WA - Submission Package - WA2022MS0004O - (WA-22-0016) - Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Medicaid and CHIP Operations Group
601 E. 12th st., Room 335
Kansas City, MO 64106

Center for Medicaid & CHIP Services

December 16, 2022

Sue Birch
Health Care Authority Director
Health Care Authority
PO Box 45502
Olympia WA , WA 98504

Re: Approval of State Plan Amendment WA-22-0016

Dear Sue Birch,

On October 03, 2022, the Centers for Medicare and Medicaid Services (CMS) received Washington State Plan Amendment (SPA) WA-22-0016 which updates the agency administration information for Washington State's single state agency, the Health Care Authority.

We approve Washington State Plan Amendment (SPA) WA-22-0016 with an effective date(s) of October 01, 2022.

If you have any questions regarding this amendment, please contact Edwin Walaszek at edwin.walaszek1@cms.hhs.gov

Sincerely,

James G. Scott

Director, Division of Program Operations

Center for Medicaid & CHIP Services

WA - Submission Package - WA2022MS0004O - (WA-22-0016) - Administration

Medicaid State Plan Administration

Organization

Designation and Authority

MEDICAID | Medicaid State Plan | Administration | WA2022MS0004O | WA-22-0016

CMS-10434 OMB 0938-1188

Package Header

Package ID	WA2022MS0004O	**SPA ID**	WA-22-0016
Submission Type	Official	**Initial Submission Date**	10/3/2022
Approval Date	12/16/2022	**Effective Date**	10/1/2022
Superseded SPA ID	18-0017		
	User-Entered		

A. Single State Agency

1. State Name: Washington

☑ 2. As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named here agrees to administer the Medicaid program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Centers for Medicare and Medicaid Services (CMS).

3. Name of single state agency:

Washington State Health Care Authority

4. This agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

B. Attorney General Certification:

☑ The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

Name	Date Created	
18-0017-AgencyOrganization-Att-1.1-A-AG-Certification	11/5/2018 5:05 PM EST	
18-0017-AgencyOrganization-AttorneyGeneralDelegationLetter	12/18/2018 1:30 PM EST	

C. Administration of the Medicaid Program

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

◉ 1. The single state agency is the sole administrator of the state plan (i.e. no other state or local agency administers any part of it). The agency administers the state plan directly, not through local government entities.

○ 2. The single state agency administers portions of the state plan directly and other governmental entity or entities administer a portion of the state plan.

Designation and Authority

MEDICAID | Medicaid State Plan | Administration | WA2022MS0004O | WA-22-0016

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D. Additional information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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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WA - Submission Package - WA2022MS0004O - (WA-22-0016) - Administration

Medicaid State Plan Administration

Organization

Eligibility Determinations and Fair Hearings

MEDICAID | Medicaid State Plan | Administration | WA2022MS0004O | WA-22-0016

CMS-10434 OMB 0938-1188

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A. Eligibility Determinations (including any delegations)

1. The entity or entities that conduct determinations of eligibility for families, adults, and individuals under 21 are:

- [x] a. The Medicaid agency
- [ ] b. Delegated governmental agency

2. The entity or entities that conduct determinations of eligibility based on age (65 or older), or having blindness or a disability are:

- [ ] a. The Medicaid agency
- [x] b. Delegated governmental agency
  - [x] i. Single state agency under Title IV-A (TANF) (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
  - [ ] ii. An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
  - [x] iii. The Social Security Administration determines Medicaid eligibility for:
    - [x] (1) SSI beneficiaries
    - [ ] (2) Optional state supplement recipients
  - [ ] iv. Other

3. Assurances:

- [x] a. The Medicaid agency is responsible for all Medicaid eligibility determinations.
- [x] b. There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).
- [x] c. The Medicaid agency does not delegate authority to make eligibility determinations to entities other than government agencies which maintain personnel standards on a merit basis.
- [x] d. The delegated entity is capable of performing the delegated functions.

