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State/Territory Name: Washington

State Plan Amendment (SPA) #: 14-0011

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS/RX-200
Seattle, Washington 98104

CENTERS FOR MEDICARE & MEDICAID SERVICES

Division of Medicaid & Children's Health Operations

Dorothy Frost Teeter, Director
MaryAnne Lindeblad, Medicaid Director
Health Care Authority
Post Office Box 45502
Olympia, Washington 98504-5010

JUL 3 1 2014

RE: Washington State Plan Amendment (SPA) Transmittal Number 14-0011

Dear Ms. Teeter and Ms. Lindeblad:

The Centers for Medicare & Medicaid Services (CMS) Seattle Regional Office has completed its review of State Plan Amendment (SPA) Transmittal Number WA 14-0011 submitted on 1/24/14. This SPA describes the methodology used by the state for determining the appropriate FMAP rates, including the increased FMAP rates, available under the provisions of the Affordable Care Act applicable for the medical assistance expenditures under the Medicaid program associated with enrollees in the new adult group adopted by the state and described in 42 CFR 435.119.

Based on the information provided, the Medicaid SPA WA 14-0011 is approved with an effective date of January 1, 2014. We are enclosing the approved Form CMS-179 and the Medicaid state plan pages.

If you have any additional questions or require any further assistance, please contact me, or have your staff contact James Moreth at (360) 943-0469 or James.Moreth@cms.hhs.gov.

Sincerely,

[redacted]

Carol J.C. Peverly
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc:
Ann Myers, SPA Coordinator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **14-0011**

2. STATE: Washington

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2014

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 433.206(P&I)

7. FEDERAL BUDGET IMPACT:
a. FFY 2014 [redacted] $0 (P&I)
b. FFY 2015 [redacted] $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
[redacted]
Supplement 18 to Attachment 2.6-A pages 1 - 14 (new)(P&I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

10. SUBJECT OF AMENDMENT

FMAP Claiming

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Exempt

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
MARYANNE LINDEBLAD

14. TITLE:
MEDICAID DIRECTOR

15. DATE SUBMITTED:
1-24-14

16. RETURN TO:
Ann Myers
Office of Rules and Publications
Legal and Administrative Services
Health Care Authority
626 8th Ave SE MS: 42716
Olympia, WA 98504-2716

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 1/24/14

18. DATE APPROVED: 7/31/14

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2014

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Carol J.C. Peverly

22. TITLE:
Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

7/22/14: State authorizes P&I change to box 7 and 8
7/31/14: State authorizes P&I change to box 6

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

The State will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals, and as applicable, appropriate population-based adjustments.

Part 1 – Adult Group Individual Income-Based Determinations

For individuals eligible in the adult group, the state will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan (Part 2) approved by CMS on March 31, 2014. In general, and subject to any adjustments described in this SPA, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in Table 1.

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Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

Covered Populations Within New Adult Group		Applicable Population Adjustment			
Population Group	**Relevant Population Group Income Standard** For each population group, indicate the lower of: • The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or • 133% FPL.	**Resource Proxy**	**Enrollment Cap**	**Special Circumstances**	**Other Adjustments**
		Enter "Y" (Yes), "N" (No), or "NA" in the appropriate column to indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments.			
A	B	C	D	E	F
Parents/Caretaker Relatives	Attachment A, Column C, Line 1 of Part 2 of the CMS-approved MAGI Conversion Plan, including any subsequent CMS-approved modifications to the MAGI Conversion Plan	No	No	No	No
Disabled Persons, non-institutionalized	Attachment A, Column C, Line 2 of Part 2 of the CMS-approved MAGI Conversion Plan, including any subsequent CMS-approved modifications to the MAGI Conversion Plan	No	No	No	No
Disabled Persons, institutionalized	Attachment A, Column C, Line 3 of Part 2 of the CMS-approved Conversion Plan, including any subsequent CMS-approved modifications to the MAGI Conversion Plan	No	No	No	No
Children Age 19 or 20	Attachment A, Column C, Line 4 of Part 2 of the CMS-approved MAGI Conversion Plan, including any subsequent CMS-approved modifications to the MAGI Conversion Plan	n/a	n/a	n/a	n/a
Childless Adults	Attachment A, Column C, Line 5 of Part 2 of the CMS-approved MAGI Conversion Plan, including any subsequent CMS-approved modifications to the MAGI Conversion Plan	n/a	n/a	Yes	n/a

