DEPARTMENT OF HEALTH & HUMAN SERVICES **Centers for Medicare & Medicaid Services**

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

APR 1 2 2012

Douglas Porter, Director
Health Care Authority
Post Office Box 45502
Olympia, Washington 98504-5010

RE: Washington State Plan Amendment (SPA) Transmittal Number 11-013

Dear Mr. Porter:

The Centers for Medicare & Medicaid Services (CMS) Seattle Regional Office has completed its review of State Plan Amendment (SPA) Transmittal Number 11-013. This amendment is a technical correction to the Medicaid State plan and makes no program or financial changes.

Washington submitted this SPA in response to a companion letter issued in 2011. As you are aware, when the State converted its Managed Care program from operating under 1915(b) waiver authority to operating under 1932(a) State plan authority in 2003, it had not used a preprint to document Healthy Options, the State's Medicaid Managed Care program. The 2011 companion letter required the State to submit an amendment documenting the Healthy Options program using the appropriate preprint.

This SPA is approved effective October 1, 2011.

If you have any questions or require any further assistance, please contact me, or have your staff contact Tania Seto at (206) 615-2343 or Tania.Seto@cms.hhs.gov.

Sincerely,

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

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: **11-13**

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: Oct. 1, 2011

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 2013 $0
b. FFY 2014 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attach 3.1-F, Part 2, pgs 1-13 (new) (P&I)
~~Att. 3.1-F pp. 13 – 25 (new)~~ remove (P&I)
~~Supplement A to Att. 3.1-F pp. 1, 2 (new)~~ **remove (P&I)**
~~Attachment 3.1-F, Part 2, 13-25(new)(P&I)~~
~~Supplement A to Attach 3.1-F, pgs 1-2 (new)(P&I)~~
Supplement A to Attach. 3.1-F, Part 2, pg 1&2(new) (P&I)

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:

Health Options Managed Care

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: [signature]

13. TYPED NAME:
Doug Porter

14. TITLE:
Director, Health Care Authority

15. DATE SUBMITTED:
9-29-11

16. RETURN TO:
Ann Myers
Health Care Authority
626 8th Ave SE MS: 45504
POB 5504
Olympia, WA 98504-5504

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 29, 2011

18. DATE APPROVED: **APR 12 2012**

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: **OCT 01 2011**

20. SIGNATURE OF REGIONAL OFFICIAL: [signature]

21. TYPED NAME: Carol J. C. Peverly

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

23. REMARKS:

1/23/2012 - Pen & Ink changes authorized by the State (block 8).

3/12/12 - Pen & Ink changes authorized by state (Box 8)
3/14/12 - Pen & Ink changes authorized to box 8

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

HEALTHY OPTIONS (HO)

Citation	Condition or Requirement
1932(a)(1)(A)	A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Washington enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of “special needs” beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with

_X_ i. MCOs
____ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

____ i. fee for service;
_X_ ii. capitation;
____ iii. a case management fee;
____ iv. a bonus/incentive payment;
____ v. a supplemental payment, or
____ vi. other. (Please provide a description below).

Note: In addition to the capitation payment the State makes a one-time payment for labor and delivery called the Delivery Case Rate (DCR). The DCR is considered with the overall rate in the certification of actuarial soundness.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

HEALTHY OPTIONS (HO)

Citation		Condition or Requirement
1905(t) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv)	3.	For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.

If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

____i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.

____ii. Incentives will be based upon specific activities and targets.

____iii. Incentives will be based upon a fixed period of time.

____iv. Incentives will not be renewed automatically.

____v. Incentives will be made available to both public and private PCCMs.

____vi. Incentives will not be conditioned on intergovernmental transfer agreements.

_X_ vii. Not applicable to this 1932 state plan amendment.

42 CFR 438.50(b)(4)

4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)*

The state utilizes the following processes, meetings and correspondence to invite stakeholder input to managed care activities:

- *Statewide Title XIX committee meetings.*
- *Monthly open public meetings focusing on the MCO's who provide Healthy Options services but open to anyone.*
- *Public website providing information about Healthy Options updates and program changes.*
- *Regular consultation with American Indian/Alaska Native tribal organizations and clinics on all program changes.*
- *Notification of a comprehensive list of stakeholders about changes in the Healthy Options program.*
- *Notification of enrollees about all proposed substantive changes to the program regarding benefits, administration of benefits (i.e. grievance and appeals, authorizations and denials), service area, or enrollment.*

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

HEALTHY OPTIONS (HO)