Eligibility Determinations and Fair Hearings

MEDICAID | Medicaid State Plan | Administration | WA2022MS0004O | WA-22-0016

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B. Fair Hearings (including any delegations)

☑ The Medicaid agency has a system of hearings that meets all of the requirements of 42 CFR Part 431, Subpart E.

☑ The Medicaid agency is responsible for all Medicaid fair hearings.

1. The entity or entities that conduct fair hearings with respect to eligibility based on applicable modified adjusted gross income (MAGI) are:

☑ a. Medicaid agency

☐ d. Delegated governmental agency

3. For all other Medicaid fair hearings (not related to an eligibility determination based on MAGI):

☑ All other Medicaid fair hearings are conducted at the Medicaid agency or at another state agency authorized under an ICA waiver.

Eligibility Determinations and Fair Hearings

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C. Evidentiary Hearings

The Medicaid agency uses local governmental entities to conduct local evidentiary hearings.

- ○ Yes
- ◉ No

D. Additional information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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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Medicaid State Plan Administration

Organization

Organization and Administration

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A. Description of the Organization and Functions of the Single State Agency

1. The single state agency is:

- (•) a. A stand-alone agency, separate from every other state agency
- ( ) b. Also the Title IV-A (TANF) agency
- ( ) c. Also the state health department
- ( ) d. Other:

2. The main functions of the Medicaid agency and where these functions are located within the agency are described below. This description should be consistent with the accompanying organizational chart attachment. (If the function is not performed by the Medicaid agency, indicate in the description which other agency performs the function.)

a. Eligibility Determinations

The Health Care Authority (HCA) is designated as the single state agency and has final authority for eligibility determinations. According to Washington State law and as permitted by Medicaid law, HCA & the Department of Social and Health Services (DSHS - the Title IV-A Agency) have established an agreement regarding the provision of certain eligibility determinations for non-MAGI Medicaid programs. This agreement defines the responsibilities of HCA as the administrator of the Medicaid State Plan, and DSHS as the representative of the agency's interest along with HCA, for the Medicaid program. HCA oversees & monitors the program functions delegated to DSHS.

In HCA, the Medical Eligibility Determination Services (MEDS) section in the Medicaid Customer Support (MCS) division is responsible for completing MAGI-based eligibility & post-enrollment determination for children & adults in Apple Health (including Alien Emergency Medical services for those eligible for Medicaid but for their immigration & citizenship status, under MAGI-based income methodology), Breast & Cervical Cancer Treatment Program, & family planning programs. The Office of Medicaid Eligibility & Policy (OMEP) in MCS develops Apple Health/Apple Health for Kids eligibility rules & policy, ensures eligibility systems support & enrolls foster care & adoption support children into Medicaid when DSHS has determined they are eligible.

Per agreement, HCA delegates to DSHS the management of non-MAGI-based eligibility determinations for the following programs: SSI & SSI-related programs for the aged, blind and disabled eligibility groups; Alien Emergency Medical services for those eligible for Medicaid but for their immigration & citizenship status, under non-MAGI-based income methodology; the Medicare Savings program; & long-term services & supports programs.

b. Fair Hearings (including expedited fair hearings)

The Medicaid agency, the Health Care Authority (HCA), oversees & administers the administrative (fair) hearings system in compliance with 42 CFR 431.10(e). HCA does not delegate ability to issue final decisions or waive its single state agency authority in administration of fair hearings & appeals & retains full oversight.

HCA Board of Appeals (BOA) conducts hearings & issues final orders or contracts with the state's Office of Administrative Hearings (OAH) to conduct the fair hearing & issue an Initial Order by an Administrative Law Judge (ALJ). HCA chooses which appeals to send to OAH & which appeals to conduct internally. Under both systems, HCA retains full administrative control over the hearings with the ability to issue a final order. HCA can choose to keep or refer any case type. There are certain case types that always are heard directly by HCA. HCA also keeps any case related to ICF-IID certification. HCA allows OAH to hear most client eligibility & client service case types. That is because those cases are very routine in nature & the central panel agency is very equipped to conduct the hearing & issue an initial decision. This allows HCA's BOA to directly hear the most complex case types noted above. In all instances, HCA retains final agency control of the administrative hearing decision.

