, complete this subsection. If the State does not impose NQTLs, please go to Section 6.2.7-MHPAEA.

The State assures that the processes, strategies, evidentiary standards or other factors used in the application of any NQTL to mental health or substance use disorder benefits are no more stringent than the processes, strategies, evidentiary standards or other factors used in the application of NQTLs to medical/surgical benefits within the same classification.

Guidance: Examples of NQTLs include medical management standards to limit or exclude benefits based on medical necessity, restrictions based on geographic location, provider specialty, or other criteria to limit the scope or duration of benefits, provider reimbursement

rates and provider network design (ex: preferred providers vs. participating providers).
Additional examples of possible NQTLs are provided in § 457.496(d)(4)(ii).

6.2.6.2 – MHPAEA The State or MCE contracting with the State must comply with parity if they provide coverage of medical or surgical benefits furnished by out-of-network providers.

6.2.6.2.1- MHPAEA Does the state or MCE contracting with the State provide coverage of services provided by out of network providers?

Yes

No

6.2.6.2.2- MHPAEA If yes, please assure the following:

The State attests that when determining access to out-of-network providers within a benefit classification, the processes, strategies, evidentiary standards, or other factors used to determine access to those providers for mental health/ substance use disorder benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used to determine access for out- of-network providers for medical/surgical benefits.

Availability of Plan Information

6.2.7- MHPAEA The State must provide beneficiaries, potential enrollees, and providers with information related to medical necessity criteria and denials of payment or reimbursement for mental health or substance use disorder services.

6.2.7.1- MHPAEA Medical necessity criteria determinations must be made available to any current or potential enrollee or contracting provider, upon request.

The state attests that the following entities provide this information:

State

Managed Care entities

Both

6.2.7.2- MHPAEA Reason for any denial for reimbursement or payment for mental health or substance use disorder benefits must be made available to the enrollee by the health plan or the State. The state attests that the following entities provide denial information:

State

Managed Care entities

Both

6.3. The State assures that, with respect to pre-existing medical conditions, one of

the following two statements applies to its plan: (42CFR 457.480)

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

6.3.2. The State contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.6.2. (formerly 6.4.2) of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA. (Formerly 8.6.) (Section 2103(f)) Describe:

Guidance: States may request two additional purchase options in Title XXI: cost effective coverage through a community-based health delivery system and for the purchase of family coverage. (Section 2105(c)(2) and (3)) (457.1005 and 457.1010)

6.4. Additional Purchase Options- If the State wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the State must address the following: (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

6.4.1. **Cost Effective Coverage-** Payment may be made to a State in excess of the 10 percent limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving

the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the State to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

- 6.4.1.1.** Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The State may cross reference Section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))
- 6.4.1.2.** The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))

Guidance: Check below if the State is requesting to provide cost-effective coverage through a community-based health delivery system. This allows the State to waive the 10 percent limitation on expenditures not used for Medicaid or health insurance assistance if coverage provided to targeted low-income children through such expenditures meets the requirements of Section 2103; the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under Section 2103; and such coverage is provided through the

use of a community-based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Services Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923.

If the cost-effective alternative waiver is requested, the State must demonstrate that payments in excess of the 10 percent limitation will be used for other child health assistance for targeted low-income children; expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); expenditures for outreach activities as provided in Section 2102(c)(1) under

the plan; and other reasonable costs incurred by the State to administer the plan. (42CFR, 457.1005(a))

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

Guidance: Check 6.4.2.if the State is requesting to purchase family coverage. Any State requesting to purchase such coverage will need to include information that establishes to the Secretary's satisfaction that: 1) when compared to the amount of money that would have been paid to cover only the children involved with a comparable package, the purchase of family coverage is cost effective; and 2) the purchase of family coverage is not a substitution for coverage already being provided to the child. (Section 2105(c)(3)) (42CFR 457.1010)

6.4.2. **Purchase of Family Coverage-** Describe the plan to purchase family coverage. Payment may be made to a State for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42CFR 457.1010)

6.4.2.1. Purchase of family coverage is cost-effective. The State's cost of purchasing family coverage, including administrative expenditures, that includes coverage for the targeted low-income children involved or the family involved (as applicable) under premium assistance programs must not be greater than the cost of obtaining coverage under the State plan for all eligible targeted low-income children or families involved; and (2) The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage, including

administrative costs, for children or families under premium assistance programs to the cost of other CHIP coverage for these children or families, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

6.4.2.2. The State assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42CFR 457.1010(b))

6.4.2.3. The State assures that the coverage for the family otherwise meets title XXI requirements. (42CFR 457.1010(c))

6.4.3-PA: Additional State Options for Providing Premium Assistance (CHIPRA # 13, SHO # 10-002 issued February, 2, 2010) A State may elect to offer a premium assistance subsidy for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(B), to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage. No subsidy shall be provided to a targeted low-income child (or the child's parent) unless the child voluntarily elects to receive such a subsidy. (Section 2105(c)(10)(A)). Please remember to update section 9.10 when electing this option. Does the State provide this option to targeted low-income children?

- Yes
- No

6.4.3.1-PA Qualified Employer-Sponsored Coverage and Premium Assistance Subsidy

6.4.3.1.1-PA Provide an assurance that the qualified employer-sponsored insurance meets the definition of qualified employer-sponsored coverage as defined in Section 2105(c)(10)(B), and that the premium assistance subsidy meets the definition of premium

assistance subsidy as defined in 2105(c)(10)(C).

6.4.3.1.2-PA Describe whether the State is providing the premium assistance subsidy as reimbursement to an employee or for out-of-pocket expenditures or directly to the employee's employer.

6.4.3.2-PA: Supplemental Coverage for Benefits and Cost Sharing Protections Provided under the Child Health Plan.

6.4.3.2.1-PA If the State is providing premium assistance for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(E)(i), provide an assurance that the State is providing for each targeted low-income child enrolled in such coverage, supplemental coverage consisting of all items or services that are not covered or are only partially covered, under the qualified employer-sponsored coverage consistent with 2103(a) and cost sharing protections consistent with Section 2103(e).

6.4.3.2.2-PA Describe whether these benefits are being provided through the employer or by the State providing wraparound benefits.

6.4.3.2.3-PA If the State is providing premium assistance for benchmark or benchmark-equivalent coverage, the State ensures that such group health plans or health insurance coverage offered through an employer will be certified by an actuary as coverage that is equivalent to a benchmark benefit package described in Section 2103(b) or benchmark equivalent coverage that meets the requirements of Section 2103(a)(2).

6.4.3.3-PA: Application of Waiting Period Imposed Under State Plan: States are required to apply the same waiting period to premium assistance as is applied to direct coverage for children under their CHIP State plan, as specified in Section 2105(c)(10)(F).

6.4.3.3.1-PA Provide an assurance that the waiting period for children in premium assistance is the same as for those children in direct coverage (if State has a waiting period in place for children in direct CHIP coverage).

6.4.3.4-PA: Opt-Out and Outreach, Education, and Enrollment Assistance

6.4.3.4.1-PA Describe the State's process for ensuring parents are permitted to disenroll their child from qualified employer-sponsored coverage and to enroll in CHIP effective on the first day of any month for which the child is eligible for such assistance and in a manner that ensures continuity of coverage for the child (Section 2105(c)(10)(G)).

6.4.3.4.2-PA Describe the State's outreach, education, and enrollment efforts related to premium assistance programs, as required under Section 2102(c)(3). How does the State inform families of the availability of premium assistance, and assist them in obtaining such subsidies? What are the specific significant resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the State child health plan? (Section 2102(c))

6.4.3.5-PA Purchasing Pool- A State may establish an employer-family premium assistance purchasing pool and may provide a premium assistance subsidy for enrollment in coverage made available through this pool (Section 2105(c)(10)(I)). Does the State provide this option?

160Yes

No

6.6.3.5.1-PA Describe the plan to establish an employer-family premium assistance purchasing pool.

6.6.3.5.2-PA Provide an assurance that employers who are eligible to participate: 1) have less than 250 employees; 2) have at least one employee who is a pregnant woman eligible for CHIP or a member of a family that has at least one child eligible under the State's CHIP plan.

6.6.3.5.3-PA Provide an assurance that the State will not claim for any administrative expenditures attributable to the establishment or operation of such a pool except to the extent such payment would otherwise be permitted under this title.

6.4.3.6-PA Notice of Availability of Premium Assistance- Describe the procedures that assure that if a State provides premium assistance subsidies under this Section, it must: 1) provide as part of the application and enrollment process, information describing the availability of premium assistance and how to elect to obtain a subsidy; and 2) establish other procedures to ensure that parents are fully informed of the choices for child health assistance or through the receipt of premium assistance subsidies (Section 2105(c)(10)(K)).

6.4.3.6.1-PA Provide an assurance that the State includes information about premium assistance on the CHIP application or enrollment form.

Section 7. Quality and Appropriateness of Care

Guidance:

Methods for Evaluating and Monitoring Quality- ¹⁶¹ Methods to assure quality include the application of

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performance measures, quality standards consumer information strategies, and other quality improvement strategies.

Performance measurement strategies could include using measurements for external reporting either to the State or to consumers and for internal quality improvement purposes. They could be based on existing measurement sets that have undergone rigorous evaluation for their appropriateness (e.g., HEDIS). They may include the use of standardized member satisfaction surveys (e.g., CAHPS) to assess members' experience of care along key dimensions such as access, satisfaction, and system performance.

Quality standards are often used to assure the presence of structural and process measures that promote quality and could include such approaches as: the use of external and periodic review of health plans by groups such as the National Committee for Quality Assurance; the establishment of standards related to consumer protection and quality such as those developed by the National Association of Insurance Commissioners; and the formation of an advisory group to the State or plan to facilitate consumer and community participation in the plan.