Citation	Condition or Requirement
1932(a)(1)(A)	5. The state plan program will__/will not _X_ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory_____/ voluntary_X_ enrollment will be implemented in the following county/area(s): *See Supplement A to Att. 3.1-F Part 2* i. county/counties (mandatory)________ ii. county/counties (voluntary)________ iii. area/areas (mandatory)________ iv. area/areas (voluntary) ________
	C. State Assurances and Compliance with the Statute and Regulations. If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.
1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)	1. _X_The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2. ____The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3. _X_The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.
1932(a)(1)(A 42 CFR 431.51 1905(a)(4)(C)	4. _X_The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5. _X_The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) CFR 438.6(c) 42 CFR 438.50(c)(6)	6. _X_The state assures that all applicable requirements of 42 CFR 42 438.6(c) for payments under any risk contracts will be met.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

HEALTHY OPTIONS (HO)

Citation	Condition or Requirement
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	7. ____The state assures that all applicable requirements of 42 CFR 447.362 for payments under any non-risk contracts will be met.
45 CFR 74.40	8. _X_The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.
	D. Eligible groups
1932(a)(1)(A)(i)	1. List all eligible groups that will be enrolled on a mandatory basis. *TANF and TANF-related families and children* *CHIP*
	2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50. Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.
1932(a)(2)(B) 42 CFR 438(d)(1)	i. ____Recipients who are also eligible for Medicare. *Medicare clients are not eligible for Healthy Options.* If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*
1932(a)(2)(C) 42 CFR 438(d)(2)	ii. _X_Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii. ___Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. ___Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) CFR 438.50(3)(iii)	v. ___Children under the age of 19 years who are in foster care or 42 other out-of- the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. ___Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

HEALTHY OPTIONS (HO)

Citation	Condition or Requirement
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. _X_ Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.
	E. Identification of Mandatory Exempt Groups
1932(a)(2) 42 CFR 438.50(d)	1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title B. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)* *Children are enrolled in the Washington State Department of Health's Children with Special Health Care Needs (CSHCN) Program.*
1932(a)(2) 42 CFR 438.50(d)	2. Place a check mark to affirm if the state's definition of title V children is determined by: _X_ i. program participation, ____ ii. special health care needs, or ____ iii. both
1932(a)(2) 42 CFR 438.50(d)	3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system. _X_ i. yes ____ ii. no
1932(a)(2) 42 CFR 438.50 (d)	4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self- identification)* i. Children under 19 years of age who are eligible for SSI under title XVI; *Children in this category have a particular Recipient Aid Category (RAC) in MMIS. That RAC is not eligible for enrollment into managed care.* ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act; *Children in this category have a particular Recipient Aid Category (RAC) in MMIS. That RAC is not eligible for enrollment into managed care.*

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

HEALTHY OPTIONS (HO)

Citation	Condition or Requirement
	iii. Children under 19 years of age who are in foster care or other out- of-home placement; *Children in this category have a particular Recipient Aid Category (RAC) in MMIS. That RAC is not eligible for enrollment into managed care.*
	iv. Children under 19 years of age who are receiving foster care or adoption assistance. *Children in this category have a particular Recipient Aid Category (RAC) in MMIS. That RAC is not eligible for enrollment into managed care.*
1932(a)(2) 42 CFR 438.50(d)	5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)* *The recipient contacts the Medicaid Agency's customer service representatives and requests an exemption from mandatory enrollment based on the child's special needs and continuing care received from a network of providers who do not participate in managed care.*
1932(a)(2) 42 CFR 438.50(d)	6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)*
	i. Recipients who are also eligible for Medicare. *Recipients in this category have a particular Recipient Aid Category (RAC) in MMIS. That RAC is not eligible for enrollment into managed care.*
	ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act. *AI/AN who are members of Federally recognized Tribes self identify.*

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

HEALTHY OPTIONS (HO)

Citation	Condition or Requirement
42 CFR 438.50	F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment *N/A*
42 CFR 438.50	G. List all other eligible groups who will be permitted to enroll on a voluntary basis *N/A*
	H. Enrollment process.
1932(a)(4) 42 CFR 438.50	1. Definitions i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient. ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.
1932(a)(4) 42 CFR 438.50	2. State process for enrollment by default. Describe how the state's default enrollment process will preserve: i. The existing provider-recipient relationship (as defined in H.1.i). *The State's enrollment process allows potential enrollees two opportunities to maintain his or her relationship with his or her provider: First, potential enrollees may complete an enrollment form, specifying the provider and MCO he or she wishes to enroll with; second, if the enrollee has received an assignment letter notifying him or her of the State's plan selection, the enrollee may again request his or her provider from the MCO to which the enrollee has been assigned.* *If the enrollee is assigned to an MCO with which his or her provider does not contract, he or she may request a disenrollment or change of MCO's to enable him or her to continue the relationship with his or her provider.*

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

HEALTHY OPTIONS (HO)

Citation	Condition or Requirement

ii. The relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

Many of the providers who contract with the Healthy Options MCO's, including Federally Qualified Health Centers (FQHC's) and Rural Health Centers (RHC's) have traditionally served Medicaid clients. The auto enrollment process used by the state takes into account the role these providers have had in the care of Medicaid recipients.

iii. The equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

MCOs set their capacity and the Medicaid Agency analyses their network to confirm their capacity. The capacity is set in the MMIS system as the limit to their enrollment.