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Part 2 – Population-based Adjustments to the Newly Eligible Population Based on Resource Test, Enrollment Cap or Special Circumstances

A. Optional Resource Criteria Proxy Adjustment (42 CFR 433.206(d))

1. The state:

__ Applies a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

_X_ Does not apply a resource proxy adjustment (Skip items 2 through 3 and go to Section B).

Table 1 indicates the group or groups for which the state applies a resource proxy adjustment to the expenditures applicable for individuals eligible and enrolled under 42 CFR 435.119. A resource proxy adjustment is only permitted for a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

The effective date(s) for application of the resource proxy adjustment is specified and described in Attachment B.

2. Data source used for resource proxy adjustments:
The state:

__ Applies existing state data from periods before January 1, 2014.

__ Applies data obtained through a post-eligibility statistically valid sample of individuals.

Data used in resource proxy adjustments is described in Attachment B.

3. Resource Proxy Methodology: to be submitted as a new SPA at a later date.

B. Enrollment Cap Adjustment (42 CFR 433.206(e))

1. __ An enrollment cap adjustment is applied by the state (complete items 2 through 4).

X An enrollment cap adjustment is not applied by the state (skip items 2 through 4 and go to Section C).

2. Attachment C describes any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009 that are applicable to populations that the state covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable section 1115 demonstration special terms and conditions as confirmed by CMS, or in alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).

3. The state applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:

   __ Yes. The combined enrollment cap adjustment is described in Attachment C

   __ No.

4. Enrollment Cap Methodology: Attachment C describes the methodology for calculating the enrollment cap adjustment, including the use of combined enrollment caps, if applicable.

C. Special Circumstances (42 CFR 433.206(g)) and Other Adjustments to the Adult Group FMAP Methodology

1. The state:

   X Applies a special circumstances adjustment(s).

   __ Does not apply a special circumstances adjustment.

2. The state:

   X Applies additional adjustment(s) to the adult group FMAP methodology (complete item 3).

   __ Does not apply any additional adjustment(s) to the adult group FMAP methodology (skip item 3 and go to Part 3).

3. Attachment D describes the special circumstances and other proxy adjustment(s) that are applied, including the population groups to which the adjustments apply and the methodology for calculating the adjustments.

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Part 3 – One-Time Transitions of Previously Covered Populations into the New Adult Group

A. Transitioning Previous Section 1115 and State Plan Populations to the New Adult Group

X Individuals previously eligible for Medicaid coverage through a section 1115 demonstration program or a mandatory or optional state plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan and/or a section 1902(e)(14)(A) waiver. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to new adult group, the adult group FMAP methodology is applied pursuant to and as described in Attachment E, and where applicable, is subject to any special circumstances or other adjustments described in Attachment D.

__ The state does not have any relevant populations requiring such transitions.

Part 4 - Applicability of Special FMAP Rates

A. Expansion State Designation

The state:

__ Does not meet the definition of expansion state in 42 CFR 433.204(b). (Skip section B and go to Part 5)

X Meets the definition of expansion state as defined in 42 CFR 433.204(b), determined in accordance with the CMS letter confirming expansion state status, dated 02/22/2013,.

B. Qualification for Temporary 2.2 Percentage Point Increase in FMAP.

The state:

X Does not qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).

