DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region 10
2201 Sixth Avenue, MS/RX 43
Seattle, Washington 98121

DEC 28 2010

Susan Dreyfus, Secretary
Department of Social and Health Services
Post Office Box 45010
Olympia, Washington 98504-5010

RE: Washington State Plan Amendment (SPA) Transmittal Number 10-008

Dear Ms. Dreyfus:

The Centers for Medicare & Medicaid Services (CMS) Seattle Regional office has completed its review of State Plan Amendment (SPA) Transmittal Number 10-008. This amendment provides for a voluntary program entitled *Aging & Disability Services Chronic Care Program*, which provides interventions to enrollees who have one or more chronic medical conditions in addition to supporting the services needed by clients.

This SPA is approved effective April 1, 2010.

If you have any additional questions or require any further assistance, please contact me, or have your staff contact Gilson DaSilva at (206) 615-2065 or gilson.dasilva@cms.hhs.gov.

Sincerely,

Barbara K. Richards

Barbara K. Richards
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc:
Douglas Porter, Assistant Secretary, Medicaid Purchasing Administration
MaryAnne Lindeblad, Assistant Secretary, Aging and Disability Services Administration
Ann Meyers, State Plan Coordinator, Department of Social and Health Services

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: **10-008**

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
April 1, 2010

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:
Section 1937 of the Act, 42 CFR part 440

7. FEDERAL BUDGET IMPACT:
a. FFY 2010 $446,331
b. FFY 2011 $1,279,283

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 3.1-C pages 16 - 28

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Aging and Disability Services Chronic Care Management

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: Susan N. Dreyfus 6/7/10

13. TYPED NAME:
Susan N. Dreyfus

14. TITLE:
Secretary

15. DATE SUBMITTED:

16. RETURN TO:
Ann Myers
Department of Social and Health Services
Health and Recovery Services Administration
626 8th Ave SE MS: 45504
Olympia, WA 98504-5504

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: JUN 09 2010

18. DATE APPROVED: DEC 28 2010

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: APR 01 2010

20. SIGNATURE OF REGIONAL OFFICIAL: Barbara K. Richards for

21. TYPED NAME: Barbara K. Richards

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

23. REMARKS:

FORM HCFA-179 (07-92)

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State WASHINGTON

ALTERNATIVE BENEFITS

BENCHMARK BENEFIT PACKAGE/BENCHMARK EQUIVALENT BENEFIT PACKAGE

3.1 Amount, Duration, and Scope of Services

Medicaid is provided in accordance with the requirements of sections 1902(a), 1902(e), 1902(z), 1903(i), 1905(a), 1905(p), 1905(r), 1905(s), 1906, 1915, 1916, 1920, 1925, 1929, and 1933 of the Act; section 245(h) of the Immigration and Nationality Act; and 42 CFR Parts 431, 440, 441, 442, and 483

C. Benchmark Benefit Package and Benchmark Equivalent Benefit Package (provided in accordance with 1937 of the Act and 42 CFR Part 440).

The State elects to provide alternative benefits:

X Provided

¦ Not Provided

¦ Title of Alternative Benefit Plan A
¦ Title of Alternative Benefit Plan B
X Title of Alternative Benefit Plan C Aging and Disability Services Administration: *Chronic Care Management Program*

1. Populations and geographic area covered

The State will provide the benefit package to the following populations:

a) ¦ Populations who are full benefit eligibility individuals in a category established on or before February 8, 2006, that may be required to enroll in an alternative benefit plan to obtain medical assistance.
(Note: Populations listed in section 1b. may not be required to enroll in a benchmark plan, even if they are part of an eligibility group included in 1a.)

For full benefit Medicaid eligibility groups included in the alternative benefit plan, please indicate in the chart below:

- Each eligibility group the state will require to enroll in the alternative benefit plan;
- Each eligibility group the state will allow to voluntarily enroll in the alternative benefit plan;
- Specify any additional targeted criteria for each included group (e.g., income standard);
- Specify the geographic area in which each group will be covered.

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Required Enrollment	Opt-In Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
		Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance		
		Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV)		
		Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI)		
		Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII)		
		Other mandatory categorically needy groups eligible under 1902(a)(10)(A)(i) as listed below and include the citation from the Social Security Act for each eligibility group: • •		
		Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX)		
		Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX)		
		Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)		
		Medicaid expansion/optional targeted low-income children eligible under 1902(a)(10)(A)(ii)(XIV)		
		Other optional categorically needy groups eligible under 1902(a)(10)(A)(ii) as listed below and include the citation from the Social Security Act for each eligibility group: • •		

b) X The following populations will be given the option to voluntarily enroll in an alternative benefit plan.