Information strategies could include: the disclosure of information to beneficiaries about their benefits under the plan and their rights and responsibilities; the provision of comparative information to consumers on the performance of available health plans and providers; and consumer education strategies on how to access and effectively use health insurance coverage to maximize quality of care.

Quality improvement strategies should include the establishment of quantified quality improvement goals for the plan or the State and provider education. Other strategies include specific purchasing specifications, ongoing contract monitoring mechanisms, focus groups, etc.

Where States use managed care organizations to deliver CHIP care, recent legal changes require the State to use managed care quality standards and quality strategies similar to those used in Medicaid managed care.

Tools for Evaluating and Monitoring Quality- Tools and types of information available include, HEDIS (Health Employer Data Information Set) measures, CAHPS (Consumer Assessments of Health Plans Study) measures, vital statistics data, and State health registries (e.g., immunization registries).

Quality monitoring may be done by external quality review organizations, or, if the State wishes, internally by a State board or agency independent of the State CHIP Agency. Establishing grievance measures is also an important aspect of monitoring.

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.

Guidance: The State must specify the qualifications of entities that will provide coverage and the conditions of participation. States should also define the quality standard they are using, for example, NCQA Standards or other professional standards. Any description of the information strategies used should be linked to Section 9. (Section 2102(a)(7)(A)) (42CFR, 457.495)

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. (Section 2102(a)(7)(A)) (42CFR 457.495(a)) Will the State utilize any of the following tools to assure quality? (Check all that apply and describe the activities for any categories utilized.)

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

The state contracts only with MCOs that are regulated by the Office of the Insurance Commissioner (OIC), which regulates and monitors financial solvency and other consumer protection safeguards.

HCA monitors the quality and appropriateness of care through:

- Monitoring and analysis of quality standards and performance measures for well-baby care, well-child care, and immunizations required through encounter data, chart review, HEDIS reporting, and a variety of other contract monitoring activities listed below;
- Client interviews;
- Biennial client satisfaction/health status surveys for managed care clients;
- Complaint management system;
- Exemption/disenrollment/fair hearing database;
- Standards for health plan internal quality improvement programs;
- Network adequacy standards; and

- On-site contract compliance monitoring and technical assistance. Contract monitoring is performed through the following actions:
 - Requiring the same encounter data reporting (form, format, periodicity) as required under Medicaid HO;
 - Generating HEDIS reporting and the above mentioned quality measures with the same criteria as Medicaid HO and similar FFS review;
 - Applying utilization controls for FFS coverage that are consistent with all current utilization review requirements under the state’s Medicaid plan. Examples of controls include external review of hospital claims data, exception-to-policy procedures, data audits, pre- authorization for extended coverage utilization, and drug utilization review;
 - Performing at minimum annual, on-site quality and operational reviews of the MCO contractors;
 - Reviewing of the MCOs by an External Quality Review Organization (EQRO), as required by federal law (Section 1902 (a) (30) (C) of the Social Security Act);
 - Requiring that MCOs maintain an internal program of quality assurance, as required by federal regulations (42 CFR 434.34);
 - Performing biennial client satisfaction surveys;
 - Monitoring of actions, grievances and appeals at both the health plan level and the Medicaid state agency level.

7.1.1. Quality standards

In addition to the utilization controls described in Section 3.2, National Committee for Quality Assurance (NCQA) standards are the guidelines for contract requirements and monitoring. Generally, the NCQA standards address the following:

- Quality Management and Improvement – program structure, program operations, health services contracting, availability of practitioners;
- Accessibility of services, member satisfaction, health management systems, primary care provider role, scope and content of clinical quality improvement (QI) activities, clinical measurement activities, effectiveness of the QI

program, and delegation of QI activity;

- Utilization Management;
- Credentialing and Re-credentialing;
- Members' Rights and Responsibilities; and
- Preventative Health Services and Medical Records.

Quality standards for FFS will be consistent with all quality utilization review requirements under the state's Medicaid plan, and the additional quality activities listed in Section 7.1

7.1.2. Performance measurement

7.1.2 (a) CHIPRA Quality Core Set

7.1.2 (b) Other

Health Plan Employer Data and Information Set (HEDIS) performance measures will be reported and preventive health services relevant to the program such as EPSDT and child immunizations will be evaluated with the same criteria as the current HO program and similar FFS review. See further performance criteria in Section 7.1.4.

7.1.3. Information strategies

Encounter data, HEDIS measures, provider network adequacy standards, and health care experience data will be reported by health plans. The current complaint management system will be maintained at both the health plan level

and the State level to assure timely resolution of client complaints and grievances. FFS information strategies will be consistent with all information requirements under the state's Medicaid plan.

7.1.4. Quality improvement strategies

Guidance: Provide a brief description of methods to be used to assure access to covered services, including a description of how the State will assure the quality and appropriateness of the care provided. The State should consider whether there are sufficient providers of care for the newly enrolled populations and whether there is reasonable access to care. (Section 2102(a)(7)(B))

The following strategies and activities have been implemented and are consistent with the MC and FFS programs:

- Monitoring and analysis of quality standards and performance measures for well- baby care, well-child and adolescent care, and childhood immunizations required through encounter data, chart review, HEDIS reporting, and a variety of other contract monitoring activities listed below;
- Client interviews;
- Biennial client satisfaction/health status surveys for managed care clients;
- Complaint management system;
- Exemption/disenrollment/fair hearing database;
- Standards for health plan internal quality improvement programs;
- Network adequacy standards; and
- On-site contract compliance monitoring and technical assistance.

7.2. Describe the methods used, including monitoring, to assure: (Section 2102(a)(7)(B)) (42CFR 457.495)

7.2.1. Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))

The methods used to assure access to covered services, including well-baby care, well-child care, well-adolescent care, and childhood and adolescent immunizations,

are based on the Healthy Options (HO) program. The methods, including monitoring, will be the following:

Availability of Practitioners

MCOs must have a written access plan describing the mechanisms used to assure the availability of primary care providers (PCPs) and physician specialists, hospitals, and pharmacies. Standards for the number and geographic distribution of PCPs and specialty care practitioners are established in the procurement

requirements. MCOs submit their provider networks to HCA. MCOs must collect and analyze data to measure performance against these standards and implement corrective action when necessary.

As part of the procurement process, HO bidders are required to submit GeoNetwork analysis that describes how its network compares to HCA access guidelines for distribution (travel distance) and capacity of primary care providers (PCPs), obstetrical providers, hospitals and pharmacies. This information is compared to BHP and Public Employee Benefit Board (PEBB) networks to judge whether there is sufficient capacity. HO, BHP and PEBB plans are required to submit monthly updates of provider network changes.

Accessibility of Services

- Covered services for managed care enrollees, such as types of practitioners and providers, location of practitioners and providers, and timeliness, must be made at least as accessible as for members enrolled under the MCO's other state, federal, or private contracts.
- Coverage for medical advice through a toll-free telephone number on a 24 hours per day, 7 days per week basis must be made available to members for the purpose of rendering medical advice concerning the emergency, urgent or routine nature of a medical condition, and authorizing care at other facilities when the use of participating facilities is not practical. This advice and authorization must be made by a licensed health care professional.
- Mechanisms must be established to assure the accessibility of primary care services, urgent care services and member services.
- Standards (which apply to HO, BHP, PEBB and CHIP) must be established that are no longer than the following:
 - Non-symptomatic (i.e., preventive care) office visit – within 30 calendar days;
 - Non-urgent, symptomatic (i.e., routine care) office visit – within 10 days;
 - Urgent, symptomatic (i.e., presentation of medical conditions requiring immediate attention, not life-threatening) office visit within 48 hours; and

- Emergency medical care within 24 hours per day, 7 days per week.
- MCOs must collect and analyze data to measure their performance against the above standards. FFS quality standards and utilization controls are consistent with all quality and utilization review requirements under the state's Medicaid plan.
- Washington State Well-Child Exam Forms, developed collaboratively with the Washington Chapter of the American Academy of Pediatrics, the Department of Health, Head Start/ECEAP staff, health plan staff and many other stakeholder groups as part of a statewide focus on improving well-child care. Historical EPSDT chart review studies consistently demonstrated that providers using a structured charting or screening tool were significantly more likely to meet the minimum documentation requirements for a qualifying well-child visit. These forms are free of charge to providers who deliver well-child care to Medicaid clients. The forms are unique to each age category and include the ages listed below:
 - Infancy – 2-4 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 18 months, and 2 years
 - Early childhood – 3 years, 4 years, 5 years, 6 years, 8 years, and 10 years
 - Late childhood – 12 years
 - Adolescence – 14 years, 16 years, 18 years
 - Each age-specific document is a two-page, NCR form. The first sheet is for the child's medical record. On the back of the first page includes information about different components of the exam. The second page is given to the family after the exam. The back of the second page provides the family with both parent education and some information about the child's growth and development between the current visit and the next anticipated visit. The forms are available in hard copy and can be ordered through MAA. The forms can also be downloaded at the DSHS website: <http://www1.dshs.wa.gov/msa/forms/eforms.html> (beginning at form # 13- 683).
- Pay for Performance incentives for 2-year-old immunizations and well-child care have been part of the Health Options/CHIP contract since 2004. DSHS

set aside \$1,000,000 each to be paid for improved performance on 2-year-old immunizations and well-child care. Calculations are based on a point system that rewards health plans for both their current year performance relative to other plans and for their improvement from previous year to current year relative to other plans. The four highest performing plans share in the reward.

- EPSDT Rate Increase for Foster Care Children as a result of several studies that suggested that children in foster care were not receiving adequate health care services. HCA increased the rate of reimbursement for well-child care (for this population only) in late fall, 2001.

