



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

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

JUN 28 2007

Robin Arnold-Williams, Secretary  
Department of Social and Health Services  
Post Office Box 45010  
Olympia, Washington 98504-5010

**RE: Washington State Plan Amendment 07-002**

Dear Ms. Arnold-Williams:

The Centers for Medicare & Medicaid Services (CMS) has completed our review of State Plan Transmittal Number 07-002. This State Plan Amendment establishes a benchmark benefits package that provides disease management services in addition to the other Medicaid services offered for adult Medicaid recipients with complex medical needs who are diagnosed with certain chronic medical conditions.

In accordance with this State Plan Amendment, the State will provide the disease management services through two prepaid ambulatory health plan contracts with United Healthcare Services, Inc., and the City of Seattle. CMS will conduct its review of these contracts separately from approval of this State Plan Amendment. All other services will be provided as fee-for-service and reimbursed as described in Washington's Medicaid State Plan.

This Plan amendment is approved effective January 1, 2007, as requested by the State.

If you have any questions concerning this State Plan Amendment, please contact Jan Mertel at (206) 615-2317 or [Jan.Mertel@cms.hhs.gov](mailto:Jan.Mertel@cms.hhs.gov).

Sincerely,

Karen S. O'Connor  
Associate Regional Administrator  
Division of Medicaid and Children's Health  
Operations

cc:

Douglas Porter, Assistant Secretary, HRSA  
Alison Robbins, Contracts Manager  
Alice Lind, Office Chief - Care Coordination  
Ann Myers, State Plan Coordinator

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:  
**07-002**

2. STATE  
Washington

FOR: HEALTH CARE FINANCING ADMINISTRATION

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  
Jan. 1, 2007

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:

7. FEDERAL BUDGET IMPACT:

a. FFY 2007 \$0 (Jan. - September) \$1.67 million

b. FFY 2008 \$0 (October - September) \$3.43 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  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

3.1-C pages 2 through ~~8~~ (P+I)  
10 (P+I)

10. SUBJECT OF AMENDMENT:

Chronic Care Management (Disease management) (P+I)

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:

*Blake P. Howard*

16. RETURN TO:

Ann Myers  
Department of Social and Health Services  
Health and Recovery Services Administration  
626 8<sup>th</sup> Street MS: 45504  
Olympia, WA 98504-5504

13. TYPED NAME:

ROBIN ARNOLD-WILLIAMS

14. TITLE:

Secretary

15. DATE SUBMITTED:

March 29, 2007

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

MAR 29 2007

18. DATE APPROVED:

JUN 28 2007

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:

JAN - 1 2007

20. SIGNATURE OF REGIONAL OFFICIAL:

*Karen S. O'Connor by JAS*

21. TYPED NAME:

KAREN S. O'CONNOR

22. TITLE:

Associate Regional Administrator

23. REMARKS:

Division of Medicaid &  
Children's Health

Pen+Inc change authorized by the state on 4/2/07. (gm)

Pen+Inc changes authorized by the state on 5/23/07.

Pen+Inc change authorized by the state on 6/27/07.

" " " " " " 6/27/07 (block 7 - Apr. changed to January)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**ALTERNATIVE BENEFITS**

**BENCHMARK BENEFIT PACKAGE/BENCHMARK EQUIVALENT BENEFIT PACKAGE**

1937(a), X The State elects to provide alternative benefits under Section 1937 of the  
1937(b) Social Security Act.

**A. Populations**

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

- a.    Required Populations who are full benefit eligible individuals in a category established on or before February 8, 2006, will be required to enroll in an alternative benefit package to obtain medical assistance except if within a statutory category of individuals exempted from such a requirement.

List the population(s) subject to mandatory alternative coverage:

\_\_\_\_\_  
\_\_\_\_\_

- b. X Opt-In Populations who will be offered opt-in alternative coverage and who will be informed of the available benefit options prior to having the option to voluntarily enroll in an alternative benefit package.