In all hearings, there is an HCA hearing representative representing the single state Medicaid agency. HCA's Office of Legal Affairs (OLA) in the division of Legal Services (DLS) represents HCA in hearings regarding Medicaid benefits/services, & MAGI-based, Breast & Cervical Cancer, & family planning eligibility. HCA has delegated to the Department of Social & Health Services (DSHS) the function of representing the Medicaid agency at administrative hearings (including expedited

hearings) regarding decisions made by DSHS related to non-MAGI eligibility determinations, NF discharges & adverse PASRR determinations.

The HCA hearing representative may choose to adopt the Initial Order or appeal the initial order to the HCA BOA. If the HCA hearing representative chooses not to appeal an initial order, that order converts to a final order with the passage of time, which is the process by which the single state Medicaid agency adopts an initial order. All HCA hearing representatives receive training on their role representing HCA in fair hearings.

An initial order made by an ALJ can be reviewed by a review judge at any party's request. The review judge is within the HCA BOA & is an HCA employee. The review judge reviews initial orders and the hearing record, exercising decision-making power as if hearing the case as a presiding officer. In some cases, review judges conduct hearings under state law as a presiding officer. After reviewing initial orders or conducting hearings, review judges enter final orders. The review judge must not have been involved in the initial HCA action. A final order is an order that is the final HCA decision. All appeals of initial decisions to the HCA BOA must be made within twenty-one days of service of the initial decision. Regardless of whether a party appeals or chooses not to appeal, all final administrative actions must be rendered within ninety (90) days of the date of the request for hearing.

The Medicaid appeals system is overseen by the HCA Chief Review Judge/Appeals Administrator (CRJ/AA). This position contracts with OAH & retains complete oversight of the OAH ALJ services provided to ensure compliance with the rules of the single state Medicaid agency.

The contract with OAH has performance requirements to ensure compliance with state and federal Medicaid laws, ensure that applicants & recipients receive timely hearings, & ensure due process. The CRJ/AA has the power to stop sending cases to OAH at any time if a performance issue is identified or to withhold payment.

c. Health Care Delivery, including benefits and services, managed care (if applicable)

Health care delivery is managed in various sections of several divisions:

1. Clinical Quality and Care Transformation (CQCT)

CQCT makes clinical policy decisions to guide medical coverage, to maintain quality standards and ensure evidence-based practices for our clients' medical care, and to support statewide care transformation. CQCT includes:

- Authorization Services Office
  - Medical/DME
  - Dental
  - Pharmacy
- Clinical Support
  - Behavioral health
  - Physical health
  - Dental
  - Maternity and family
- Data
  - Health Information Technology
  - Data Management
  - Data Governance
  - Data Analytics, Research, Evaluation
- Health Services and Management
- Health Technology Assessment Program
- Pharmacy Services
  - Drug Price Transparency Program
  - P&T/DUR Board

2. Division of Behavioral Health and Recovery (DBHR)

Provides program support for behavioral health (substance use, mental health, & problem gambling) and includes:

- Adult Behavioral Health Crisis & Treatment Services
- Behavioral Health Recovery Support Services
- Child, Youth, & Family Behavioral Health Treatment Services
- Office of Recovery Partnerships
- Substance Use Prevention & Mental Health Promotion

3. Medicaid Customer Service Division (MCS)

Provides high-quality customer service to support clients' access to obtain health care, while also supporting the efficient utilization of Medicaid funding to provide care appropriately and efficiently. MCS includes:

- Coordination of Benefits (COB) & Claims Processing: Ensures Medicaid is the payer of last resort by preventing duplication of payment when more than one insurance plan or payer (other health insurance, personal injury, Medicare, etc.) covers a person. Responsible for providing timely and accurate adjudication of fee-for-service claims for providers who provide services to Medicaid clients.
- Medical Assistance Customer Service Center (MACSC): Helps Apple Health clients and providers with questions and issues about Medicaid coverage, managed care billing, claims, and enrollment
- Medical Eligibility Determination Services (MEDS): Completes eligibility and post-enrollment determinations for children and adult in Apple Health, Breast and Cervical Cancer Treatment program and Take Charge family planning
- Operations: Consists of centralized support functions that facilitate the operational effectiveness of the division including training development, quality assurance, and data support. Supports provider outreach and training, with a primary focus in assisting providers with Direct Date Entry in ProviderOne (P!), P! user maintenance, billing guide updates, and general assistance with Washington Apple Health procedures through the Provider Relations team.

4. Medicaid Programs Division (MPD)

Provides access to services and includes:

- Business Operations: Leads overall management of the implementation, deployment, and reporting for National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care for the Health Care Authority
- Community Services: Manages family health care services, nonemergency medical transportation, Innovative and Strategic Federal Reimbursement contracts and programs with government organizations, and language access services for Medicaid providers serving Medicaid enrolled clients.
- Medicaid Contracts and Compliance: Coordinates and assures adherence to state and federal law and federal lock-in program rules. Manages and oversees contracted managed care organizations delivering Medicaid services.
- Office of Medicaid Eligibility and Policy: Develops Apple Health/Apple Health for Kids eligibility rules and policy, ensures eligibility systems support, and conducts stakeholder outreach.
- Quality Oversight and Program Alignment: Monitors fee-for-service and managed care providers to ensure compliance with contractual requirements; provides clinical-based technical assistance to managed care organizations; investigates and resolves enrollee access to care issues and q

d. Program and policy support including state plan, waivers, and demonstrations (if applicable)

Program and policy support is managed in various sections of several division:

1. Clinical Quality and Care Transformation (CQCT)

CQCT makes clinical policy decisions to guide medical coverage, to maintain quality standards and ensure evidence-based practices for our clients' medical care, and to support statewide care transformation. CQCT includes:

- Authorization Services Office
- Clinical Support
- Data
- Health Services and Management
- Health Technology Assessment Program
- Pharmacy Services

2. Medicaid Customer Service Division (MCS)

Provides high-quality customer service to support clients' access to obtain health care, while also supporting the efficient utilization of Medicaid funding to provide care appropriately and efficiently. MCS includes:

- Coordination of Benefits (COB) & Claims Processing
- Medical Assistance Customer Service Center (MACSC)
- Medical Eligibility Determination Services (MEDS)
- Operations

3. Medicaid Programs Division (MPD)

Provides access to services and includes:

- Business Operations
- Community Services
- Medicaid Contracts and Compliance
- Office of Medicaid Eligibility and Policy
- Quality Oversight and Program Alignment
- Strategic Design and Program Oversight

4. Office of Tribal Affairs (OTA)

Advises the agency on how to maintain its government-to-government relationships with tribes in accordance with federal Medicaid requirements & chapter 43.376 RCW

5. Policy Division (POLICY)

Helps guide state policy, strategy, and transformation efforts to achieve better health, better care, and lower costs. Areas of focus include:

- Office of Health Innovation and Reform
- Office of Paying for Value
- Office of Legislative Affairs and Analysis
- Office of Board and Commissions
- Office of Health Equity

6. Program Integrity Division (PI)

Conducts audits and reviews of fee-for-service and managed care providers to ensure compliance with Medicaid laws and contractual requirements and prevent and recover improper payments. PI includes:

- Clinical Review and Audit
- Compliance, Operations, and Oversight
- Provider Enrollment

7. Division of Legal Services

Provides professional legal support to the agency and includes:

* Office of the Chief Legal Officer
* Board of Appeals
* Enterprise Risk Management
* Office of Legal Affairs
* Office of Contracts and Procurement
* Office of Rules and Publications: Manages the State Plan Amendment process

8. DSHS (per agreement):

- 1915(b), 1915 (c), and 1115 waivers
- Certain Chronic Care Management services
- Home and Community-Based Services programs including Medicaid Personal Care Services and the Community First Choice Program
- Residential Habilitation Centers/Public Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID)
- Privately operated, licensed boarding homes or nursing homes that have Medicaid certification as Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID) (42 CFR 483.400)
- Long-term Services and Supports (adult family homes, assisted living, enhanced services facilities, and the community residential services and support programs) and nursing facility services. DSHS will administer and pay for administrative and programmatic services related to long-term services and supports and nursing facility services
- Program of All-Inclusive Care for the Elderly (PACE)

e. Administration, including budget, legal counsel

1. Office of the Director

Provides visionary leadership for the broader health care marketplace pursuant to the agency's role as the state's largest purchaser of health care services and in accordance with HCA's statutory direction. The OD is also responsible for overseeing the Executive Leadership Team (ELT), overall agency vision, operations, and providing strategic direction to ELT.

2. Central Services Administration (CSA)

Plans, directs, and coordinates all supportive services and operations for the agency, ensuring smooth, efficient, and accountable operations. CSA includes the

following divisions:
- Division of Legal Services
- Employee Resources Division
- Planning and Performance Division

3. Medicaid Services Administration (MSA)
Has primary responsibility for ensuring HCA offers high-quality, cost-effective care to Apple Health clients while adhering to federal Medicaid requirements. MSA includes the:
- Medicaid Programs Division
- Medicaid Customer Service Division
- Division of Program Integrity

4. IT Innovation and Customer Experience Administration (ITICEA)
Aligns agency technology and people assets to enhance the programs and services offered by HCA in a way that leverages human-centered design principles to improve the health equity of Washingtonians. ITICEA includes the:
- Enterprise Technology Services Division
- Medicaid Customer Service Division
- Healthcare Workforce Development experts

5. Division of Legal Services (DLS)
DLS provides professional legal support to the agency by overseeing and includes the:
- Office of the Chief Legal Officer
- Board of Appeals (BOA)
- Enterprise Risk Management Office (ERMO)
- Office of Legal Affairs (OLA)
- Office of Contracts and Procurement (OCP)
- Office of Rules and Publications (ORP)

6. Financial Services Division (FSD)
- Budget preparations & expenditure monitoring
- Accounting & payroll
- Per-capita Medicaid forecasting
- Managed care rate-setting methods for Medicaid clients
- Setting fee-for-service rate schedules for physicians, dentists, hospitals, clinics, & others

7. Medicaid Customer Service Division (MCS)
Provides high-quality customer service to support clients' access to obtain health care, while also supporting the efficient utilization of Medicaid funding to provide care appropriately and efficiently. MCS includes:
- Coordination of Benefits (COB) & Claims ProcessingMedical Assistance Customer Service Center (MACSC)• Medical Eligibility Determination Services (MEDS)

8. Office of Tribal Affairs (OTA) (within the Office of the Director):
- Advises the agency on how to maintain its government-to-government relationships with tribes in accordance with federal Medicaid requirements & chapter 43.376 RCW
- Works with tribes, the Indian Health Service, & Urban Indian Health Programs to understand their issues and concerns
- Develops agency program policies & rules that address those issues and concerns

9. Program Integrity Division (PI)
Conducts audits and reviews of fee-for-service and managed care providers to ensure compliance with Medicaid laws and contractual requirements and prevent and recover improper payments. PI includes:
- Clinical Review and Audit
- Compliance, Operations, and Oversight
- Provider Enrollment

f. Financial management, including processing of provider claims and other health care financing