7.2.2. Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))

Please see response to Section 7.2.1 regarding access to covered services. The same criteria apply to all covered services.

For emergency services, the definition of emergency in the plan will be based on the current definition addressing need as defined by the “prudent layperson”. As noted above, standards assuring access and network adequacy must be written by MCOs specifying how to access emergency medical care within 24 hours per day, 7 days per week. In addition, emergency care services for medical emergencies must be provided in non-participating facilities when a member:

- Has a medical emergency meeting the contract definition and is not able to use a participating hospital (42 CFR 434.30), or
- Presents at a non-participating hospital emergency department and the member’s condition is determined to be non-emergency. In such instances, the MCO must cover facility and professional services for medical screening examinations as defined in the contract.

7.2.3. Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to ~~160~~ specialists experienced in treating the specific

medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

The State's contract with MCOs requires the MCO to provide all medically necessary specialty care for enrollees. If an enrollee needs specialty care from a specialist who is not available within the MCO's provider network, the MCO must provide the necessary services with a qualified specialist outside of the MCO's provider network.

7.2.4. Decisions related to the prior authorization of health services are completed in accordance with State law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d)) Exigent medical circumstances may require more rapid response according to the medical needs of the patient.

Washington follows Washington Administrative Code 182-501-0165 related to the prior authorization of services.

Section 8. Cost-Sharing and Payment

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 9.

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

(42CFR 457.505) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

8.1.1. Yes, [AI/AN children, and unborn children are exempt from cost-sharing].

8.1.2. No, skip to question 8.8.

8.1.1-PW Yes

8.1.2-PW No, skip to question 8.8.

Guidance: It is important to note that for families ¹⁷⁰ below 150 percent of poverty, the same limitations on

Effective Date: October 24, 2019

Approval Date:

cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the family cannot exceed 5 percent of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge by age and income (if applicable) and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2.1. Premiums:
Tier 1 (210%-260%FPL): \$20/mo. per child; family maximum of \$40/mo.
Tier 2 (261%-312%FPL): \$30/mo. per child; family maximum of \$60/mo.
Non-payment of premiums may be temporarily forgiven/waived for CHIP applicants and/or existing beneficiaries during the Federal COVID-19 public health emergency period.

8.2.2. Deductibles:

8.2.3. Coinsurance or copayments:

8.2.4. Other:

8.2-DS **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and dental insurance. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

8.2.1-DS Premiums: 171

- 8.2.2-DS Deductibles:
- 8.2.3-DS Coinsurance or copayments:
- 8.2.4-DS Other:

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)(1)(A)) (42CFR 457.505(b))

Applicants are notified of their premium obligation upon submission of their electronic application through the state-based exchange at www.wahealthplanfinder.org. In addition to this electronic notification, applicants receive an award letter describing their premium obligation. Notices include the statutory reference for the premium assessment.

No premium is assessed for the first month of coverage, and coverage is not delayed for payment of a premium. In the second month the family receives a monthly billing statement. These statements include the current amount owed as well as any overdue amount. The statement informs the client that accounts over 90 days past due may result in loss of healthcare coverage and provides a phone number for the parent to call if their income goes down, a family member moves in or out of their home, or a child under age 19 becomes pregnant or disabled, as their children may be eligible for a medical program with no premiums. Clients may also directly report changes in their circumstances by updating their account at www.wahealthplanfinder.org.

Guidance: The State should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.

8.4. The State assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

8.4.1. Cost-sharing does not favor children from higher income families over ¹⁷²

lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)

8.4.2. No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)

8.4.3 No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

8.4.1- MHPAEA There is no separate accumulation of cumulative financial requirements, as defined in § 457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits (§ 457.496(d)(3)(iii)).

8.4.2- MHPAEA If applicable, any different levels of financial requirements that are applied to different tiers of prescription drugs are determined based on reasonable factors, regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits (§ 457.496(d)(3)(ii)(A)).

8.4.3- MHPAEA Cost sharing applied to benefits provided under the State child health plan will remain capped at five percent of the beneficiary’s income as required § 457.560 (§ 457.496(d)(i)(D)).

8.4.4- MHPAEA Does the State apply financial requirements to any mental health or substance use disorder benefits? If yes, specify the classification(s) of benefits in which

the State applies financial requirements on any mental health or substance use disorder benefits.

Yes (Specify: _____)

No

Guidance: If the state does not apply financial requirements on any mental health or

substance use disorder benefits, the state meets parity requirements for financial requirements. If the state does apply financial requirements to mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue below.

8.4.5- MHPAEA Does the State apply any type of financial requirements on any medical/surgical benefits?

Yes

No

Guidance: If the State does not apply financial requirements on any medical/surgical benefits, the State may not impose financial requirements on mental health or substance use disorder benefits.

8.4.6- MHPAEA Within each classification of benefits in which the State applies a type of financial requirement on any mental health or substance use disorder benefits, the State must determine the proportion of medical and surgical benefits in the class which are subject to the limitation.

The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above (Section 6.2.5.2) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits (§ 457.496(d)(3)(i)(E)).

Guidance: Please include the state's methodology as an attachment to the State child health plan.

8.4.7- MHPAEA For each type of financial requirement applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of financial requirement to at least two-thirds ("substantially all") of all the medical/surgical benefits within the same classification? (§ 457.496(d)(3)(i)(A))¹⁷⁴

Yes

No

Guidance: If the State does not apply a type of financial requirement to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose financial requirements on mental health or substance use disorder benefits in that classification. (§ 457.496(d)(3)(i)(A))

8.4.8- MHPAEA For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in § 457.496(d)(3)(i)(B)(1)) of that type which is applied to medical/surgical benefits in the classification. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State assures:

The same reasonable methodology applied in determining the dollar amounts used in determining whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement also is applied in determining the dollar amounts used to determine the predominant level of a type of financial requirement applied to medical/surgical benefits within a classification. (§ 457.496(d)(3)(i)(E))

The level of each type of financial requirement applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominate level of that type which is applied by the State to medical/surgical benefits within the same classification. (§ 457.496(d)(2)(i))

Guidance: If there is no single level of a type of financial requirement that exceeds the one-half threshold, the State may combine levels within a type of financial requirement such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominate level is the least restrictive level of the levels combined to meet the one-half threshold (§ 457.496(d)(3)(i)(B)(2)).

8.5. Describe how the State will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the State for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

The maximum premium assessed for Tier 1 families is \$40/mo. This represents at most 1.3% of the family's income. The maximum premium assessed for Tier 2 families is \$60/mo. This represents at most 1.6% of the family's income.

8.6. Describe the procedures the State will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

Applicants are given the opportunity to report their AI/AN status during the application process. When they report that their children are AI/AN no premium is assessed. If a child is not self-identified at the time of application, client materials, as well as the billing invoice, provide information on excluding AI/AN children from the cost-sharing requirement. If premiums were inadvertently paid for an AI/AN child, a refund is issued.

8.7. Provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

Guidance: Section 8.7.1 is based on Section 2101(a) of the Act provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

8.7.1. Provide an assurance that the following disenrollment protections are being applied:

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (Section 2103(e)(3)(C))

- 8.7.1.1. State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))

Families are notified on each billing statement that failure to pay required premiums for 3 months may result in termination of coverage.

Waive premium lock-out policy (eligibility policy): Premium lock-out policy is temporarily suspended and coverage is available regardless of whether the family has paid their outstanding premium during the Federal COVID-19 public health emergency. **See CS21**

- 8.7.1.2. The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))

Families are notified prior to termination that they may report changes in their income or circumstances that may result in their children being eligible for coverage without a premium.

- 8.7.1.3. In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))

Families that report a decrease in income, an increase in the number of family members, or that their children are AI/AN will have their eligibility for Medicaid automatically redetermined.

- 8.7.1.4 The State provides¹⁷⁷ the enrollee with an opportunity for an **Approval Date:**

Effective Date: October 24, 2019

impartial review to address disenrollment from the program.
(42CFR 457.570(c))

Families may request an administrative hearing, and continued coverage pending the outcome of the hearing, if they disagree with the Agency disenrolling their children from healthcare coverage.

8.8. The State assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1. No Federal funds will be used toward State matching requirements. (Section 2105(c)(4)) (42CFR 457.220)

8.8.2. No cost-sharing (including premiums, deductibles, copayments, coinsurance and all other types) will be used toward State matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)

8.8.3. No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

8.8.5. No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)

8.8.6. No funds provided under this title will be used to pay for any abortion

or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration

Guidance: States should consider aligning its strategic objectives with those discussed in Section II of the CHIP Annual Report.

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))

Washington's CHIP strategic objective is to increase the number of children in households between 210% and 312% 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 210% of FPL who have health insurance coverage.

Guidance: Goals should be measurable, quantifiable and convey a target the State is working towards.

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))

Guidance: The State should include data sources to be used to assess each performance goal. In addition, check all appropriate measures from 9.3.1 to 9.3.8 that the State will be utilizing to measure performance, even if doing so duplicates what the State has already discussed in Section 9.

It is acceptable for the State to include performance measures for population subgroups chosen by the State for special emphasis, such as racial or ethnic minorities, particular high-risk or hard to reach populations, children with special needs, etc.

HEDIS (Health Employer Data and Information Set) 2008 contains performance measures relevant to children and adolescents younger than 19. In addition, HEDIS 3.0 contains measures for the general population, for which breakouts by children's age bands (e.g., ages < 1, 1-9, 10-19) are required. Full definitions, explanations of data sources, and other important guidance on the use of HEDIS measures can be found in the HEDIS 2008 manual published by the National Committee on Quality Assurance. So that State HEDIS results are

Effective Date: October 24, 2019

Approval Date:

consistent and comparable with national and regional data, states should check the HEDIS 2008 manual for detailed definitions of each measure, including definitions of the numerator and denominator to be used. For states that do not plan to offer managed care plans, HEDIS measures may also be able to be adapted to organizations of care other than managed care.

