Table of Contents

State/Territory Name: Washington

State Plan Amendment (SPA) #: WA-25-6000

This file contains the following documents in the order listed:

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

December 15, 2025

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

Dear Interim Director Wilson:

Your Title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) WA-25-6000, submitted June 23, 2025, has been approved. The effective date for this SPA is July 1, 2025.

Through WA-25-6000, Washington demonstrates compliance with section 5121 of the Consolidated Appropriations Act, 2023 (CAA, 2023) by modifying CHIP eligibility requirements for the treatment of incarcerated youth and providing pre-release services to eligible juveniles. The state also elects to use section 5122 of the CAA, 2023 to provide full CHIP coverage to eligible juveniles who are inmates of a public institution pending disposition of charges. Washington will utilize its approved re-entry 1115 demonstration to provide all mandatory 5121 pre-release services. However, any services provided post-release will be provided through the CHIP state plan.

Your Project Officer is Jennifer McIlvaine. She is available to answer your questions concerning this amendment and other CHIP-related matters and can be reached at jennifer.mcilvaine@cms.hhs.gov.

If you have additional questions, please contact Mary Beth Hance, Acting Director, Division of State Coverage Programs, at (410) 786-4299. We look forward to continuing to work with you and your staff.

Sincerely,

/Signed by Jessica Stephens/

Jessica Stephens
Acting 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: **Ryan Moran** Position/Title: Director, Health Care Authority
Name: **Charissa Fotinos MD, MSc** Position/Title: Medicaid, CHIP, and Behavioral Health Medical Director, Health Care Authority

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)
- Added new assurances related to the coverage of vaccines (Sections 2103(c)(1)(D) and (c)(12)); (Section 11405(b)(1) of the Inflation Reduction Act (IRA)); (SHO # 23-003, issued June 27, 2023)

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 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 State's 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 an 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.

Amendments 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
Submitted date: June 30, 2020
Approved Date: November 3, 2021
Effective Date: October 24, 2019

Amendment 22-1000: CHIP State Plan Amendment for coverage required by the American Rescue Plan Act. To demonstrate compliance with the American Rescue Plan Act provisions that require states to cover treatment including treatment of a condition that may seriously complicate COVID-19 treatment), testing, and vaccinations for COVID-19 without cost sharing in CHIP
Submitted Date: March 25, 2022
Approved Date: April 7, 2022
Effective Date: March 11, 2021

Amendment 24-1000: CHIP State Plan Amendment for vaccine coverage required under current regulations at 42 CFR § § 457.410(b)(2) and 457.520(b)(4), which require states to cover age-appropriate vaccines in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP) without cost sharing.
Submitted Date: May 28, 2024
Approved Date: June 13, 2024
Effective Date: October 1, 2023

Amendment 24-2000: See Appendix 2 & Table below

Amendment 24-3000: CHIP State Plan Amendment updates of various administratively related items including links, program names, WAC references, and available supported languages.
Submitted Date: December 16, 2024
Approved Date: August 18, 2025
Effective Date: July 1, 2024

Amendment 24-4000: See Appendix 2 & Table below

Amendment 24-5000: CHIP State Plan Amendment increase the percentage of the Federal Poverty Level (FPL) from 193% to 210% for eligibility for the agency's pregnancy-related programs.
Submitted Date: December 2, 2024
Approved Date: August 18, 2025
Effective Date: November 1, 2024

Amendment 25-6000: CHIP State Plan Amendment provides CAA, 2023 required reentry services under section 5121 and the optional reentry services under section 5122 to eligible juveniles.
Submitted Date: June 25, 2025
Approved Date:
Effective Date: July 1, 2025

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 about CHIP SPA WA 25-6000 via email, with hard copy letters to the Tribal Chairpersons, on April 17, 2025. 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 CS9 CS15	Eligibility – Targeted Low-Income Children Eligibility – Coverage from Conception to Birth MAGI-Based Income Methodologies	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
WA-14-0002 Effective/ Implementation	Establish 2101(f)	CS14	Children Ineligible for Medicaid as a Result of the Elimination of	Incorporate within a separate subsection under section 4.1
WA-14-0004 Effective/ Implementation	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 CS18 CS19 CS20	Non-Financial Eligibility – Residency Non-Financial – Citizenship Non-Financial – Social Security Number Substitution of Coverage	Supersedes the current section 4.1.5 Supersedes the current sections 4.1.9.1 Supersedes the current section 4.1.9.2
WA-15 - 0001		CS28	Hospital	See Appendix 2
WA-20-0002 Effective/ Implementation Date: January 1, 2020	MAGI Eligibility & Methods	CS10	Eligibility – Children who have access to Public Employee coverage	See Appendix 2