1. Financial Services Division (FSD)
FSD directs and executes the agency's financial-related activities and delivers a fiscal perspective in agency-wide decisions and strategies. FSD includes:
- Accounting
- Budget Operations
- ERB Finance
- Federal Financial Reporting
- Financial Analytics
- Health Care Rates & Finance
- Hospital Finance & Drug Rebate
- Operations
- Performance Accountability
- Premium Payment & Compact of Free Association

2. Medicaid Customer Service Division (MCS)
Provides high-quality customer service to support clients' access to obtain health care, while also supporting the efficient utilization of Medicaid funding to provide care appropriately and efficiently. MCS includes:
- Coordination of Benefits (COB) & Claims Processing: Ensures Medicaid is the payer of last resort by preventing duplication of payment when more than one insurance plan or payer (other health insurance, personal injury, Medicare, etc.) covers a person. Responsible for providing timely and accurate adjudication of fee-for-service claims for providers who provide services to Medicaid clients.
- Medical Assistance Customer Service Center (MACSC): Helps Apple Health clients and providers with questions and issues about Medicaid coverage, managed care billing, claims, and enrollment
- Medical Eligibility Determination Services (MEDS): Completes eligibility and post-enrollment determinations for children and adult in Apple Health, Breast and Cervical Cancer Treatment program and Take Charge family planning

- Operations: Consists of centralized support functions that facilitate the operational effectiveness of the division including training development, quality assurance, and data support. Supports provider outreach and training, with a primary focus in assisting providers with Direct Date Entry in ProviderOne (P!), P! user maintenance, billing guide updates, and general assistance with Washington Apple Health procedures through the Provider Relations team.

g. Systems administration, including MMIS, eligibility systems

1. IT Innovation and Customer Experience Administration (ITICEA)

ITICEA focuses on leveraging technology and person-centered design principles to enhance internal and external customer service, as well as focusing on shaping the health care work force. ITICEA includes:

- Enterprise Technology Services Division
- Medicaid Customer Service Division

2. Enterprise Technology Services (ETS) division

ETS provides information technology (IT) systems and support to the agency. ETS includes:

- Application Services
- Enterprise Data Delivery / Enterprise Data Warehouse
- Infrastructure & End-User Services
- Medicaid Services
- ProviderOne Operations
- Public Employees Benefits & School Employees Benefits IT Services
- Security Services
- Services Capability Management & Business Analysis
- Strategic Services / Enterprise Architecture

3. Medicaid Customer Service Division (MCS)

Provides high-quality customer service to support clients' access to obtain health care, while also supporting the efficient utilization of Medicaid funding to provide care appropriately and efficiently. MCS includes:

- Coordination of Benefits (COB) & Claims Processing: Ensures Medicaid is the payer of last resort by preventing duplication of payment when more than one insurance plan or payer (other health insurance, personal injury, Medicare, etc.) covers a person. Responsible for providing timely and accurate adjudication of fee-for-service claims for providers who provide services to Medicaid clients.
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h. Other functions, e.g., TPL, utilization management (optional)

Office of Audit and Accountability (AUDIT)

The agency's internal audit function and serves as the primary point of contact for all external audits and regulatory reviews of agency operations. AA also houses the Improving Interoperability post-payment and public employee benefits audit functions.

2. Communications Division (COM)

Helps with internal & external communications, including strategic messaging & communications planning, media relations, constituent services, & visual communications, including forms and publications.

3. The Employee Resources Division (ERD)

Creates conditions that support the success of all HCA employees through thoughtful space use, relevant & accessible administrative policies, safe & healthy work environment, efficient mail & imaging processes, trainings that enrich the workforce, & a culture of equity & belonging.