The following performance goals have been identified:

1. Increase the number of children between 210% and 312% of FPL who have health care coverage.
2. Reduce the percentage of uninsured children between 210% and 312% FPL.
3. Increase the number of children below 210% of FPL who have health coverage.
4. Reduce the percentage of uninsured children below 210% of FPL.
5. Track the satisfaction and health care of CHIP children compared to Medicaid children and non-Medicaid children

- 9.3.** Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the State's performance, taking into account suggested performance indicators as specified below or other indicators the State develops: (Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

HCA and the Governor's Office of Financial Management (OFM) Forecast Section will analyze WSPS data to measure the number and percentage of children who are uninsured. The WSPS is a comprehensive survey conducted under contract with Washington State University's Social and Economic Sciences Research Center. The survey is modeled after U.S. Bureau of the Census's Current Population Survey. However, the survey is a statewide survey with a greatly enhanced sample size (6,950 households in 1998) to allow for statistically reliable analyses for the state and regions within the state. There are expanded samples of racial and ethnic minorities to be able to compare socio-economic characteristics of people of different racial and ethnic backgrounds. The WSPS is conducted biennially. Therefore, the CHIP uninsured performance measures will be reported every two years.

The assessment of CHIP enrollees' satisfaction with their health care and services is based on HCA's work with the Consumer Assessment of Health Plans (CAHPS).

These surveys are conducted every other year in accordance with CAHPS

Consortium (A group of national survey experts associated with the Harvard Medical School, RAND, and the Research Triangle Institute protocols). The last survey was conducted in 2007, and 78% of respondents indicated there was no problem getting access to care. The survey included both HO enrollees and Medicaid FFS clients. HCA has been using HEDIS- and EPSDT related measures to assess the effectiveness of its HO contractors to provide medically appropriate services to Medicaid clients. HCA contracts with its external review organization to generate a set of similar, child appropriate measures for CHIP enrollees.

Check the applicable suggested performance measurements listed below that the State plans to use: (Section 2107(a)(4))

- 9.3.1. The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2. The reduction in the percentage of uninsured children.
- 9.3.3. The increase in the percentage of children with a usual source of care.
- 9.3.4. The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5. HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6. Other child appropriate measurement set. List or describe the set used.
- 9.3.7. If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
 - 9.3.7.1. Immunizations
 - 9.3.7.2. Well childcare
 - 9.3.7.3. Adolescent well visits
 - 9.3.7.4. Satisfaction with care
 - 9.3.7.5. Mental health
 - 9.3.7.6. Dental care
 - 9.3.7.7. Other, list:

HCA will track and compare CHIP dental access and usage with Medicaid children.

9.3.8. Performance measures for special targeted populations.

9.4. The State assures it will collect all data, maintain records, and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)

Guidance: The State should include an assurance of compliance with the annual reporting requirements, including an assessment of reducing the number of low-income uninsured children. The State should also discuss any annual activities to be undertaken that relate to assessment and evaluation of the program.

9.5. The State assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the State's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)

Washington State will report on the number of CHIP enrolled children on an annual basis. The number and percentage of uninsured children between 210% and 312% FPL will be reported on a biennial basis using available population 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 or audit. (Section 2107(b)(3)) (42CFR 457.720)

Guidance: The State should verify that they will participate in the collection and evaluation of data as new measures are developed or existing measures are revised as deemed necessary by CMS, the states, advocates, and other interested parties.

9.7. The State assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))

9.8. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they

apply to a State under Title XIX: (Section 2107(e)) (42CFR 457.135)

- 9.8.1. Section 1902(a)(4)(C) (relating to conflict-of-interest standards)
- 9.8.2. Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
- 9.8.3. Section 1903(w) (relating to limitations on provider donations and taxes)
- 9.8.4. Section 1132 (relating to periods within which claims must be filed)

Guidance: Section 9.9 can include discussion of community-based providers and consumer representatives in the design and implementation of the plan and the method for ensuring ongoing public involvement. Issues to address include a listing of public meetings or announcements made to the public concerning the development of the children's health insurance program or public forums used to discuss changes to the State plan.

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 ensuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))

Over the past decade of expanding services to children, Washington State has relied on several strategies to assure high levels of community involvement:

- The public had an opportunity to testify on the Governor's proposed CHIP during both the 1998 and 1999 legislative sessions. The public also had an opportunity to comment on an alternative CHIP program that was being offered by House Republicans. Stakeholders and advocacy groups met throughout the 1999 session to comment on and ask legislators to pass the Governor's proposal, which was enacted on a bipartisan basis during the 1999 session.
- HCA also worked with the Seattle Campaign for Kids 2001 and a potential CHIP demonstration project prior to the 1999 session. Input in that project was reflected in the Governor's proposal and HCA's CHIP operational design.

Effective Date: October 24, 2019

Approval Date:

- During the development of the CHIP state plan, HCA involved representatives of various stakeholder groups including the state medical association, the state hospital association, provider groups, representatives of the Legislature, health care plans, client rights organizations and client advocacy groups. The public meetings held to review the plan submittal were jointly sponsored by HCA and the Children’s Alliance – a statewide children’s advocacy group.
- HCA sponsored fourteen local community groups to provide feedback on the Healthy Options program. The Healthy Options Committees were asked to provide input, as well as feedback throughout implementation.
- HCA consulted with the American Indian Health Commission of Washington State and the Northwest Portland Area Indian Health Board on the design of CHIP. CHIP had been an item of discussion for over a year with these groups.
- HCA also provided an opportunity for all interested parties to review and comment on the original State Plan application through HCA’s CHIP website.
- Public testimony during the 2007 session in which the state legislature passed SSSB 5093 “Cover All Kids” with bipartisan support, approving an increase in the CHIP program to 300%FPL.

The combination of statewide and local input provided a robust mechanism for assuring broad input into the planning, implementation, and ongoing development of CHIP.

9.9.1. Describe the process used by the State to ensure interaction with Indian Tribes and organizations in the State on the development and implementation of the procedures required in 42 CFR 457.125. States should provide notice and consultation with Tribes on proposed pregnant women expansions. (Section 2107(c)) (42CFR 457.120(c))

HCA consulted with the American Indian Health commission of Washington State and the Northwest Portland Area Indian Health Board on the design of CHIP. HCA has coordinated with and will continue to work with representatives of the Tribes in the state of Washington, urban Indian organizations, and Indian advocacy groups, including the Northwest Portland Area Indian Health Board, the American Indian

Health Commission, and the DSHS Indian Policy Advisory Committee. Although the total number of Indian children served by CHIP continues to be small (just over 1,000), the ongoing commitment by the State to Indian health issues is viewed by the Tribes as an important move.

9.9.2. For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR 457.65(b) through (d).

The CHIP expansion to 300% of FPL was authorized by Second Substitute Senate Bill (2SSB 5093) which was signed into law by the Governor on March 13, 2007, and which became effective July 22, 2007. The legislation has been codified under Section 74.09.470 of the Revised Code of Washington (RCW). The expansion provisions are found in RCW.74.09.470 (1).

2SSB 5093 was subject to public comment in the House Health Care & Wellness Committee, House Appropriations Committee, Senate Health & Long-Term Care Committee and Senate Ways & Means Committee. The bill was also subject to debate and vote by the House and Senate.

9.9.3. Describe the State's interaction, consultation, and coordination with any Indian tribes and organizations in the State regarding implementation of the Express Lane eligibility option.

9.10. Provide a 1-year projected budget. A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- Planned use of funds, including:
 - Projected amount to be spent on health services;
 - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
 - Assumptions on which the budget is based, including cost per child

- and expected enrollment.
- Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low-income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc.
 - All cost sharing, benefit, payment, eligibility need to be reflected in the budget.
 - Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
 - Include a separate budget line to indicate the cost of providing coverage to pregnant women.
 - States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
 - Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
 - Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
 - Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
 - Total 1-year cost of adding prenatal coverage
 - Estimate of unborn children covered in year 1

The budget below applies to SPA 19-0001.

STATE: Washington	FFY Budget
Federal Fiscal Year	FFY2019
State's enhanced FMAP rate	88%
Benefit Costs	
Insurance payments	0
Managed care	\$ 110,553,505
<u>per member/per month rate</u>	\$ 145.32

STATE: Washington	FFY Budget
Fee for Service	\$ 54,163,749
Total Benefit Costs	\$ 164,717,254
(Offsetting beneficiary cost sharing payments)	(\$ 14,197,181)
Net Benefit Costs	\$ 150,520,073
Cost of Proposed SPA Changes – Benefit	\$ 0*
Administration Costs	
Personnel	\$ 1,120,793
General administration	\$ 1,788,636
Contractors/Brokers	\$ 2,070,161
Claims Processing	\$ 20,489
Outreach/marketing costs	\$ 0
Health Services Initiatives	\$ 1,656,012
Other	
Total Administration Costs	\$ 6,656,091
10% Administrative Cap	\$ 16,724,453
Cost of Proposed SPA Changes	\$ 0*
Federal Share	\$ 138,315,024
State Share	\$18,861,140
Total Costs of Approved CHIP Plan	\$ 157,176,164

NOTE: Include the costs associated with the current SPA.

*There are no new costs associated with this SPA.

The Source of State Share Funds: State Appropriations.

Section 10. Annual Reports and Evaluations

Guidance: The National Academy for State Health Policy (NASHP), CMS and the states developed framework for the annual report that states have the option to use to complete the required evaluation report. The framework recognizes the diversity in State approaches to implementing CHIP and provides consistency across states in the structure, content, and format of the evaluation report. Use of the framework and submission of this information will

allow comparisons to be made between states and on a nationwide basis. The framework for the annual report can be obtained from NASHP's website at <http://www.nashp.org>. Per the title XXI statute at Section 2108(a), states must submit reports by January 1st to be compliant with requirements.