WA-24-2000 Effective/ Implementation Date: July 1, 2024	MAGI Eligibility & Methods	CS27	General Eligibility – Continuous Eligibility	See Appendix 2
WA-24-4000 Effective/ Implementation Date: July 1, 2024	Non-Financial Eligibility	CS21	Non-Financial Eligibility – Non-Payment of Premiums	See Appendix 2
WA-24-5000 Effective/ Implementation Date: Pending	MAGI Eligibility & Methods	CS9	Eligibility – Coverage from Conception to Birth	Pending
WA-25-6000	Non-Financial Eligibility	CS31		

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 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 an 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 Crysvita®
    - cerliponase alfa, as marketed under the brand name BrineuraTM
    - edaravone, as marketed under the brand name RadicavaTM
    - eteplirsen, as marketed under the brand name Exondys 51TM
    - nusinersen, as marketed under the brand name Spinraza®
    - pegvaliase-pqpz, as marketed under the brand name Palynziq TM

- tisagenlecleucel-t, as marketed under the brand name KymriahTM
- voretigene neparvovec-rzyl, as marketed under the brand name LuxturnaTM

- Sexual reassignment surgery as described in WAC 182-531-1675(1)(c) as well as hospitalizations, physician, and Ancillary Services required to treat postoperative complications of these procedures
- Substance-Using Pregnant People (SUPP) 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 BH-ASO
- Substance use treatment services covered through HCA's 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 ALTSA
- Nursing facility stays that do not meet rehabilitative or skilled criteria are covered through ALTSA.
- Mental health services separately purchased for all Medicaid clients by 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
- Any service provided to an enrollee while incarcerated with the Washington State Department of Corrections (DOC) unless participating in MTP 2.0 reentry initiative or services provided to an eligible juvenile per CAA, 2023.

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)

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 below 150 percent of poverty, the same limitations on 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.

For eligible incarcerated youth who are post-adjudication, premiums are

waived during the duration of their carceral stay. Premiums will continue to be required for CHIP eligible youth who are being held in facilities pre-trial while pending disposition of charges.

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:

8.2.2-DS ☐ Deductibles:

8.2.3-DS ☐ Coinsurance or copayments:

8.2.4-DS ☐ Other:

CHIP Eligibility

State Name: Washington

OMB Control Number: 0938-1148

Transmittal Number: WA - 25 - 6000

Incarcerated CHIP Beneficiaries — CS31

2102(d) and 2110(b)(7) of the SSA

Targeted Low-Income Children Who Become Incarcerated

☒ The state assures that it does not terminate eligibility for children enrolled in a separate CHIP because the child is an inmate of a public institution.

States may either suspend CHIP coverage or continue to provide CHIP state plan (or waiver of such plan) services otherwise not covered by the carceral facility to children who are incarcerated. States that elect to suspend CHIP coverage for the duration of a child's incarceration may implement a benefits or eligibility suspension.

The state elects to suspend CHIP coverage for the duration of a child's incarceration: Yes

If yes, then check an option below:

- (•) Benefits suspension
- ( ) Eligibility suspension

☒ The state assures that it redetermines eligibility for any child prior to their release if it has been longer than 12 months since the child's last redetermination and restores coverage for child health assistance to eligible children upon their release.

☒ Within the 30 days prior to release (or within one week of release, or as soon as practicable after release), the state assures that it provides eligible children with any screenings, diagnostic services, or case management services that would otherwise be available to children under the CHIP state plan (or waiver of such plan).

Additional information regarding implementation of mandatory provisions of section 5121 of the Consolidated Appropriations Act, 2023 (CAA, 2023), including providing screenings, diagnostic services, or case management services:

The state may determine that it is not feasible to provide the required services during the prerelease period in certain carceral facilities (e.g., identified local jails, youth correctional facilities, and state prisons) and/or certain circumstances (e.g., unexpected release or short-term stays). The state will maintain clear documentation in its internal operational plan regarding each facility and/or circumstances where the state determines that it is not

Under section 5122 of the CAA, 2023, states may consider otherwise eligible children who are inmates pending disposition of charges as eligible for CHIP and provide all services covered under the CHIP state plan.

☒ The state elects to provide all CHIP state plan benefits (or waiver of such plan) to eligible children who are inmates pending disposition of charges.

CHIP Eligibility

Children Determined Eligible for CHIP While Incarcerated

Generally, children who apply for CHIP when they are in a carceral facility are not eligible because of the eligibility exclusion for inmates of a public institution under section 2110(b) of the Act. However, section 2110(b)(7) of the Act provides an exception to this eligibility exclusion for children who are within 30 days prior to their release.

☒ The state assures that they will process any application submitted on behalf of a child and make an eligibility determination for child health assistance upon their release from the institution.

☒ Children who apply and are found eligible within 30 days prior to their release will be provided screening and diagnostic services, and case management services that are otherwise available under the CHIP state plan (or waiver of such plan).