__ Qualifies for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7), determined in accordance with the CMS letter confirming eligibility for the temporary FMAP increase, dated_____. The state will not claim any federal funding for individuals determined eligible under 42 CFR 435.119 at the FMAP rate described in 42 CFR 433.10(c)(6).

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Part 5 - State Attestations

The State attests to the following:

A. The application of the adult group FMAP methodology will not affect the timing or approval of any individual's eligibility for Medicaid.

B. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

ATTACHMENTS

Not all of the attachments indicated below will apply to all states; some attachments may describe methodologies for multiple population groups within the new adult group. Indicate those of the following attachments which are included with this SPA:

X Attachment A – Conversion Plan Standards Referenced in Table 1

__ Attachment B – Resource Criteria Proxy Methodology

__ Attachment C – Enrollment Cap Methodology

X Attachment D – Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology

X Attachment E – Transition Methodologies

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Attachment A

Most Recent Updated Summary Information for Part 2 of Modified Adjusted Gross Income (MAGI) Conversion Plan*

	Population Group	Net Standard as of 12/1/09	Converted Standard for FMAP Claiming	Same as converted eligibility standard? (yes, no, or n/a/)	Source of information in column C (New SIPP conversion or Part 1 of approved stte MAGI conversion plan)	Data source for Conversion (SIPP or state data)
	A	B	C	D	E	F
Conversions for FMAP Claiming Purposes						
1	Parents/Caretaker Relatives Dollar standards by family size 1 2 3 4 5 6 7 8 9 10 or higher Add-on	 $359 $453 $562 $661 $762 $866 $1,000 $1,107 $1,215 $1,321 n/a	 $511 $658 $820 $972 $1,127 $1,284 $1,471 $1,631 $1,792 $1,951 n/a	Yes	Part 1 of approved state MAGI conversion plan	State data
2	Noninstitutionalized Disabled persons SSI FBR%	100%	103%	n/a	New SIPP conversion	SIPP
3	Institutionalized Disabled persons SSI FBR%	300%	300%	n/a	ABD conversion template	n/a
4	Children age 19 – 20	n/a	n/a	n/a	n/a	n/a
5	Childless adults FPL%	n/a	n/a	n/a	n/a	n/a

n/a: Not applicable

*The numbers in this summary chart will be updated automatically in the case of modification in the CMS approved MAGI conversion plan.

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ATTACHMENT D

Washington State administered a Presumptive SSI program until January 1, 2014. As of January 1, 2014, these individuals were placed into the newly eligible group and will be claimed at 100% federal match. The newly eligibles are indicated by ACES Coverage Group N05, corresponding to RAC Group 1201. The Department of Social and Health Services (DSHS) has recently submitted a request to set up a new ACES Coverage Group, which can be mapped to a new RAC Code. Once this is complete, claiming for the clients in the Presumptive SSI group can be set at 75% (or an updated annual figure). Until then, the Medicaid Agency (the Health Care Authority (HCA)) needs a process to ensure claiming at only 75% for these individuals and that the weekly federal draws take this into account. To do this, HCA will utilize an approved cost allocation methodology, which is processing data through a base.

Using a base, a certain percentage of expenditures or clients can be assigned to two groups (in Washington, it would be two groups). Consider Presumptive SSI. If, for example, 15% of the expenditures in the newly eligibles are for Presumptive SSI clients, then 15% of the expenditures for the newly eligibles would be placed in one portion of the base and the other 85% of the expenditures would be placed in the other half. The 15% would target a cost objective code that would allocate 75% federal match, while the remaining 85% would target a cost objective code that would allocate 100% federal match. The initial percentages would be based on the budgeted amounts, and then going forward, estimates would be made at the beginning of each month. The estimates will be based on previous actuals. “True-ups” to the estimates will be performed monthly after fiscal month close. A journal voucher (JV) will be processed to adjust to the actuals ensuring the accounting records are correct. The JV process is as follows:

1. Obtain the client IDs for these presumptive SSI clients from the Automated Client Eligibility System (ACES) maintained by DSHS, by identifying those that are in the Adult Blind/Disabled (ABD) cash assistance program.