10.1. Annual Reports. The State assures that it will assess the operation of the State plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

10.1.1. The progress made in reducing the number of uninsured low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. The State assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))

10.3. The State assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

10.3-DC The State agrees to submit yearly the approved dental benefit package and to submit quarterly current and accurate information on enrolled dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website. Please update Sections 6.2-DC and 9.10 when electing this option.

Section 11. Program Integrity (Section 2101(a))

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue to Section 12.

11.1. The State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other

public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

11.2. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) (The items below were moved from section 9.8. Previously 9.8.6. - 9.8.9.)

- 11.2.1.** 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2.** Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3.** Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4.** Section 1128A (relating to civil monetary penalties)
- 11.2.5.** Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6.** Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and Enrollee Protections (Sections 2101(a))

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State’s Medicaid plan.

12.1. Eligibility and Enrollment Matters- Describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. Describe any special processes and procedures that are unique to the applicant’s rights when the State is using the Express Lane option when determining eligibility. All CHIP clients have an opportunity for review of eligibility and enrollment matters. Clients may contact HCA’s Medical Eligibility Determination Services (MEDS) section or the Office of Administrative Hearings (OAH) to begin the review process. The HCA

Administrative Hearing Coordinator is notified of the request for review. The Coordinator prepares the case and sets up a pre-hearing conference as a way to settle the dispute or collect information. Cases that are not resolved through a pre-hearing conference proceed to an Administrative Hearing. At the Administrative Hearing, an Administrative Law Judge gathers information from the client and agency staff. Hearings can be conducted via telephone or in person. The Judge's decision is mailed to the client and the Administrative Hearing Coordinator. Either party may appeal the decision for additional review and to the courts if need be.

Guidance: "Health services matters" refers to grievances relating to the provision of health care.

12.2 Health Services Matters- Describe the review process for health services matters that complies with 42 CFR 457.1120.

All CHIP clients also have an opportunity for review of health services matters. The process as described in section 12.1 is the same process used for review of health services matters.

12.3. Premium Assistance Programs- If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, describe how the State will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

Not applicable to Washington State's CHIP.

Key for Newly Incorporated Templates

The newly incorporated templates are indicated with the following letters after the numerical section throughout the template.

- PC- Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
- PW- Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
- TC- Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)

- DC- Dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- DS- Supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- PA- Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
- EL- Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
- LR- Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)

GLOSSARY: Adapted directly from Sec. 2110. DEFINITIONS.

CHILD HEALTH ASSISTANCE- For purposes of this title, the term ‘child health assistance’ means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the following (and includes, in the case described in Section 2105(a)(2)(A), payment for part or all of the cost of providing any of the following), as specified under the State plan:

1. Inpatient hospital services.
2. Outpatient hospital services.
3. Physician services.
4. Surgical services.
5. Clinic services (including health center services) and other ambulatory health care services.
6. Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.
7. Over-the-counter medications.
8. Laboratory and radiological services.
9. Prenatal care and pre-pregnancy family planning services and supplies.
10. Inpatient mental health services, other than services described in paragraph (18) but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.
11. Outpatient mental health services, other than services described in paragraph (19)

but including services furnished in a State-operated mental hospital and including community-based services.

12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).
13. Disposable medical supplies.
14. Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).
15. Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.
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.
17. Dental services.
18. Inpatient substance abuse treatment services and residential substance abuse treatment services.
19. Outpatient substance abuse treatment services.
20. Case management services.
21. Care coordination services.
22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
23. Hospice care.
24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is--
 - a. prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,
 - b. performed under the general supervision or at the direction of a physician, or
 - c. furnished by a health care facility that is operated by a State or local

government or is licensed under State law and operating within the scope of the license.

25. Premiums for private health care insurance coverage.

26. Medical transportation.

27. Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

28. Any other health care services or items specified by the Secretary and not excluded under this section.

TARGETED LOW-INCOME CHILD DEFINED- For purposes of this title--

1. IN GENERAL- Subject to paragraph (2), the term 'targeted low-income child' means a child--
 - a. who has been determined eligible by the State for child health assistance under the State plan;
 - b. (i) who is a low-income child, or
(ii) is a child whose family income (as determined under the State child health plan) exceeds the Medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the Medicaid applicable income level; and
 - c. who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in Section 2791 of the Public Health Service Act).
2. CHILDREN EXCLUDED- Such term does not include--
 - a. a child who is a resident of a public institution or a patient in an institution for mental diseases; or
 - b. a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.
3. SPECIAL RULE- A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State

which receives no Federal funds for the program's operation.

4. MEDICAID APPLICABLE INCOME LEVEL- The term 'Medicaid applicable income level' means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under Section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical assistance under Section 1902(l)(2) for the age of such child.
5. TARGETED LOW-INCOME PREGNANT WOMAN - The term 'targeted low-income pregnant woman' means an individual— (A) during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends; (B) whose family income exceeds 185 percent (or, if higher, the percent applied under subsection (b)(1)(A)) of the poverty line applicable to a family of the size involved, but does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and (C) who satisfies the requirements of paragraphs (1)(A), (1)(C), (2), and (3) of Section 2110(b) in the same manner as a child applying for child health assistance would have to satisfy such requirements.

ADDITIONAL DEFINITIONS- For purposes of this title:

1. CHILD- The term 'child' means an individual under 19 years of age.
2. CREDITABLE HEALTH COVERAGE- The term 'creditable health coverage' has the meaning given the term 'creditable coverage' under Section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver).
3. GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC- The terms 'group health plan', 'group health insurance coverage', and 'health insurance coverage' have the meanings given such terms in Section 2191 of the Public Health Service Act.
4. LOW-INCOME CHILD - The term 'low-income child' means a child whose family

income is at or below 200 percent of the poverty line for a family of the size involved.

5. POVERTY LINE DEFINED- The term 'poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.
6. PREEXISTING CONDITION EXCLUSION- The term 'preexisting condition exclusion' has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).
7. STATE CHILD HEALTH PLAN; PLAN- Unless the context otherwise requires, the terms 'State child health plan' and 'plan' mean a State child health plan approved under Section 2106.
8. UNINSURED CHILD- The term 'uninsured child' means a child that does not have creditable health coverage.

SPA 14-0001



CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

**Separate Child Health Insurance Program
Eligibility - Targeted Low-Income Children**

CS7

2102(b)(1)(B)(v) of the SSA and 42 CFR 457.310, 315 and 320

Targeted Low-Income Children - Uninsured children under age 19 whose household income is within standards established by the state.

The CHIP Agency operates this covered group in accordance with the following provisions:

Age

Must be under age 19.

Income Standards

Income standards are applied statewide. Yes

Are there any exceptions, e.g. populations in a county which may qualify under either a statewide income standard or a county income standard? No

Statewide Income Standards

Begin with lowest age range first.

Please note that the lower bound for CHIP eligibility should be the highest standard used for Medicaid poverty-level children for the same age group or groups entered here.

	From Age	To Age	Above (% FPL)	Up to & including (% FPL)	
+	0	19	210	312	X

Age ranges may overlap. If there is an overlap, provide an explanation. Include the age ranges for each income standard that has overlapping ages and the reason for having different income standards.

Special Program for Children with Disabilities

Does the state have a special program for children with disabilities? No

PRA Disclosure Statement



CHIP Eligibility

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 0938-1148. The time required to complete this information collection is estimated to average 50 hours 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 comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Page 2 of 2



CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Separate Child Health Insurance Program MAGI-Based Income Methodologies

CS15

2102(b)(1)(B)(v) of the SSA and 42 CFR 457.315

- The CHIP Agency will apply Modified Adjusted Gross Income methodologies for all separate CHIP covered groups, as described below, and consistent with 42 CFR 457.315 and 435.603(b) through (i).

In the case of determining ongoing eligibility for enrollees determined eligible for CHIP on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014 or the next regularly-scheduled renewal of eligibility, whichever is later.

If the state covers pregnant women, in determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

- The pregnant woman is counted just as herself.
- The pregnant woman is counted just as herself, plus one.
- The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

- Current monthly household income and family size.
- Projected annual household income for the remaining months of the current calendar year and family size.

In determining current monthly or projected annual household income, the state will use reasonable methods to:

- Include a prorated portion of the reasonably predictable increase in future income and/or family size.
- Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 457.315 and 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent.

Yes

- The CHIP Agency certifies that it has submitted and received approval for the conversion for all separate CHIP covered group income standards to MAGI-equivalent standards.

An attachment is submitted.

PRA Disclosure Statement

AUG 15 2014

SPA# WA-14-0001

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Effective Date: January 1, 2014
Page 1 of 2



CHIP Eligibility

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SPA# WA-14-0001

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Page 2 of 2



CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Separate Child Health Insurance Program CS9
Eligibility - Coverage From Conception to Birth

42 CFR 457.10

Coverage From Conception to Birth - Coverage from conception to birth when the mother is not eligible for Medicaid.

The CHIP Agency operates this covered group in accordance with the following provisions:

Age Standard

From conception through birth.

Does the state have an additional age definition or other age-related conditions? No

Income Standards

Income standards are applied statewide. Yes

Are there any exceptions, e.g. populations in a county which may qualify under either a statewide income standard or a county income standard? No

Statewide Income Standard

The statewide income standard is: From zero up to % FPL

Exempted from requirement of providing or applying for a Social Security Number.

Exempted from requirement of verifying citizenship status.