ERD includes:

- Facilities
- Human Resources
- Diversity, Equity, and Inclusion
- Mail & Imaging Services
- Safety and Wellness

4. The Employees and Retirees Benefits (ERB) division

Provides insurance coverage for eligible public & school employees, COBRA & Continuation of Coverage members, retirees & their families through two separate employer sponsored insurance programs. Oversees the design, procurement, operations (eligibility & enrollment) of more than a dozen different types of insurance benefits, as well as communication, customer support, & marketing related to the programs. ERB includes:

- Benefit Accounts – Customer Service, ACA 1095 reporting, Outreach & Training (support to employers)
- Benefit Strategy & Design
- Portfolio Management & Monitoring
- Policy, Rules, & Compliance

5. Planning & Performance Division (PPD)

- Leads the agency's organizational development initiative
- Leads continuous improvement activities
- Leads the performance management system
- Conducts Quarterly Target Reviews

3. An organizational chart of the Medicaid agency has been uploaded:

Name	Date Created	
22-0016 Agency Administration Organization Chart	12/13/2022 10:15 AM EST	

Organization and Administration

MEDICAID | Medicaid State Plan | Administration | WA2022MS0004O | WA-22-0016

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B. Entities that Determine Eligibility or Conduct Fair Hearings Other than the Medicaid Agency

Title	Description of the functions the delegated entity performs in carrying out its responsibilities:
Single state agency under Title IV-A (TANF)	According to Washington State law and as permitted by Medicaid law, HCA & the Department of Social and Health Services (DSHS) have established an agreement regarding certain functions. This agreement defines the responsibilities of HCA, the Single State Agency, as the administrator of the Medicaid State Plan, and DSHS, Title IV-A Agency, as the representative of the agency's interest along with HCA, for the Medicaid program. HCA oversees & monitors the program functions delegated to DSHS. HCA delegates to DSHS the authority to determine eligibility for and to represent HCA's interest at administrative hearings (including expedited hearings) for eligibility regarding non-MAGI programs, including SSI & SSI-related programs for the Aged, Blind, or Disabled eligibility groups, Healthcare for Workers with Disabilities, Alien Emergency Medical for those not eligible under MAGI rules, the Medicare Savings Program, and long-term care programs.
The Social Security Administration	Pursuant to a 1634 agreement, the Department for Social Security Administration determines eligibility for Supplemental Security Income recipients.

Package Header

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Submission Type	Official	**Initial Submission Date**	10/3/2022
Approval Date	12/16/2022	**Effective Date**	10/1/2022
Superseded SPA ID	18-0017		
	User-Entered		

E. Coordination with Other Executive Agencies

The Medicaid agency coordinates with any other Executive agency related to any Medicaid functions or activities not described elsewhere in the Organization and Administration portion of the state plan (e.g. public health, aging, substance abuse, developmental disability agencies):.

(•) Yes

( ) No

Name of agency:	Description of the Medicaid functions or activities conducted or coordinated with another executive agency:
Department of Social and Health Services	Maintains the eligibility system of record for Medicaid & public assistance programs. In cases where DSHS takes action on behalf of HCA, the DSHS employee acts as an authorized agent (representative) of HCA. HCA delegates to DSHS the authority to administer the programs below. HCA retains policy making authority and responsibility to monitor & oversee DSHS' administration of these Medicaid services: * Eligibility determinations for non-MAGI-based programs (SSI & SSI-related programs for the aged, blind & disabled eligibility groups, Alien Emergency Medical for those not eligible under MAGI rules, the Medicare Savings Program, & long-term services and supports programs). • Residential Habilitation Centers/Public Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID) (42 CFR 483.400). • Section 1915(b), 1915(c) waivers (42 CFR 440.180), and 1115 waivers. Note: HCA maintains overall responsibility for all waivers; DSHS is the operating agency for certain waiver and State Plan services. • Privately operated, licensed boarding homes or nursing homes that have Medicaid certification as Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID) (42 CFR 483.400) • Home and Community-Based Services (HCBS) programs within the State, including Medicaid Personal Care and the Community First Choice Program • Certain Chronic Care Management services • Approved Medicaid grants and