2. Match these clients to the medical eligibility data in Provider One to obtain a list of ABD clients that are also eligible for Medicaid in the newly eligible population segment at the same time.

3. On a monthly basis, HCA Budget pulls all expenses for these clients. Medicaid claims data for clients is obtained from various Washington State systems, including Provider One, SSPS (Social Service Payment System), etc. The Journal Voucher data is then provided to HCA Accounting to ensure federal match for these clients is exactly 75% (or updated annual figure).

Regarding the 15% figure, preliminary data suggest that for SFY14 the percentage for ProviderOne payments is 10%. The corresponding figure for DSHS expenditures may be higher. The monthly updating of the percentage figures for the base (15% and 85% in the example above) will be done manually by the accounting staff Actual expenditures for the true- ups will be determined by pulling claims experience – from Provider One on the part of HCA, and from the Social Services Payment System (SSPS) on the part of DSHS. Percentages would be determined as the percent of the newly eligible (RAC 1201/ACES group N05) constituted by the Presumptive SSI Clients. The list of the Presumptive SSI clients will be determined by DSHS using their ACES eligibility system, drawing from the list of ABD Cash Assistance clients that will be eligible in months corresponding to the months of expenditures.

With respect to the CMS 64, the monthly JV process ensures a “true-up” of the expenditures so that on a quarterly basis, the actual dollars for the Presumptive SSI are claimed appropriately at exactly 75% federal match.

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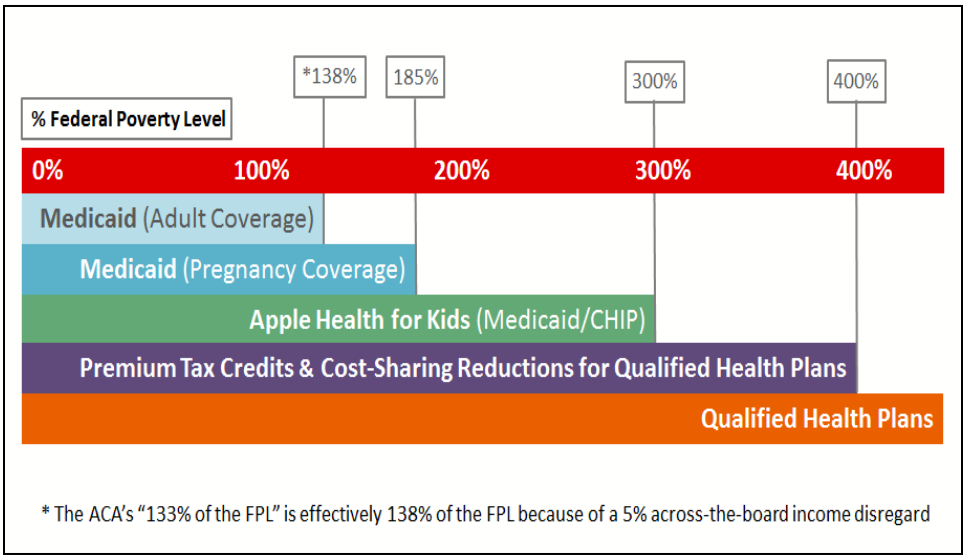
Attachment E

Washington State Revised 2014 Transition Plan

As a requirement of Washington State's 1115 Transitional Bridge Demonstration waiver, preliminary planning began early in 2012 and was revised early in 2013 as the details of the Insurance Affordability Program (IAP) continuum that will be available in 2014 evolved. An overview is shown in the following chart.