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 50 hours 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 comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

SPA# WA-14-0001

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Page 1 of 1

Washington State CHIP Budget Plan		Federal Fiscal Year Costs	Federal Fiscal Year Costs
Enhanced FMAP Rate		65.00%	65.00%
Benefit Costs		FFY 2014	FFY 2015
Insurance Payments			
Managed Care – Children (211-312%FPL) PM/PM		\$116	\$116
24,093 FFY14 eligibles; 25,497 FFY15 eligibles		\$33,890,058	\$35,605,100
5,730 FFY14 eligibles; 5,829 FFY15 eligibles; [Section 214, Title XIX] ⁽¹⁾		\$7,988,312	\$8,139,360
9,742 FFY14 eligibles; 15,917 FFY15 eligibles [Welcome Mat] ⁽²⁾		\$13,582,131	\$22,227,650
Fee for Service - Children (211-312%FPL) PM/PM		\$245	\$265
3,526 FFY14 eligibles; 3,698 FFY15 eligibles		\$10,369,378	\$11,778,054
831 FFY14 eligibles; 845 FFY15 eligibles [Section 214, Title XIX] ⁽¹⁾		\$2,444,193	\$2,692,520
1,413 FFY14 eligibles; 2,309 FFY15 eligibles [Welcome Mat] ⁽²⁾		\$4,155,740	\$7,352,981
Fee for Service - Unborn Child (193%FPL) PM/PM		\$520	\$518
5,558 FFY14 eligibles; 5,498 FFY15 eligibles		\$34,672,500	\$34,208,632
133% Medicaid Children (FMAP to EFMAP Federal Only)⁽³⁾		\$27,503,427	\$29,393,306
Total Benefit Costs		\$134,605,739	\$151,397,603
(Total offsetting beneficiary cost sharing payments)		(\$5,931,468)	(\$6,221,312)
Net Benefit Costs		\$128,674,271	\$145,176,291
Administration Costs⁽⁴⁾			
Personnel		\$1,155,368	\$1,213,136
General Administration		\$406,230	\$426,542
Contractors/Brokers (e.g., Within Reach)		\$967,280	\$1,015,644
Claims Processing		\$98,111	\$103,017
Outreach/Marketing Costs ⁽⁵⁾		\$0	\$0
Health Services Initiative – Washington Poison Center ⁽⁶⁾		\$1,089,070	\$1,089,070
Total Administration Costs		\$3,716,059	\$3,847,409
10% Administrative Cost Ceiling		\$14,297,141	\$16,130,699
Federal Share (multiplied by enhanced-FMAP rate)		\$95,679,914	\$107,153,062
State Share		\$36,710,416	\$41,870,638
Total Program Costs*		\$132,390,330	\$149,023,700
*No new sources of state funds are being used to fund the measures in this budget. The source of state matching funds remains appropriations by the state legislature.			
(1) Section 214 Medicaid Children			
Children added to Medicaid as a result of CHIPRA, Section 214 eligibility expansion are exempt from cost-sharing premiums.			
(2) Welcome Mat			
ACA Expansion - Welcome Mat Impact for Children Between 211-312% FPL			
Total Welcome Mat		\$17,737,871	\$29,580,631
Federal share		\$11,529,616	\$19,227,410
State share		\$6,208,255	\$10,353,221
(3) 133% Medicaid Children (FMAP to EFMAP Federal Only)			
Washington is a qualified state under §2105(g) to claim an "uncapped" portion of expenditures for Medicaid children at or above 133%FPL. The amount of the claim for these expenditures is based on the difference between the EFMAP for CHIP and the current FMAP rate for Medicaid. In FFY 2014 the federal share is estimated at \$27.50 million dollars; in FFY 2015 the federal share is estimated at \$29.39 million dollars.			

SPA# WA-14-0001

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Page 1 of 2

Washington State CHIP Budget Plan		Federal Fiscal Year Costs	Federal Fiscal Year Costs
Enhanced FMAP Rate		65.00%	65.00%
(4) Calculation of Unused Administration Funding		FFY2014	FFY2015
Current Program Costs		\$132,390,330	\$149,023,700
10% Administrative Cap		\$14,297,141	\$16,130,699
Federal Share		\$9,293,142	\$10,484,954
Administrative Costs - Current Plan		\$3,716,059	\$3,847,409
Federal Share		\$2,415,438	\$2,500,816
Unused Administration Funding Available		\$10,581,082	\$12,283,290
Federal Share		\$6,877,703	\$7,984,139
(6) Calculation of Children's Outreach Funding		FFY2014	FFY2015
Statewide Application Agent Program		\$0	\$0
Media Campaign & Other Outreach Contracts		\$0	\$0
Total Benefit Costs		\$0	\$0
Federal Share		\$0	\$0
State Share		\$0	\$0
Outreach costs are not currently being charged to the CHIP grant. As state funding becomes available, outreach efforts including media campaigns, application agents, etc. will be restored. If state appropriations are restored for outreach, Washington assures that administrative expenditures will not exceed the 10% cap.			
(6) WAPC Health Services Initiative Funding (Contract #1012-95481-02)		FFY2014	FFY2015
Total WAPC Health Services Initiative Funding		\$1,089,070	\$1,089,070
Federal Share		\$707,896	\$707,896
State Share		\$381,175	\$381,175
Summary of Projected Costs for SPA 14			
In FFY2014 the total projected costs for this SPA will increase the budget by \$17,737,871 dollars. The increased federal share in FFY2014 is calculated at \$11,529,616 dollars. In FFY 2015 the total projected costs for this SPA will increase the budget by \$29,580,631 dollars. The increased federal share in FFY2015 is calculated at \$19,227,410 dollars.			

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Page 2 of 2



CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Child Health Insurance Program Eligibility - Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards **CS14**

Section 2101(f) of the ACA and 42 CFR 457.310(d)

Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards

The CHIP agency provides coverage for this group of children as follows:

The state has received approval from CMS to maintain Medicaid eligibility for children who would otherwise be subject to Section 2101(f) such that no child in the state will be subject to this provision.

The state assures that separate CHIP coverage will be provided for children ineligible for Medicaid due to the elimination of income disregards in accordance with 42 CFR 457.310(d). Coverage for this population will cease when the last child protected from loss of Medicaid coverage as a result of the elimination of income disregards has been afforded 12 months of coverage in a separate CHIP (expected to be no later than April 1, 2016).

Describe the methodology used by the state to identify and enroll children in a separate CHIP who are subject to the protection afforded by Section 2101(f) of the Affordable Care Act:

The state has demonstrated and CMS has agreed that all children qualifying for section 2101(f) protection will qualify for the state's existing separate CHIP.

The state will enroll all children in a separate CHIP who lose Medicaid eligibility because of an increase in family income at their first renewal applying MAGI methods.

The state will enroll children in a separate CHIP whose family income falls above the converted MAGI Medicaid FPL but at or below the following percentage of FPL. The state has demonstrated and CMS has agreed that all or almost all the children who would have maintained Medicaid eligibility if former disregards were applied will be within this income range and therefore covered in the separate CHIP.

% FPL

The state will enroll children in a separate CHIP who are found to be ineligible for Medicaid based on MAGI but whose family income has not increased since the child's last determination of Medicaid eligibility or who would have remained eligible for Medicaid (based on the 2013 Medicaid income standard) if the value of their 2013 disregards had been applied to the family income as determined by MAGI methodology.

Other.

Describe the benefits provided to this population:

This population will be provided the same benefits as are provided to children in the state's Medicaid program.

This population will be provided the same benefits as are provided to children in the state's separate CHIP.

Other (consistent with Section 2103 of the SSA and 42 CFR 457 Subpart D).

Describe premiums and cost sharing required of this population:

Cost sharing is the same as for children in the Medicaid program.



CHIP Eligibility

- Premiums and cost sharing are the same as for targeted low-income children in the state's separate CHIP.
- No premiums, copayments, deductibles, coinsurance or other cost sharing is required.
- Other premiums and/or cost-sharing requirements (consistent with Section 2103(e) of the SSA and 42 CFR 457 Subpart E).

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 50 hours 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 comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Page 2 of 2



CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Separate Child Health Insurance Program CS24
General Eligibility - Eligibility Processing

2102(b)(3) & 2107(e)(1)(O) of the SSA and 42 CFR 457, subpart C

- The CHIP Agency meets all of the requirements of 42 CFR 457, subpart C for application processing, eligibility screening and enrollment.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard:

- The single, streamlined application developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act.
- An alternative single, stream lined application developed by the state and approved by the Secretary in accordance with section 1413(b)(1)(B) of the Affordable Care Act.

An attachment is submitted.

- An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

- The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in CFR 457.340(a), by telephone, via mail, in person and other commonly available electronic means.

The agency accepts applications in the following other electronic means.

- Other electronic means:

	Name of method	Description	
+	FAX	The applicant may fax a copy of their paper application to a published fax number.	X

Screen and Enroll Process

- The CHIP Agency has coordinated eligibility and enrollment screening procedures in place that are applied at time of initial application, periodic redeterminations, and follow-up eligibility determinations. The procedures ensure that only targeted low-income children are provided CHIP coverage and that enrollment is facilitated for applicants found to be potentially eligible for other insurance affordability programs.

Procedures include:



CHIP Eligibility

- Screening of application to identify all individuals eligible or potentially eligible for CHIP or other insurance affordability programs; and
- Income eligibility test, with calculation of household income consistent with 42 CFR 457.315 for individuals identified as potentially eligible for Medicaid or other insurance affordability programs based on household income; and
- Screening process for individuals who may qualify for Medicaid on a basis other than having household income at or below the applicable MAGI standard, based on information in the single streamlined application.

The CHIP agency has entered into an arrangement with the Exchange to make eligibility determinations for advanced premium tax credits in accordance with section 1943(b)(2) of the SSA.