List the populations/individuals who will be offered opt-in alternative coverage:

*Categorically Needy - Aged, Blind and Disabled adults aged 21 and over, as described in Section 1902(a)(10)(i)(ii) of the Social Security Act, who are currently receiving services via the fee-for-service system. These are high risk clients with complex medical needs and are diagnosed with one 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 migraine, cancer, chronic respiratory conditions including asthma and/or COPD, hematological conditions such as hemophilia, and co-morbid depression and/or anxiety.*

*Contractors will accept eligible clients in the order in which they request enrollment in the program. No eligible client will be refused enrollment in the disease management program.*

*The program is being phased in by large groups of clients (1000 per quarter in King County, 4000 per quarter statewide), which will allow careful implementation and evaluation of the program. (See attached approval from the Institutional Review Board).*

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**ALTERNATIVE BENEFITS**

**BENCHMARK BENEFIT PACKAGE/BENCHMARK EQUIVALENT BENEFIT PACKAGE**

A. Populations (contd)

For the opt-in populations/individuals, describe the manner in which the State will inform each individual that such enrollment is voluntary, that such individual may opt out of such alternative benefit package at any time and regain immediate eligibility for the regular Medicaid program under the State plan.

*Eligible individuals are encouraged to participate in the program through mailings from the state and the Disease Management (DM) contractors, and telephonic outreach by the DM contractors. Individuals who choose to participate in the opt-in program maintain eligibility for the regular Medicaid benefits at all times. The opt-in program adds additional disease management services for individuals determined to be in the high-risk group described above.*

For the opt-in populations/individuals, provide a description of the benefits available under the alternative benefit package and a comparison of how they differ from the benefits available under the regular Medicaid program, as well as an assurance that the State will inform each individual of this information.

*In addition to all regular Medicaid program benefits, the alternative benefit package includes disease management services, such as basic information about the client's disease(s), education in how to manage their condition, regularly scheduled telephonic care management and support, and assistance to enrollees in locating a primary care provider. Services are provided as follows:*

1. *When an eligible client is referred to the disease management contractor, the licensed nurse care manager:*
  - a. *Calls the client to describe the program and obtain the client's assent to participate in the program. Client is enrolled;*
  - b. *Screens and assesses the new enrollee for risk factors, health status, self-management skills, adherence to the client's treatment plan, knowledge of and adherence to prescribed medications.*
  - c. *Based on the assessment, the nurse care manager develops a six-month care plan in coordination with the client's caregivers and Primary Care Provider. The plan is based on the client's specific needs, including language barriers, mental health needs, multiple medications and others.*

*The plan includes education about self-management, appropriate use of resources, how to navigate the health care system and how to work with the client's provider to develop a plan of care and adhere to that plan, and is developed in coordination with the client and the client's family/caregivers and provider.*

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**ALTERNATIVE BENEFITS**

**BENCHMARK BENEFIT PACKAGE/BENCHMARK EQUIVALENT BENEFIT PACKAGE**

A. Populations (cont)

2. *After the care plan has been developed and agreed to by the enrollee, the nurse care manager monitors the client via telephone calls and face-to-face contact (if necessary) to ensure the enrollee understands the plan and is adhering to it and to provider instructions for care.*
3. *The nurse care manager will ensure that the enrollee's PCP and other providers are aware of the care plan and will update providers about the enrollee's progress in adhering to the plan. Local care management nurses will remain in contact with providers through the medical home project to ensure enrollee compliance with the care plan and PCP instructions.*
4. *If the enrollee needs help in accessing services through another service system, such as mental health or chemical dependency services, the nurse care manager or a licensed social worker will provide assistance to the enrollee in accessing such services by coordinating with providers in the other system.*
5. *The majority of disease management interventions will be provided telephonically by nurse care managers. The standard call frequency is once per month; however, schedules for calls are based on enrollee need and may occur more frequently. Both the statewide and local contractors are required to meet with enrollees on a face-to-face basis if it is not possible to reach enrollees by telephone, or if the enrollee is unable to participate by telephone.*
6. *In the local disease management program, the nurse care manager is required accompany each enrollee to at least one doctor visit to ensure the enrollee knows how to ask appropriate questions and use the information provided by the doctor.*

*The State anticipates that approximately 10,000 clients will be served through the medical home (primary care) component of the project and approximately 5,000 will be served through the disease management component.*

*All disease management services, including the health risk assessment, care plan development, education and monitoring, and assistance in coordinating services with other systems, will be provided by a Registered Nurse or licensed Social Worker.*

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**ALTERNATIVE BENEFITS**

**BENCHMARK BENEFIT PACKAGE/BENCHMARK EQUIVALENT BENEFIT PACKAGE**

A. Populations (cont)

*Note: For the purposes of this program, "Medical Home" is defined as "an approach to providing health care services in a high quality and cost-effective manner. The care provided through a medical home is accessible, family-centered, comprehensive, continuous, coordinated, compassionate and culturally competent. A medical home is a system of care that includes the medical provider but may also include other ancillary services, care management services, and the enrollee's family."*

c.  Geographical Classification

States can provide for enrollment of populations on a statewide basis, regional basis, or county basis.