Please indicate in the chart below:

- Each eligibility group the state will allow to voluntarily enroll in the alternative benefit plan,
- Specify any additional targeted criteria for each included group (e.g., income standard).
- Specify the geographic area in which each group will be covered.

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Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	Mandatory categorically needy low-income parents eligible under 1931 of the Act		
	Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i):		
X	Individuals qualifying for Medicaid on the basis of blindness	Categorically needy adults aged 21 and older, who are currently receiving home and community-based long-term care services. Eligible enrollees are identified by the Department as being at risk for having future high medical expenses. These are high risk individuals with complex medical needs and may be diagnosed with one or more of the following chronic medical conditions: diabetes, heart failure, coronary artery disease, cerebrovascular disease, renal failure, chronic pain associated with musculoskeletal conditions and other chronic illness including fibromyalgia, cancer, chronic respiratory conditions (asthma/COPD), depression and morbid obesity. Based on the Department's CARE assessment, enrollees must also meet one of the following five risk factors: *Living alone in their own home; *Experiencing isolating moods and behaviors (agitated and irritable); *Self rating of health as fair or poor; *Deteriorated self-sufficiency; or *Having more than eight (8) medications. (continued below)	Statewide

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Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
		The eligible population will exclude Individuals: *Under age 21; *Eligible for enrollment in the Department's Healthy Options managed care program; *Receiving hospice services; *Receiving case management services for HIV/AIDS; *Who are pregnant; *With Third Party Coverage that provides a comparable service; *Who become eligible for Medicare coverage; or *Individuals enrolled in another managed care program or other chronic care management program.	
X	Individuals qualifying for Medicaid on the basis of disability	Categorically needy adults aged 21 and older, who are currently receiving home and community-based long-term care services. Eligible enrollees are identified by the Department as being at risk for having future high medical expenses. These are high risk individuals with complex medical needs and may be diagnosed with one or more of the following chronic medical conditions: diabetes, heart failure, coronary artery disease, cerebrovascular disease, renal failure, chronic pain associated with musculoskeletal conditions and other chronic illness including fibromyalgia, cancer, chronic respiratory conditions (asthma/COPD), depression and morbid obesity. Based on the Department's CARE assessment, enrollees must also meet one of the following five risk factors: (continued below)	Statewide

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Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
		*Living alone in their own home; *Experiencing isolating moods and behaviors (agitated and irritable); *Self rating of health as fair or poor; *Deteriorated self-sufficiency; or *Having more than eight (8) medications. The eligible population will exclude Individuals: *Under age 21; *Eligible for enrollment in the Department's Healthy Options managed care program; *Receiving hospice services; *Receiving case management services for HIV/AIDS; *Who are pregnant; *With Third Party Coverage that provides a comparable service; *Who become eligible for Medicare coverage; or *Individuals enrolled in another managed care program or other chronic care management program.	
	Individuals who are terminally ill and receiving Medicaid hospice benefits under 1902(a)(10)(A)(ii)(vii)		
	Institutionalized individuals assessed a patient contribution towards the cost of care		
	Individuals dually eligible for Medicare and Medicaid		
	Disabled children eligible under the TEFRA option - section 1902(e)(3)		

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Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
X	Medically frail and individuals with special medical needs	Categorically needy adults aged 65 and older, who are currently receiving home and community-based long-term care services. Eligible enrollees are identified by the Department as being at risk for having future high medical expenses. These are high risk individuals with complex medical needs and may be diagnosed with one or more of the following chronic medical conditions: diabetes, heart failure, coronary artery disease, cerebrovascular disease, renal failure, chronic pain associated with musculoskeletal conditions and other chronic illness including fibromyalgia, cancer, chronic respiratory conditions (asthma/COPD), depression and morbid obesity. Based on the Department's CARE assessment, enrollees must also meet one of the following five risk factors: *Living alone in their own home; *Experiencing isolating moods and behaviors (agitated and irritable); *Self rating of health as fair or poor; *Deteriorated self-sufficiency; or *Having more than eight (8) medications. <u>The eligible population will exclude Individuals:</u> *Under age 21; *Eligible for enrollment in the Department's Healthy Options managed care program; *Receiving hospice services; *Receiving case management services for HIV/AIDS; *Who are pregnant; *With Third Party Coverage that provides a comparable service; *Who become eligible for Medicare coverage; or *Individuals enrolled in another managed care program or other chronic care management program.	Statewide

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Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	Children receiving foster care or adoption assistance under title IV-E of the Act		
	Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII)		
	Individuals eligible as medically needy under section 1902(a)(10)(C)(i)(III)		
	Individuals who qualify based on medical condition for long term care services under 1917(c)(1)(C)		

Limited Services Individuals

	TB-infected individuals who are eligible under 1902(a)(10)(A)(ii)(XII)		
	Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v)		

c) For optional populations/individuals (checked above in 1a. & 1b.), describe in the text box below the manner in which the State will inform each individual that:

- Enrollment is voluntary;
- Each individual may choose at any time not to participate in an alternative benefit package; and
- Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State plan.