Yes

Redetermination Processing

- Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 457.343:
 - Once every 12 months.
 - Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency.
- If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

Screening by Other Insurance Affordability Programs

The CHIP Agency provides assurance that it has adopted procedures to accept and process electronic accounts of individuals screened as potentially eligible for CHIP by other insurance affordability programs in accordance with the requirements of 42 CFR 457.348(b) and to determine eligibility in accordance with 42 CFR 457.340 in the same manner as if the application had been submitted directly to, and processed by the state.

The CHIP Agency elects the option to accept CHIP eligibility decisions made by the Exchange or other agencies administering insurance affordability programs as provided in 42 CFR 457.348 and to furnish CHIP in accordance with requirements of 42 CFR 457.340 to the same extent and in the same manner as if the applicant had been determined by the state to be eligible for CHIP.

Check all types of agencies that apply:

- The Exchange
- Medicaid
- Other agency administering insurance affordability programs

	Name of Agency	
+	Department of Social and Health Services staff assisting an applicant or a recipient of Medicaid with an online application through the Washington Healthplanfinder.	X

The CHIP Agency has entered into an agreement with agencies administering other insurance affordability programs to fulfill the requirements of 457.348(b) and will provide this agreement to the Secretary upon request.



CHIP Eligibility

PRA Disclosure Statement

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Effective Date: October 1, 2013
Page 3 of 3

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION

Paper Application Online Application

TRANSMITTAL NUMBER:

WA-14-0004-MC4

STATE:

Washington

Through December 31, 2014, the state is using an interim alternative single streamlined application. After December 31, 2014, the state will use a revised alternative single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION

Paper Application

Online Application

TRANSMITTAL NUMBER:

WA-14-0004-MC4

STATE:

Washington

Through December 31, 2014, the state is using an interim alternative single streamlined application. After December 31, 2014, the state will use a revised alternative single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.



CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Separate Child Health Insurance Program Non-Financial Eligibility - Residency

CSI7

42 CFR 457.320

Residency

- The CHIP Agency provides CHIP to otherwise eligible residents of the state, including residents who are absent from the state under certain conditions.

A child is considered to be a resident of the state under the following conditions:

- A non-institutionalized child, if capable of indicating intent and who is emancipated or married, if the child is living in the state and:
 1. Intends to reside in the state, including without a fixed address, or
 2. Has entered the state with a job commitment or seeking employment, whether or not currently employed.
- A non-institutionalized child not described above and a child who is not a ward of the state:
 1. Residing in the state, with or without a fixed address, or
 2. The state of residency of the parent or caretaker, in accordance with 42 CFR.435.403(h)(1), with whom the individual resides.
- An institutionalized child, who is not a ward of the state, if the state is the state of residence of the child's custodial parent or caretaker at the time of placement, or
- A child who is a ward of the state regardless of where the child lives, or
- A child physically located in the state when there is a dispute with one or more states as to the child's actual state of residence.

If the state covers pregnant women, a pregnant woman is considered to be a resident under the following conditions:

- A non-institutionalized pregnant woman who is living in the state and:
 1. Intends to reside in the state, including without a fixed address, or if incapable of indicating intent, is living in the state, or
 2. Entered with a job commitment or seeking employment, whether or not currently employed.
- An institutionalized pregnant woman placed in an out-of-state-institution, as defined in 42 CFR 435.1010, including foster care homes, by an agency of the state, or
- An institutionalized pregnant woman residing in an in-state-institution, as defined in 42 CFR 435.1010, whether or not the individual established residency in the state prior to entering the institution, or
- A pregnant woman physically located in the state when there is a dispute with one or more states as to the pregnant woman's actual state of residence.

The state has in place related to the residency of children and pregnant women (if covered by the state):

SPA# WA 14-0003

Approval Date: MAR 18 2015

Effective Date: January 1, 2014

Page 1 of 2



CHIP Eligibility

One or more interstate agreement(s). <input type="checkbox"/> No
A policy related to individuals in the state only for educational purposes. <input type="checkbox"/> Yes
Provide a description of the policy: <div style="border: 1px solid black; padding: 5px;">Individuals who are living in the state solely for the purposes of attending an educational institution are not considered residents of the state.</div>

PRA Disclosure Statement

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MAR 18 2015

SPA# WA 14-0003

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Page 2 of 2



CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
Non-Financial Eligibility - Citizenship CS18

Sections 2105(c)(9) and 2107(e)(1)(J) of the SSA and 42 CFR 457.320(b)(6), (c) and (d)

Citizenship

The CHIP Agency provides CHIP eligibility to otherwise eligible citizens and nationals of the United States and certain non-citizens, including the time period during which they are provided with reasonable opportunity to submit verification of their citizenship, national status or satisfactory immigration status.

The CHIP Agency provides eligibility under the Plan to otherwise eligible individuals:

Who are citizens or nationals of the United States; or

Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641), or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); or

Who have declared themselves to be citizens or nationals of the United States, or an individual having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality, or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), and 1902(ee) of the Act, and 42 CFR 435.406, 407, 956 and 457.380.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

The agency provides for an extension of the reasonable opportunity period if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process. Yes

The agency begins to furnish benefits to otherwise eligible individuals during the reasonable opportunity period on a date earlier than the date the notice is received by the individual. Yes

The date benefits are furnished is:

- The date of application containing the declaration of citizenship or immigration status.
- The date the reasonable opportunity notice is sent.
- Other date, as described:

The CHIP Agency elects the option to provide CHIP coverage to otherwise eligible children up to age 19, lawfully residing in the United States, as provided in Section 2107(e)(1)(J) of the SSA (Section 214 of CHIPRA 2009, P.L. 111-3). Yes

Otherwise eligible children means children meeting the eligibility requirements of targeted low-income children with the exception of non-citizen status.

The CHIP Agency provides assurance that lawfully residing children are also covered under the state's Medicaid program.

SPA# WA 14-0003

Approval Date: **MAR 18 2015**

Effective Date: January 1, 2014
Page 1 of 3



CHIP Eligibility

The CHIP Agency elects the option to provide CHIP coverage to otherwise eligible pregnant women, lawfully residing in the United States, as provided in Section 214 of CHIPRA 2009, P.L. 111-3. The state may not select this option unless the state also elects to cover lawfully residing children. A state may not select this option unless the state also covers Targeted Low-Income Pregnant Women.

No

- An individual is considered to be lawfully residing in the United States if he or she is lawfully present and meets state residency requirements.
- An individual is considered to be lawfully present in the United States if he or she is:
 1. A qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);
 2. A non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));
 3. A non-citizen who has been paroled into the United States in accordance with 8 U.S.C.1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;
 4. A non-citizen who belongs to one of the following classes:
 - (i) Granted temporary resident status in accordance with 8 U.S.C.1160 or 1255a, respectively;
 - (ii) Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;
 - (iii) Granted employment authorization under 8 CFR 274a.12(c);
 - (iv) Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;
 - (v) Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;
 - (vi) Granted Deferred Action status;
 - (vii) Granted an administrative stay of removal under 8 CFR 241;
 - (viii) Beneficiary of approved visa petition who has a pending application for adjustment of status;
 5. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C.1231,or under the Convention Against Torture, who:
 - (i) Has been granted employment authorization; or
 - (ii) Is under the age of 14 and has had an application pending for at least 180 days;
 6. Has been granted withholding of removal under the Convention Against Torture;
 7. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C.1101(a)(27)(J);
 8. Is lawfully present in American Samoa under the immigration laws of American Samoa; or
 9. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b)).

MAR 18 2015

SPA# WA 14-0003

Approval Date: _____

Effective Date: January 1, 2014
Page 2 of 3



CHIP Eligibility

10. Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

PRA Disclosure Statement

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MAR 18 2015

SPA# WA 14-0003

Approval Date: _____

Effective Date: January 1, 2014
Page 3 of 3



CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
Non-Financial Eligibility - Social Security Number CS19

42 CFR 457.340(b)

Social Security Number

As a condition of eligibility, the CHIP Agency must require individuals who have a social security number or are eligible for one as determined by the Social Security Administration, to furnish their social security number, or numbers if they have more than one number.

- The CHIP Agency requires individuals, as a condition of eligibility, to furnish their social security number(s), with the following exceptions:

Individuals refusing to obtain a social security number (SSN) because of well established religious objections, or

Individuals who are not eligible for an SSN, or

Individuals who are issued an SSN only for a valid non-work purpose.

- The CHIP Agency assists individuals, who are required to provide their SSN, to apply for or obtain an SSN from the Social Security Administration if the individual does not have or forgot their SSN.

- The CHIP Agency informs individuals required to provide their SSN:

By what statutory authority the number is solicited; and

How the state will use the SSN.

- The CHIP Agency provides assurance that it will verify each SSN furnished by an applicant or beneficiary with the Social Security Administration, not deny or delay services to an otherwise eligible applicant pending issuance or verification of the individual's SSN by the Social Security Administration and that the state's utilization of the SSNs is consistent with sections 205 and 1137 of the Social Security Act and the Privacy Act of 1974.

The state may request non-applicant household members to voluntarily provide their SSN, if the state meets the requirements below.

The state requests non-applicant household members to voluntarily provide their SSN.

- When requesting an SSN for non-applicant household members, the state assures that:
 - At the time such SSN is requested, the state informs the non-applicant that this information is voluntary and provides information regarding how the SSN will be used; and
 - The state only uses the SSN for determination of eligibility for CHIP or other insurance affordability programs, or for a purpose directly connected with the administration of the state plan.