1932(a)(4)
42 CFR 438.50

3. As part of the state's discussion on the default enrollment process, include the following information:

i. The state will____/will not_X_use a lock-in for managed care managed care.

ii. The time frame for recipients to choose a health plan before being auto-assigned will be at least ten days after notification of assignment.

iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*

Newly eligible recipients receive an assignment letter and have at least ten days to request disenrollment or to select another MCO. Newly eligible recipients also receive the Healthy Options client handbook, which provides information about tribal health programs and PCCM but describes recipient options to enroll in an MCO for receipt of services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

HEALTHY OPTIONS (HO)

Citation	Condition or Requirement

iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

N/A – Healthy Options enrollees may change MCOs at any time for the following month.

v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

Section 7.14 of the Healthy Options contract describes the assignment process:

7.14 Assignment of Enrollees:

7.14.1 Potential enrollees who do not select a HO plan shall be assigned to a HO plan by the Medicaid Agency as follows:

7.14.1.1 The Medicaid Agency will identify the Contractor's capacity in each service area, as stated in Exhibit A, Premiums, Service Areas, and Capacity, modified by increases and decreases in capacity made in accord with this Contract.

7.14.1.2 The Medicaid Agency will determine the total capacity of all contractors receiving assignment in each service area.

7.14.1.3 The Medicaid Agency will determine the number of households in a service area.

7.14.1.4 Assignments will be calculated based on the Contractor's capacity divided by the total capacity of a service area and then multiplied by the total number of households in a service area. The result of this calculation will determine the number of households to be assigned to the Contractor in a specific service area. In any area where the Contractor's capacity is unlimited, The Medicaid Agency will set the Contractor's capacity, for this calculation, at the total number of HO eligible's in the service area.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

HEALTHY OPTIONS (HO)

Citation	Condition or Requirement

7.14.2 *At the Medicaid Agency's sole discretion and judgment, the Agency may not make assignments of enrollees to the Contractor in a service area if the Contractor does not have sufficient capacity to accept assignments.*

7.14.3 *The Contractor may choose not to receive assignments or limit assignments in any service area by so notifying the Medicaid Agency in writing at least sixty (60) calendar days before the first of the month it is requesting not to receive assignment of enrollees.*

7.14.4 *The Medicaid Agency reserves the right to make no assignments, or to withhold or limit assignments to the Contractor, when, in its sole judgment, it is in the best interest of the Agency.*

7.14.5 *If either the Contractor or the Medicaid Agency limits assignments as described herein, the Contractor's capacity for assignments shall be that limit.*

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

The State will monitor changes in the rate of default assignment by using the MMIS system.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. _X_ The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. _X_ The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

HEALTHY OPTIONS (HO)

Citation	Condition or Requirement

Healthy Options enrollees in counties with mandatory enrollment have the choice of at least two MCO's provided that the MCO's have adequate provider access – if there is not adequate access with two plans, enrollment in that county is voluntary. Counties with one MCO are voluntary.

3. ____ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

   _X_ This provision is not applicable to this 1932 State Plan Amendment.

4. ____The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

   ___ This provision is not applicable to this 1932 State Plan Amendment.

5. _X_ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

   ___This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will___/will not_X_ use lock-in for managed care.

2. The lock-in will apply for ____ months (up to 12 months).

3. Place a check mark to affirm state compliance.

   _X_The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe any additional circumstances of "cause" for disenrollment (if any).