A broad range of discussions, presentations and webinars has been hosted to clarify general Medicaid expansion and transition details for Tribes, stakeholders, health plans and others interested. The timeline and critical milestones for preparation/planning, seamless transition and administrative closeout of the Transitional Bridge Demonstration in particular, were reviewed with CMS earlier in 2013. Underlying details have been revised following Washington State's 2013 extended Legislative sessions (ending June 30, 2013) and to incorporate evolving CMS guidance. The following chart summarizes the plan, referencing the impacted elements in red. While definition of the Alternative Benefit Plan has been delayed by about 4 months from the original plan we don't expect an impact on readiness for 2014 implementation.

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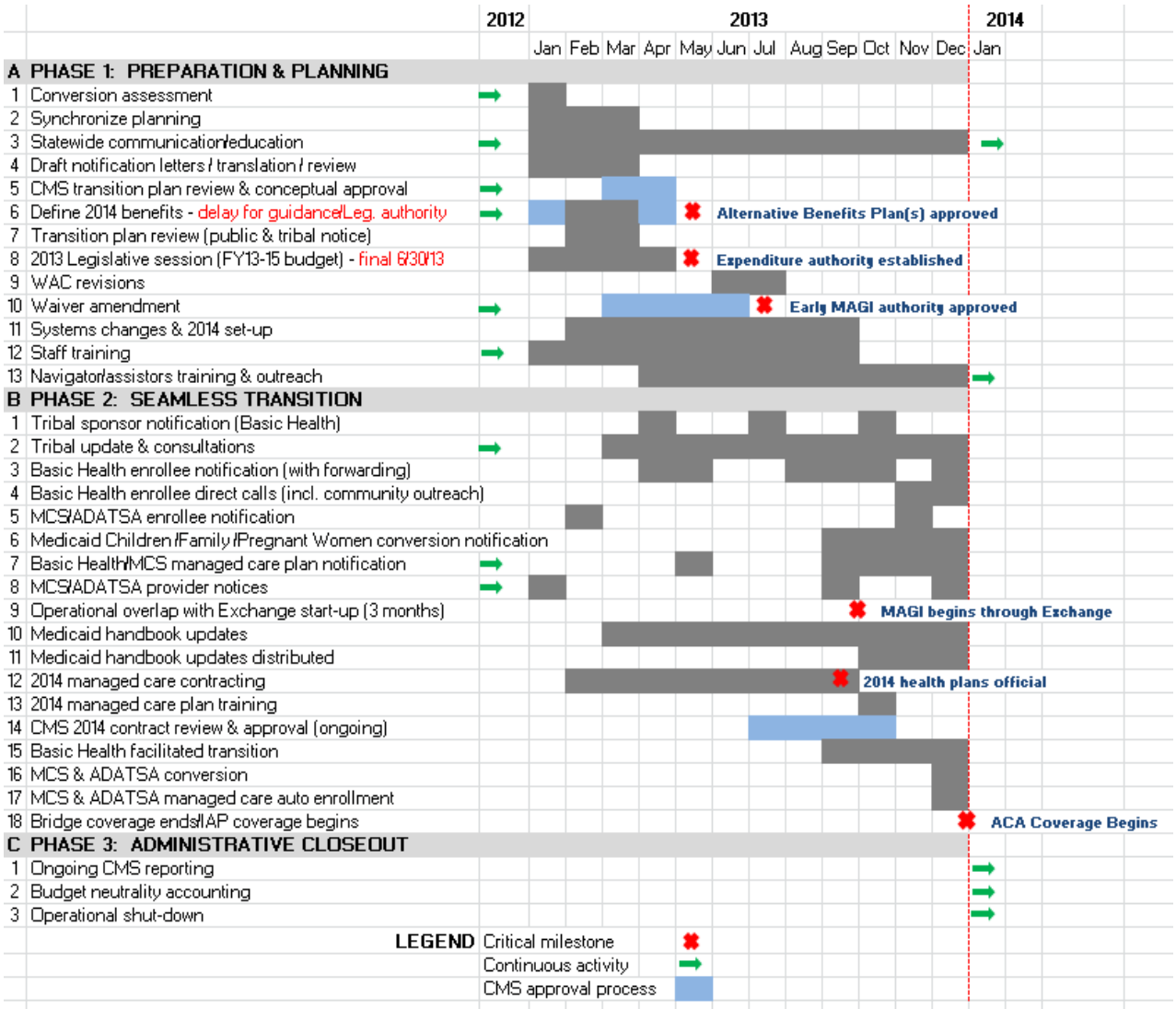
Attachment E (cont)