*Services under this alternative benefit package are available statewide.*

List any geographic variations:

*The State intends to contract with one Statewide Care Management (SCM) contractor, who will identify eligible clients using predictive modeling and will provide nurse care management and medical home assistance to high-risk clients. Additionally, the State will contract with Local Care Management (LCM) program(s) that will provide nurse care management services on a local level, and will provide medical home support services to providers who serve eligible individuals, as well as assisting all eligible individuals who do not have a medical home to find one.*

Please provide a chart, listing eligible populations (groups) by mandatory enrollment, opt-in enrollment, geography limitations, or any other requirements or limitations.

*All clients in the Aged, Blind and Disabled Categorically Needy eligibility group are eligible for the alternative benefit package of services. All enrollment is voluntary (opt-in). There are no geographical limitations other than the differences described above. Dual eligible Medicare clients will be phased in to the program as the new information system ("ProviderOne") allows for enrollment.*

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**ALTERNATIVE BENEFITS**

**BENCHMARK BENEFIT PACKAGE/BENCHMARK EQUIVALENT BENEFIT PACKAGE**

**B. Description of the Benefits**

The State will provide the following alternative benefit packages (check all that apply).

1937(b) 1.  Benchmark Benefits

a.  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.

b.  State Employee Coverage – A health benefits coverage plan that is offered and generally available to State employees within the State involved. Attach a copy of the State's employee benefits plan package.

c.  Coverage Offered Through a 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. Attach a copy of the HMO's benefit package.

d.  Secretary-approved Coverage – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide a description of the State's plan. Provide a full description of the benefits package including the benefits provided and any applicable limits.

*The alternative benefits package includes all Medicaid State Plan services, plus disease management services and assistance in locating a primary care provider for clients in the high-risk group. Disease management services include a nurse advice line and education and disease management services. Washington's disease management program is designed to help patients better understand and manage their chronic health condition(s)(including diabetes, heart failure and respiratory conditions) through education, lifestyle changes and adherence to a prescribed plan of care, and to provide assistance to patients in accessing needed services. The purpose of the program is to support patients and providers in reinforcing patient adherence to their plan of care.*

The covered State plan services supported by this program are those specified and limited in Attachment 3.1-A, Amount, Duration and Scope of Services, Categorically Needy.

2.  Benchmark-Equivalent Benefits.

Specify which benchmark plan or plans this benefit package is equivalent to, and provide the information listed above for that plan: \_\_\_\_\_.

a.  The State assures that the benefit package(s) have been determined to have an actuarial value equivalent to the specified benchmark plan or plans in an actuarial report that: 1) has been prepared by an individual who is a member of the American Academy of Actuaries; 2) uses generally accepted actuarial principles and

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**ALTERNATIVE BENEFITS**

**BENCHMARK BENEFIT PACKAGE/BENCHMARK EQUIVALENT BENEFIT PACKAGE**

B. Description of the Benefits (cont)

methodologies; 3) uses a standardized set of utilization and price factors; 4) uses a standardized population that is representative of the population being served; 5) applies 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 6) 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. Attach a copy of the report.

b.  The State assures that if the State provides additional services under the benchmark benefit package(s) from any one of all the following categories: 1) prescription drugs; 2) mental health services; 3) vision services, and/or 4) hearings services, the coverage of the related benchmark-equivalent benefit package(s) will have an actuarial value that is at least 75 percent of the actuarial value of the coverage of that category of services included in the benchmark benefit package. Attach 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.  The State assures that the actuarial report will select and specify the standardized set and populations used in preparing the report.