   Healthy Options enrollees may change plans every month without cause. Ending enrollment in managed care is allowed if the Medicaid Agency determines that the enrollee's healthcare needs cannot be met in managed care.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

HEALTHY OPTIONS (HO)

Citation	Condition or Requirement
	K. Information requirements for beneficiaries Place a check mark to affirm state compliance.
1932(a)(5) 42 CFR 438.50 42 CFR 438.10	X The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)
1932(a)(5)(D) 1905(t)	L. List all services that are excluded for each model (MCO & PCCM)

MCOs either cover or coordinate medical services for program enrollees, whether they are covered by the MCO or through the State's fee for service system. Services that are excluded from managed care or FFS coverage are:

1.1.1. *Services Not Covered by Either the Medicaid Agency or the Contractor in accord with WAC 388-501-070:*

- 1.1.1.1. *Any ancillary services provided in association with services not covered by either the Medicaid Agency or the Contractor.*
- 1.1.1.2. *Medical examinations for Social Security Disability.*
- 1.1.1.3. *Services for which plastic surgery or other services are indicated primarily for cosmetic reasons.*
- 1.1.1.4. *Physical examinations required for obtaining continuing employment, insurance or governmental licensing.*
- 1.1.1.5. *Sports physicals*
- 1.1.1.6. *Experimental and Investigational Treatment or Services, determined in accord with the Experimental and Investigational Services, provision of this Section and services associated with experimental or investigational treatment or services.*
- 1.1.1.7. *Reversal of voluntary induced sterilization.*
- 1.1.1.8. *Personal Comfort Items, including but not limited to guest trays, television and telephone charges.*
- 1.1.1.9. *Massage Therapy*
- 1.1.1.10. *Acupuncture*
- 1.1.1.11. *TMJ for Adults*
- 1.1.1.12. *Diagnosis and treatment of infertility, impotence, and sexual dysfunction.*

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

HEALTHY OPTIONS (HO)

Citation | Condition or Requirement

1.1.1.13. *Naturopathy*
1.1.1.14. *Tissue or organ transplants that are not specifically listed as covered.*
1.1.1.15. *Immunizations required for international travel purposes only.*
1.1.1.16. *Court-ordered services*
1.1.1.17. *Gender dysphoria surgery and other services not covered by the Medicaid Agency for gender dysphoria.*
1.1.1.18. *Any service provided to an incarcerated enrollee, beginning when a law enforcement officer takes the enrollee into legal custody and ending when the enrollee is no longer in legal custody.*
1.1.1.19. *Pharmaceutical products prescribed by any provider related to a service not covered by either the Medicaid Agency or the Contractor.*
1.1.1.20. *Any non covered service under the Medicaid Agency's fee-for-service program (WAC 388-501-070), except when the service is provided by the Contractor under the Contractor's Exception to Rule and Limitation Extension policies and procedures as described in this Contract.*

1932 (a)(1)(A)(ii)

M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will_____/will not_X_ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. ____ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

   The state does not limit the number of MCO's. The state will contract with any qualified MCO.

4. __X__ The selective contracting provision in not applicable to this state plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

B.5. The state plan program will implement mandatory enrollment into managed care on a statewide basis. If not statewide, voluntary enrollment will be implemented in the following county/area(s):

County	Asuris NW Health	CUP	CHPW	Group Health	Kaiser	Molina	Regence Blue Shield
Adams			X			X	
Asotin			X			X	
Benton			X			X	
Chelan			X			X	
Clallam (v)*						X	H
Clark		X	X		H	H	
Columbia			X			X	
Cowlitz			X		H	H	
Douglas			X			X	
Ferry			X			X	
Franklin			X			X	
Garfield (v)*						X	
Grant			X			X	
Grays Harbor			X			X	H
Island			X				H
Jefferson **(FFS)****			BHP				
King		X (p)	X	X (p)		H	
Kitsap			X	X		H	
Kittitas			X			X	
Klickitat (**v**)***			X				
Lewis			X			X	
Lincoln			H			X	
Mason			X			H	
Okanogan			X			X	
Pacific			X			X	H
Pend Orielle			X			X	
Pierce		X	X	H (p)		X	H

"H" = Healthy Options/CHIP - represents where plan will be contracted for Healthy Options/CHIP only.
"X" = Healthy Options/CHIP/BHP+ - represents where plan will be contracted for all three coverages.
"(p)" = Partial County - represents where plan will serve only certain zip codes in a county.
"V" = Voluntary County - represents county where enrollment in managed care is not mandatory.

*Voluntary counties with Default Enrollment
**FFS- For HO/CHIP
***Voluntary County enrollment at client's request

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

B.5.The state plan program will implement mandatory enrollment into managed care on a statewide basis. If not statewide, voluntary enrollment will be implemented in the following county/area(s):

County	Asuris NW Health	CUP	CHPW	Group Health	Kaiser	Molina	Regence Blue Shield
San Juan			X			H	H
Skagit			X			H	H
Skamania** (**FFS**)			BHP				
Snohomish			X	X		H	H(p)
Spokane	H		X	X		X	
Stevens			X			X	
Thurston			X	X		X	
Wahkiakum (V)*			X				
Walla Walla			X			X	
Whatcom			X			X	
Whitman			X			X	
Yakima			X			X	H

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