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A. Coverage in 2014

Through the authority of the Transitional Bridge waiver Washington State will adopt MAGI-based eligibility determination methods beginning on October 1, 2013 to help facilitate a streamlined enrollment process for 2014 for all IAPs. (A general fact sheet on 2014 eligibility for Medicaid/CHIP is available at: http://www.hca.wa.gov/hcr/me/documents/ME2014_Changes_Comparison_Fact_Sheet.pdf. Populations covered through current 1115 Demonstrations will transition to 2014 coverage as follows.

Eligibility Category			**Benefits**	**Delivery System**
Population	**Current Authority**	**1/1/2014 Authority**		
Medical Care Services-Disability Lifeline Medical Care Services-ADATSA Basic Health (up to 133% FPL based on MAGI methods)	Early Medicaid expansion adults (1115 Transitional Bridge waiver)	Mandatory State Plan expansion adults up to 133% FPL *(renewal typically occurs 12 months from enrollment under State Plan)*	Alternative Benefit Plan	Same as current Medicaid State Plan – primarily managed care, some FFS
Basic Health (over 133% FPL based on MAGI methods)	Early Medicaid expansion adults (1115 Transitional Bridge waiver)	State Health Benefit Exchange adults not eligible for Medicaid *(renewal typically occurs during open enrollment period under marketplace rules)*	Essential Health benefits	Qualified Health Plans
Take Charge (Pre-pregnancy family planning up to 250% FPL)	Family planning waiver	Waiver amendment in process to limit eligibility to: (a) individuals not eligible for Medicaid, with incomes up to 250% FPL and (b) Youth/victims of domestic violence requiring confidential services	Family planning services	Approved Take Charge providers - local clinics, doctors' offices and pharmacies

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B. Process for Transition

During the preparation and planning for the required Transitional Bridge close-out, an assessment of demonstration populations was conducted to determine the potential to (a) automate conversion to the 2014 State Plan expansion adult group or (b) support seamless transition through the WashingtonHealthPlanFinder (www.wahealthplanfinder.org.)

Screening of cases showed that income requirements for eligibility to the Medical Care Services-Disability Lifeline and Medical Care Services-ADATSA demonstration populations (i.e., "Transition Eligibles") aligned fully with eligibility for the 2014 Medicaid expansion adults. An automated conversion will occur for individuals enrolled in these programs in December 2013.

Screening of the Basic Health "Transition Eligible" population determined that an automated conversion would not be possible - details required to support MAGI household and income requirements are not available in current data, nor available in the sponsorship program through which external organizations subsidize enrollment in Basic Health (e.g., Tribes.) In addition, collection of additional (tax-related) data not needed for Basic Health eligibility determination would have required Legislative action *before* all details of the MAGI determination methodology were known. The process for transition of Basic Health individuals will involve heavy facilitation through multiple notices and assistance from Basic Health sponsors (e.g., Tribes), health plans who serve current enrollees, and advocacy organizations. Individuals may also obtain coverage for 2014 through Washington's healthplanfinder portal, paper forms, or other call-center/personal assistance.

The Take Charge program covers a limited family planning benefit to help participants avoid unintended pregnancies. The 2013 Legislature authorized continuation of the program in 2014 for individuals not otherwise eligible for Medicaid, and for youth requiring confidential access to services. Otherwise, current beneficiaries will continue coverage through their certification period. They will then receive a renewal notice requiring them to apply for coverage in the same manner as other Medicaid recipients. (A waiver amendment is being drafted.)