(1)  Inclusion of Basic Services – This coverage includes benefits for items and services within the following categories of basic 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, as designated by the Secretary.
- Clinic services (including health center services) and other ambulatory health care services.
- Federally qualified health care services
- Rural health clinic services
- Prescription drugs
- Over-the-counter medications
- Prenatal care and pre-pregnancy family services and supplies

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**BENCHMARK BENEFIT PACKAGE/BENCHMARK EQUIVALENT BENEFIT PACKAGE**

B. Description of the Benefits (cont)

- Inpatient Mental Health Services not to exceed 30 days in a calendar year
  - Outpatient mental health services furnished in a State-operated facility and including community-based services
  - Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices)
  - Disposable medical supplies including diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formulas and dietary supplements.
  - Nursing care services, including home visits for private duty nursing, not to exceed 30 days per calendar year
  - Dental services
  - Inpatient substance abuse treatment services and residential substance abuse treatment services not to exceed 30 days per calendar year
  - Outpatient substance abuse treatment services
  - Case management services
  - Care coordination services
  - Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
  - Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services.
  - Premiums for private health care insurance coverage
  - Medical transportation
  - Enabling services (such as transportation, translation, and outreach services
  - Any other health care services or items specified by the Secretary and not included under this section
- (2) Additional benefits for voluntary opt-in populations:
- Home and community-based health care services
  - Nursing care services, including home visits for private duty nursing

Attach a copy of the benchmark-equivalent plan(s) including benefits and any applicable limitations.

3. Wrap-around/Additional Services

a.  The State assures that wrap-around or additional benefits will be provided for individuals under 19 who are covered under the State plan under section 1902(a)(10)(A) to ensure early and periodic screening, diagnostic and treatment (EPSDT) services are provided when medically necessary. Wrap-around benefits must be sufficient so that, in combination with the benchmark or benchmark-equivalent benefits package, these individuals receive the full EPSDT benefit, as medically necessary. Attach a description of the manner in which wrap-around or additional services will be provided to ensure EPSDT services are provided when medically necessary (as determined by the State).

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**ALTERNATIVE BENEFITS**

**BENCHMARK BENEFIT PACKAGE/BENCHMARK EQUIVALENT BENEFIT PACKAGE**

B. Description of the Benefits (cont)

b.  The State has elected to also provide wrap-around or additional benefits.

Attach a list of all wrap-around or additional benefits and a list of the populations for which such wrap-around or additional benefits will be provided.

*The following services will be provided for all eligible Aged, Blind and Disabled, Categorically Needy clients, age 21 and over:*

- 1) *Identification of clients with complex medical needs, including chronic conditions such as heart failure, diabetes, and respiratory conditions using predictive modeling.*
- 2) *Referral of identified clients to either local or statewide program, depending on the client's location.*
- 3) *Health risk assessment and development of care plan, based on the client's desire to participate in the program and the client's identified needs;*
- 4) *Assistance to clients in:*
  - a. *Locating a medical home (Primary Care Provider) and learning to use the medical home appropriately;*
  - b. *Improving health outcomes using evidence-based medicine; and*
  - c. *Preventing avoidable medical costs through improved self-management skills.*
- 5) *Offering support to potential providers to enable them to accept new clients. The support of medical home development includes sharing information with providers about their Disease Management population, supporting the use of client registries to allow improved tracking of preventive measures provided to clients with chronic illness, receiving referrals directly from providers for clients with high-risk disease states, exchanging care plan information to improve symptom management and avoidance of emergency department services, and providing direct feedback on quality of care provided for Disease Management clients.*

**C. Service Delivery System**

Check all that apply.

1.  The alternative benefit package will be furnished 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.
2.  The alternative benefit package will be furnished 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 1915(b)(1).
3.  The alternative benefit package will be furnished through a managed care entity consistent with applicable managed care requirements.
4.  Alternative benefits provided through premium assistance for benchmark-equivalent in employer-sponsored coverage.

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**ALTERNATIVE BENEFITS**

**BENCHMARK BENEFIT PACKAGE/BENCHMARK EQUIVALENT BENEFIT PACKAGE**

C. Service Delivery System (cont)

5.  Alternative benefits will be provided through a combination of the methods described in items 1-4. Please specify how this will be accomplished.

*Alternative benefit services for Disease Management will be offered through Prepaid Ambulatory Health Plans (PAHPs) under contract with the state. All other Medicaid State Plan services will be provided via the state's fee-for-service system.*

D. Additional Assurances

a.  The State assures that individuals will have access, through benchmark coverage, benchmark-equivalent coverage, or otherwise, 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).

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

E. Cost Effectiveness of Plans

Benchmark or benchmark-equivalent coverage and any additional benefits must be provided in accordance with economy and efficiency principles.

F. Compliance with the Law

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.

G. Implementation Date

The State will implement this State Plan amendment on January 1, 2007.