Eligible individuals voluntarily enroll in the Chronic Care Management Program and have the ability to decline participation in the program or to disenroll from the program at any time.

Potential enrollees are referred to chronic care management by the Department's referral and enrollment process or by Department case managers or providers in other settings. When an eligible individual is referred to the chronic care management program, the contractor's staff contacts the potential enrollee to describe the program and obtain the individual's consent to participate in the program. After consenting to enroll in the program, the enrollee and the nurse care manager develop a health action plan. The enrollee may choose to involve the enrollee's caregivers, family, primary care provider, and others in the plan development. Enrollees who opt into this alternate benefits program are informed by the nurse care manager that the program is optional and that they may opt out at any time.

Individuals who choose to participate in the program maintain eligibility for the regular Medicaid Benefit at all times.

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2. Description of the Benefits

X The State will provide the following alternative benefit package (check the one that applies).

a) X Benchmark Benefits

FEHBP-equivalent Health Insurance Coverage – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(l) of Title 5, United States Code.

State Employee Coverage – A health benefits coverage plan that is offered and generally available to State employees within the State involved.

In the text box below please provide either a World Wide Web URL (Uniform Resource Locator) link to the State's Employee Benefit Package or insert a copy of the entire State's Employee Benefit Package.

Coverage Offered Through a Commercial Health Maintenance Organization (HMO) – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State involved.

In the text box below please provide either a World Wide Web URL link to the HMO's benefit package or insert a copy of the entire HMO's benefit package.

X **Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide a full description of the benefits in the plan, including any applicable limitations. Also include a benefit by benefit comparison to services in the State plan or to services in any of the three Benchmark plans above.

In addition to all regular Medicaid program benefits, the alternative benefit identifies enrollees who have one or more chronic medical conditions, targets them for intervention, provides a system to ensure the interventions occur, and coordinates with other health care providers to ensure the enrollee gets needed services. The benefit package provides nursing assessment, health education regarding chronic conditions, medication education, education on appropriate use of health care resources, early recognition of changes in health condition, self-management skills, "translation" of primary care provider treatment plan, and linkage to the PCP office. Additionally, the program provides assistance to enrollees in locating a primary care provider and coordinates with the long term care case manager to access mental health and/or chemical dependency treatment services. CCM services will be provided through 12 PAHP contractors, located throughout the state.The CCM services are described below:

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1. *After enrollment in the program:*
   a. *The licensed nurse care manager screens and assesses the new enrollee for risk factors, health status, self-management skills and confidence level, knowledge of the enrollee's treatment plan, knowledge of and adherence to prescribed medications.*
   b. *Based on the assessment, the nurse care manager and the enrollee develop a Health Action Plan. The enrollee may choose to involve the enrollee's caregivers, family, primary care provider, and others in the plan development.*
   c. *The Health Action Plan is an enrollee-centered care plan identifying health-related problems, interventions, and goals. The plan is based on the enrollee's specific needs, including language barriers, mental health and chemical dependency needs.*
   d. *The plan includes education about self-management, effective use of medical and social services resources, how to navigate the health care system, and how to work with the enrollee's provider to develop a plan of care and achieve self-identified health goals.*

2. *After the Health Action Plan has been developed and agreed to by the enrollee, the nurse care manager coaches the enrollee evaluates the enrollee's response to the plan, and provides instructions for self-management.*

3. *Contact with the enrollee is in person and by telephone, dependent on the needs of the enrollee. Services may be provided in the following settings:*
   a. *The enrollee's home;*
   b. *The enrollee's PCP office or other healthcare setting; or*
   c. *Another setting selected by the enrollee.*

4. *When needed, the nurse care manager will coordinate with providers in the health system to assist the enrollee to access services as well as coordinate with the long term care case manager to access services such as mental health or chemical dependency treatment.*

5. *The frequency of contact between the nurse care manager and the enrollee, beyond the required monthly contact, is determined by the enrollee's level of need. The nurse care manager is required to meet with enrollees on a face-to-face basis if it is not possible to reach the enrollee by telephone, or if the enrollee is unable to participate by telephone.*