PRA Disclosure Statement

MAR 18 2015

SPA# WA 14-0003

Approval Date: _____

Effective Date: January 1, 2014

Page 1 of 2



CHIP Eligibility

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MAR 18 2015

SPA# WA 14-0003

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Effective Date: January 1, 2014

Page 2 of 2



CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

**Separate Child Health Insurance Program
Non-Financial Eligibility - Substitution of Coverage** CS20

457.310(b)(2) and (b)(3), 457.320(a)(9) and 2110(b)(1)(C) of the SSA

Substitution of Coverage

The CHIP Agency provides assurance that it has methods and policies in place to prevent the substitution of group health coverage or other commercial health insurance with public funded coverage. These policies include:

Substitution of coverage prevention strategy:

	Name of policy	Description	
+	Tracking of the number of applicants who drop group health insurance	Each applicant will be asked if they have dropped group health insurance coverage in the 4 months preceding their application. If the incidence of dropped coverage exceeds 5% of approved applications, the Agency will conduct a survey to see if one of nine "good cause" reasons apply. The outcome of the survey will determine if substitution of coverage is a substantial enough issue to require implementation of a waiting period not to exceed the statutory maximum.	X

A waiting period during which an individual is ineligible due to having dropped group health coverage.

If the state covers pregnant women, the waiting period does not apply to pregnant women.

If the state elects to offer dental only supplemental coverage, the following assurances apply:

The other coverage exclusion does not apply to children who are otherwise eligible for dental only supplemental coverage as provided in section 2110(b)(5) of the SSA.

The waiting period does not apply to children eligible for dental only supplemental coverage.

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Page 1 of 1



CHIP Eligibility

State Name:

OMB Control Number: 0938-1148

Transmittal Number: WA - 14 - 0005

Expiration date: 10/31/2014

Separate Child Health Insurance Program Non-Financial Eligibility - Non-Payment of Premiums CS21

42 CFR 457.570

Non-Payment of Premiums

Does the state impose premiums or enrollment fees?

Can non-payment of premiums or enrollment fees result in loss of CHIP eligibility?

Does the state have a premium lock out period?

Please describe the lock-out period:

When a family fails to pay the required premium for 3 consecutive months, coverage is suspended for CHIP for a period not to exceed 90 days. The family may resolve this suspension at any time by paying the delinquent premium or reporting a change in their circumstances resulting in eligibility for Medicaid. If the family pays the delinquent premium at any time during the initial certification period, eligibility will be restored to the first day of the lock-out period and no new application will be necessary. If the family does not pay the delinquent premium, they will need to reapply at the end of the 90 days and will have their eligibility for CHIP redetermined.

What is the length of the time premium lock-out period?

Select a length of time:

- One month
- Two months
- 90 days
- Other (not to exceed 90 days)

Are there exceptions to the required lock-out period?

- Individual's income decreased to a level where no premium is required or within Medicaid standards
- Other financial hardship
- Other

	Describe	
+	The debt is written off after twelve months	X
+	The family pays the delinquent premium during the lock-out period	X

The state assures that:

It does not require the collection of past due premiums or enrollment fees as a condition of eligibility for enrollment once the lock-out period has expired; and

SPA# WA 14-0003

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Effective Date: January 1, 2014

Page 1 of 2



CHIP Eligibility

It provides enrollees with an opportunity for an impartial review to address disenrollment from the program in accordance with section 457.1130(a)(3); and

The child will be reenrolled in CHIP during the lock-out period upon payment of past due premiums or enrollment fees.

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MAR 18 2015

SPA# WA 14-0003

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Page 2 of 2



CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
General Eligibility - Continuous Eligibility CS27

2105(a)(4)(A) of the SSA and 42 CFR 457.342 and 435.926

The CHIP Agency may provide that children who have been determined eligible under the state plan shall remain eligible, regardless of any changes in the family's circumstances, during a continuous eligibility period up to 12 months, or until the time the child reaches an age specified by the state (not to exceed age 19), whichever is earlier.

The CHIP Agency elects to provide continuous eligibility to children under this provision. Yes

- For children up to age 19
- For children up to age

The continuous eligibility period begins on the effective date of the child's most recent determination or redetermination of eligibility, and ends:

- At the end of the months continuous eligibility period.

Exceptions to the continuous eligibility period:

- The child attains the age specified by the state Agency or age 19.
- The child or child's representative requests voluntary disenrollment.
- The child is no longer a resident of the state.
- The Agency determines that eligibility was erroneously granted at the most recent determination or renewal of eligibility because of Agency error or fraud, abuse, or perjury attributed to child or child's representative.
- The child dies.
- There is a failure to pay required premiums or enrollment fees on behalf of a child, as provided for in the state plan.
- Other

	Describe	
+	a child who becomes an inmate of a public institution, as defined in WAC 388-500-0005. If the child is released during the certification period, eligibility is restored from the date of release through the continuous eligibility period.	X

PRA Disclosure Statement

MAR 18 2015

SPA# WA 14-0003

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Page 1 of 2



CHIP Eligibility

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Page 2 of 2

APPENDIX 2: Hospital Presumptive Eligibility
SPA 15-0001



CHIP Eligibility

State Name:

OMB Control Number: 0938-1148

Transmittal Number: WA - 15 - 0001

Expiration date: 10/31/2014

Separate Child Health Insurance Program
General Eligibility - Presumptive Eligibility for Children **CS28**

42 CFR 457.355 and 435.1102, 2107(e)(1)(L) and 1920A of the SSA

The CHIP Agency covers children when determined presumptively eligible by a qualified entity.

Describe the population of children to whom presumptive eligibility applies:

Children from birth to age of 19 with income no more than 312%FPL.
Unborn children from conception to birth, whose mothers are ineligible for Medicaid, with income no more than 193%FPL.

Describe the duration of the presumptive eligibility period and any limitations:

The presumptive period begins on the date the determination is made, and continues through the date the eligibility determination for regular CHIP is made; but no longer than the end of the month following the month of the PE determination if no CHIP application is filed.

Limitations -

Individuals will only be approved for one PE period within twenty four months.
For unborn children from conception to birth there is one PE period per pregnancy.

Describe the application process and eligibility determination factors used:

Qualified entities will first attempt an application for CHIP through our state-based exchange portal at www.wahealthplanfinder.org which provides a real-time determination of eligibility. If the entity is unable to submit an application through the portal because it is unavailable, malfunctions, posts an error message, or the individual lacks the information to complete the application, then the entity will complete a PE worksheet.

The PE worksheet requires the individual to attest to only the following minimum information to identify their eligibility:

1. Full name, date of birth, and address.
2. Basis of eligibility (child < 19, or pregnant woman).
3. Washington residency and citizenship or immigration status.
4. Household size and income.

The qualified entity will make a determination of PE based on the individuals' declaration and issue a notice of approval or denial at the time the determination is made. The PE determination will be transmitted to the Health Care Authority(HCA) within 5 days.

The qualified entity will not be required to determine whether the pregnant woman is eligible for Medicaid, or for CHIP under the unborn provision. Designated staff at HCA will use the information on the PE worksheet to establish the appropriate program eligibility segment within our MMIS system and follow up on obtaining any missing information needed to complete a full application through the state-based exchange at www.wahealthplanfinder.org.

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SPA# WA-15-0001

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Page 1 of 3



CHIP Eligibility

- The CHIP Agency uses qualified entities, as defined in section 1920A, to determine eligibility presumptively for children.

Separate Child Health Insurance Program **CS30**
General Eligibility - List of Qualified Entities

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements, and that meets at least one of the following requirements. Select the types of entities used to determine presumptive eligibility:

- Furnishes health care items and services covered under the approved plan and is eligible to receive payments under the approved plan
- Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act
- Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990
- Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants, and Children (WIC) under section 17 of the Child Nutrition Act of 1966
- Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)
- Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)
- Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs
- Is a state or Tribal child support enforcement agency under title IV-D of the Act
- Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act
- Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act
- Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 *et seq.*)

- Any other entity the state so deems, as approved by the Secretary

	Name of entity	Description	
+	Qualified hospitals that elect to determine presumptive eligibility	A qualified hospital is a contracted provider who has signed a PE agreement with HCA. They must have staff who have successfully completed training and background checks required to establish access as an application assister in the state-based exchange, in addition to completion of the PE training.	X

- The CHIP Agency assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and provided adequate training to the entities and organizations involved. A copy of the training materials has been included.



CHIP Eligibility

	An attachment is submitted.	
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Page 3 of 3



CHIP Eligibility

State Name:

OMB Control Number: 0938-1148

Transmittal Number: WA - 20 - 0002

Separate Child Health Insurance Program Eligibility - Children Who Have Access to Public Employee Coverage **CS10**

Sec. 2110(b)(2)(B) and (b)(6) of the SSA

Children Who Have Access to Public Employee Coverage - Otherwise eligible targeted low-income children who have access to public employee coverage on the basis of a family member's employment.

The CHIP Agency operates this covered group in accordance with the following provisions:

Select one of the following conditions as described in Section 2110(b)(6) of the Social Security Act:

- Maintenance of agency contribution as provided in 2110(b)(6)(B) of the SSA.
- Hardship criteria as provided in section 2110(b)(6)(C) of the Social Security Act.

Coverage under this option is extended to children whose household income is:

Select one of the options for the income standard when compared to Targeted Low Income Children

- The same as the standards for Targeted Low-Income Children
- Lower than the income standards for Targeted Low-Income Children

Indicate whether coverage under this option is extended to all children who have access to public employee coverage, or only certain children:

- All children who have access to public employee coverage
- Certain children who have access to public employee coverage:

Attach methodology the state has used to calculate financial hardship.

An attachment is submitted.

The state provides assurance that the state will, on an annual basis, recalculate the financial status to determine if the hardship condition continues to be met.

Children who are eligible for public employee health benefits coverage who are not described above are excluded from eligibility under the plan.

Children considered to have access to public employee coverage, and therefore not excluded from CHIP through this option, otherwise meet the definition of targeted low-income child provided at 42 CFR 457.310.

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CHIP Eligibility

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