Population	Action by State	Action by Beneficiary (or Sponsor)
Automated Conversion to 2014 Medicaid		
Medical Care Services-Disability Lifeline and Medical Care Services-ADATSA	• Standard beneficiary notice of program termination and automated conversion to Medicaid, with reasons and official authorization	None
Seamless Facilitated Transition to 2014 IAP (Medicaid or HBE)		
Basic Health	• Beneficiary notice re program termination and action needed to activate 2014 coverage, with reasons and official authorization • Training of health plans, community-based organizations, Tribes/other sponsors to provide additional support	Individuals will choose from electronic, phone, mail-in and other assisted options (e.g., current sponsors) to expedite 2014 coverage
Take Charge	• Based on waiver amendment beneficiaries will be asked to follow standard 2014 Medicaid application process	Individuals will not need to take action until their 2014 renewal notification

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C. Notification/Notices

As shown in the Transitional Bridge Demonstration waiver Gantt chart above, planning for communication with beneficiaries, health plans, providers and sponsors began in 2012. Conversations with Take Charge providers has been increasing since December 2012 when the Governor's budget for 2013-15 leveraged the ACA-related opportunities to streamline current programs whose enrollees would have expanded benefits available through 2014 IAP options.

As required, notices comply with the notice requirements in 42 CFR 431.206, 431.210 and 431.213 and where applicable, information on appeal and hearing rights as outlined in 42 CFR 431.220 and 431.221 is included. In general, the terms and conditions of the Transitional Bridge waiver which expires December 31, 2013, make the need for hearing and appeal rights not relevant since the programs will not continue for Transition Eligibles.

A full list and sample of actual notices is included in Attachment 1. Multiple versions of these notices have been reviewed through email, webinar, teleconference and verbal interactions with State agency staff, advocates, Tribal representatives and others. The notification process is as follows:

Population	Timing and Delivery of Beneficiary Notices	Support for Questions
Basic Health	**Letter # a: Member alert** Preliminary announcement mailed early July 2013 along with the monthly notice for premium payment (September coverage)	• Online at www.wahealthplanfinder.org. • Call 1-800-660-9480 or Exchange • Mail to PO Box 946, Olympia, WA 98507 • Email at CustomerSupport@wahbexchange.org • Call 1-855-923-4633 to find a cost free in-person assister • Health plans, community organizations, and other tribal sponsors, etc. • Follow-up personal phone call (and facilitation) will occur for individuals who have not activated coverage for 2014 by the end of November
	Letter # b: 90-day first notice Notification of need to provide details for 2014 coverage determination through the Washington HealthPlanFinder – included in September notice for premium payment for November coverage	
	Letter # c: 60-day second notice Follow-up notification of need to provide details for 2014 coverage determination through the Washington HealthPlanFinder – included in October notice for premium payment for December coverage *for those who have not already completed 2014 coverage action*	

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Attachment E (cont)

Population	Timing and Delivery of Beneficiary Notices	Support for Questions
Basic Health (cont)	**Letter # d: termination notice where individual has activated 2014 coverage** Final notice to be mailed in December	
	Letter # e: termination notice where individual has not activated 2014 coverage Final notice to be mailed in December	
Medical Care Services-Disability Lifeline And Medical Care Services-ADATSA	**Letter # f:** MCS/ADATSA conversion notice Official notice of automatic upgrade to Medicaid coverage – mailed the end of November.	• Online at www.wahealthplanfinder.org. • Call 1-855-923-4633 or 1-855-627-9604 • Fax to 360-841-7620 • Mail to PO Box 946, Olympia, WA 98507 • Email at CustomerSupport@wahbexchange.org • Call 1-855-923-4633 to find a cost free in-person assister • Local Community Service Offices (CSO).
Take Charge	Standard renewal letter – no change	Family planning clinics and all other standard Medicaid support avenues