   The nurse care manager is also required to maintain contact with the enrollee's primary providers and other health care specialists to exchange information and updates on the enrollee's conditions. This may be accomplished in the following ways:

   a. *Accompany the enrollee to periodic medical appointments to ensure the enrollee knows how to ask appropriate questions and utilize the information provided by the practitioner; and/or*
   b. *Maintain telephonic or other forms of contact with the provider to ensure that both parties are aware of changes in the enrollee's condition or treatment plan.*

6. *All chronic care management services, including the evaluation of predictive risk factors, health action plan development, education and monitoring, and assistance in coordinating services with other systems, will be provided by a Registered Nurse, with support from other health and social services providers as needed.*

7. *Data collection and analysis will be performed by the State. Process measures will be performed by the State and the PAHP. Measures include medical and HCBS costs and health-related outcomes.*

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b) ¦ Benchmark-Equivalent Benefits.

Specify which benchmark plan or plans this benefit package is equivalent to:

(i) Inclusion of Required Services – The State assures the alternative benefit plan includes coverage of the following categories of services: (Check all that apply).

¦ Inpatient and outpatient hospital services;

¦ Physicians' surgical and medical services;

¦ Laboratory and x-ray services;

¦ Well-baby and well-child care services as defined by the State, including age-appropriate immunizations in accordance with the Advisory Committee on Immunization Practices;

¦ Other appropriate preventive services including emergency services and family planning services included under this section.

(ii) ¦ Additional services ☐

Insert a full description of the benefits in the plan including any limitations.

(iii) ¦ The State assures that the benefit package has been determined to have an aggregate actuarial value equivalent to the specified benchmark plan in an actuarial report that:

- Has been prepared by an individual who is a member of the American Academy of Actuaries;
- Using generally accepted actuarial principles and methodologies;
- Using a standardized set of utilization and price factors;
- Using a standardized population that is representative of the population being served;
- Applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
- Takes into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

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Insert a copy of the report.

iv ¦ The State assures that if the benchmark plan used by the State for purposes of comparison in establishing the aggregate value of the benchmark-equivalent package includes any of the following four categories of services, the actuarial value of the coverage for each of these categories of services in the benchmark-equivalent coverage package is at least 75 % of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State:

- Prescription drugs;
- Mental health services;
- Vision services, and/or
- Hearings services,

In the text box below provide a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c) ___ Additional Benefits

___ Insert a full description of the additional benefits including any limitations.

¦ Other Additional Benefits (If checked, please describe)

3. Service Delivery System

Check all that apply.

¦ The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider.

¦ The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1905(a)(25) and 1905(t).

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¦ The alternative benefit plan will be provided through a managed care organization consistent with applicable managed care requirements (42 CFR 438, 1903(m), and 1932).

¦ The alternative benefit plan will be provided through PIHPs (Pre-paid Inpatient Health Plan) consistent with 42 CFR 438.

X The alternative benefit plan will be provided through PAHPs (Pre-paid Ambulatory Health Plan).

Alternative benefit services are offered through Prepaid Ambulatory Health Plan (PAHP) contracts between chronic care management providers and the state. The reimbursement rates for services provided through the PAHP have been actuarially certified. All other Medicaid State Plan services are provided via the state's fee-for-service system and Regional Support Network for Mental Health Services.

¦ The alternative benefit plan will be provided through a combination of the methods described above. Please describe how this will be accomplished.

4. Employer Sponsored Insurance

¦ The alternative benefit plan is provided in full or in part through premiums paid for an employer sponsored health plan.

5. Assurances

___ The State assures EPSDT services will be provided to individuals under 21 years old who are covered under the State Plan under section 1902(a)(10)(A).

¦ Through Benchmark only

¦ As an Additional benefit under section 1937 of the Act

X The State assures that individuals will have access to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

X The State assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Act.

X The State assures transportation (emergency and non-emergency) for individuals enrolled in an alternative benefit plan. Please describe how and under which authority(s) transportation is assured for these beneficiaries

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Enrollee transportation to and from Medicaid services is provided through the transportation services program derived from and authorized under the State Plan Attachment 3.1-A page 62 Section 24, Transportation. Transportation is provided through a statewide system of transportation brokers.

6. Economy and Efficiency of Plans

X The State assures that alternative benefit coverage is provided in accordance with Federal upper payment limits, procurement requirements, and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

7. Compliance with the Law

X The State will continue to comply with all other provisions of the Social Security Act in the administration of the State plan under this title.

8. Implementation Date

X The State will implement this State Plan amendment on *April 1, 2010*.