Name of agency:	Description of the Medicaid functions or activities conducted or coordinated with another executive agency:
	demonstration projects. Note: HCA maintains overall responsibility for all Medicaid grants and demonstration projects; DSHS manages certain grant and project services. • Long-term Services and Supports (adult family homes, assisted living, enhanced services facilities, boarding homes, and the community residential services and support programs) and nursing facility services. DSHS will administer and pay for administrative and programmatic services related to long-term services and supports and nursing facility services • HCA recognizes DSHS as the State Survey Agency for Medicare and Medicaid Survey and Certification as described in the Federal State Operations Manual. State Medicaid Agency functions delegated to the DSHS State Survey Agency include: >Minimum Data Set (MDS) review & analysis for calculating case mix adjusted Medicaid rates >Administration of Medicaid enforcement & compliance remedies for deficient nursing facilities, including civil fines, collections, and formal & informal hearings as delegated to DSHS. > Quality Improvements & Evaluation System > The Quality Assurance Nurses (QAN) program, including case mix accuracy & utilization review of Nurse Aide registry (NATCEP) program > Investigation of allegations of resident/client abuse, neglect, or misappropriation of nursing facility, adult family home, assisted living, enhanced services facility residents, including findings, as appropriate > Licensing and oversight of licensed or certified long term serviced and supports providers including: Adult Family Homes, Assisted Living Facilities, Enhanced Services Facilities, and Supported Living providers.
Department of Commerce	Promotes sustainable community and economic development by administering over 100 programs and several state boards and commissions focused on helping communities achieve positive growth. Partners with HCA to administer the behavioral health ombudsman program.
Office of Administrative Hearings	Conducts all initial (first level) administrative hearings
Department of Health	Regulates provider licensure within scope-of-practice standards set in

Name of agency:	Description of the Medicaid functions or activities conducted or coordinated with another executive agency:
	state law & addresses population-based public health issues.
Department of Corrections	Partners with HCA and the Department of Labor & Industries in the HCA-administered Health Technology Assessment program and Prescription Drug Program which set common standards for evidence-based practices.
Office of the Insurance Commissioner	Regulates & oversees Washington State's health insurance industry, including the licensing & oversight of all carriers & assurance of consumer protections.

Organization and Administration

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F. Additional information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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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Medicaid State Plan Administration

Organization

Single State Agency Assurances

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A. Assurances

- [x] 1. The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.
- [x] 2. All requirements of 42 CFR 431.10 are met.
- [x] 3. There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with 42 CFR 431.12. All requirements of 42 CFR 431.12 are met.
- [x] 4. The Medicaid agency does not delegate, other than to its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.
- [x] 5. The Medicaid agency has established and maintains methods of personnel administration on a merit basis in accordance with the standards described at 5 USC 2301, and regulations at 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.
- [x] 6. All requirements of 42 CFR Part 432, Subpart B are met, with respect to a training program for Medicaid agency personnel and the training and use of sub-professional staff and volunteers.

B. Additional information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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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Submission - Summary

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Submission Type Official
Initial Submission Date 10/3/2022
Approval Date 12/16/2022
Effective Date N/A
Superseded SPA ID N/A

State Information

State/Territory Name: Washington
Medicaid Agency Name: Health Care Authority

Submission Component

- (•) State Plan Amendment
- (•) Medicaid
- ( ) CHIP

Submission - Summary

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SPA ID and Effective Date

SPA ID WA-22-0016

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Designation and Authority	10/1/2022	18-0017
Eligibility Determinations and Fair Hearings	10/1/2022	18-0017
Organization and Administration	10/1/2022	18-0017
Single State Agency Assurances	10/1/2022	18-0017

Submission - Summary

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Effective Date N/A
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Executive Summary

Summary Description Including Goals and Objectives SPA WA 22-0016 updates the agency administration information for Washington State's single state agency, the Health Care Authority.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2022	$0
Second	2023	$0

Federal Statute / Regulation Citation

1902(a) of the Act

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Submission - Summary

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Governor's Office Review

- ○ No comment
- ○ Comments received
- ○ No response within 45 days
- ◉ Other

Describe Exempt

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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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