Table of Contents

State/Territory Name: Washington

State Plan Amendment (SPA) #: 14-0004

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

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

Division of Medicaid & Children's Health Operations

JUN 04 2014

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

RE: Washington State Plan Amendment (SPA) Transmittal Number 14-0004

Dear Ms. Teeter and Ms. Lindeblad:

The Centers for Medicare & Medicaid Services (CMS) Seattle Regional Office has completed its review of State Plan Amendment (SPA) Transmittal Number WA 14-0004. This amendment is made pursuant to section 1932(a) of the Social Security Act. It accomplishes several substantive revisions including changing the program name to "Apple Health;" adding a "low birth weight baby case payment;" making enrollment mandatory; expanding the eligibility groups to include pregnant women (mandatory), the new adult expansion group (mandatory), and SSI/foster kids (voluntary); and adding a new description of the MCO assignment process.

This SPA is approved with the effective date of January 1, 2014, as requested by the state.

If you have any additional questions or require any further assistance, please contact me, or have your staff contact Rick Dawson at (206) 615-2387 or Rick.Dawson@cms.hhs.gov.

Sincerely,

[redacted]

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

cc: Alison Robbins, Manager, HCS, HCA
Ann Myers, state Plan Coordinator, LAS, HCA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **14-0004**

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
Jan. 1, 2014

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:
1932(a)(1)(A) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2014 $2,081,223,755
b. FFY 2015 $2,781,844,500

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-F Part 2 pgs 1 - ~~17~~ 14 (pages 14 - [redacted] new) (P&I)
Supplement A to Attachment 3.1-F Part 2 pages 1 – 2 (remove)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-F Part 2 pgs 1 - 13

10. SUBJECT OF AMENDMENT:
Apple Health 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:
[redacted]

13. TYPED NAME:
MARYANNE LINDEBLAD

14. TITLE:
MEDICAID DIRECTOR

15. DATE SUBMITTED:
3-31-14

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
3/31/14

18. DATE APPROVED:
JUN 04 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
1/1/14

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Carol J.C. Peverly

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

23. REMARKS:

6.02.14: State authorizes P&I change to box 8

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

APPLE HEALTH MANAGED CARE

Citation	Condition or Requirement

932(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 organizations [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
____ vi. Other (please provide a description below).

Note: In addition to the capitation payment the State makes two one-time payments:

1) The Delivery Case Rate (DCR) is paid for labor and delivery.

2) Low Birth Weight Baby Case Payment is paid for infants needing intensive care after birth.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

APPLE HEALTH MANAGED CARE

Citation	Condition or Requirement

Both payments are considered with the overall rate in the certification of actuarial soundness.

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

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 MCOs that provide Apple Health managed care programs but open to anyone*
   - *Public website providing information about Apple Health managed care updates and program changes*

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

APPLE HEALTH MANAGED CARE

Citation	Condition or Requirement

- *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 Apple Health managed care 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*

1932(a)(1)(A)

5. The state plan program will _X_/will not 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):

   i. county/counties (mandatory)_____

   Apple Health managed care is mandatory in all counties of Washington except Clallam, Skamania and Klickitat counties. All other counties have two or more Apple Health contracted MCOs with adequate networks.

   ii. county/counties (voluntary) Clallam, Skamania and Klickitat

   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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

APPLE HEALTH MANAGED CARE

Citation	Condition or Requirement
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.
1932(a)(1)(A) CFR 447.362 42 CFR 438.50(c)(6)	7. _____ The state assures that all applicable requirements of 42 CFR 42 447.362 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* • *Pregnant women* • *Children enrolled under the Children's Health Insurance Program (CHIP)* • *Families or individuals eligible for an Alternative Benefit Plan (ABP) as a result of the federal Affordable Care Act*
	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. If enrollment is voluntary, describe the circumstances of enrollment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

APPLE HEALTH MANAGED CARE

Citation		Condition or Requirement
		(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.	X 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.	X Children under the age of 19 years who are eligible under 1902(e)(3) of the Act
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v.	X Children under the age of 19 years who are in foster care or other out-of- the-home placement
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi.	X Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E. 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:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

APPLE HEALTH MANAGED CARE

Citation	Condition or Requirement
	_X_ i. Program participation ,____ ii. Special health care needs _____ 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 ProviderOne. That RAC is not eligible for mandatory 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 ProviderOne. That RAC is not eligible for mandatory enrollment into managed care.* 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 ProviderOne. That RAC is not eligible for mandatory enrollment into managed care (these children may voluntarily enroll in 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 ProviderOne. That RAC is not eligible for mandatory enrollment into managed care (these children may voluntarily enroll in managed care).*

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

APPLE HEALTH MANAGED CARE

Citation	Condition or Requirement
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 or parent of a CSHCN contacts the Medicaid Agency's customer service center and requests an exemption from mandatory enrollment based on the child's special health care needs. The exemption or disenrollment is granted without further documentation.*
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 Medicare status codes in ProviderOne. These codes are 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

APPLE HEALTH MANAGED CARE

Citation	Condition or Requirement
42 CFR 438.50	F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment *Beneficiaries for whom a nursing facility is the primary residence and who have been determined eligible for long-term care are not enrolled in managed care.*
42 CFR 438.50	G. List all other eligible groups who will be permitted to enroll on a voluntary basis *Foster children are eligible for voluntary enrollment; children in the Medically Intensive Children's program may also enroll on a voluntary basis.*
	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*

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

APPLE HEALTH MANAGED CARE

Citation	Condition or Requirement

disenrollment or change of MCO to enable him or her to continue the relationship with his or her provider.

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 Apple Health MCOs, including Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), 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.)*

- *The State has two methods of enrolling beneficiaries into MCO managed care:*
  - *Proactive enrollment by the beneficiary*
  - *Assignment of beneficiaries by the State, as described in H.3.v*

- *Each MCO submits a provider network for each of the service areas in which the MCO wishes to participate –*
  - *If the MCO has 80-100% compliance with contractual requirements in the service area, HCA allows proactive enrollment and assignment in that service area.*
  - *If the MCO has 60-79% compliance with contractual requirements in the service area, HCA allows proactive enrollment in the service area.*
  - *If compliance falls below 60%, there is no enrollment OR assignment; the MCO may keep enrollees who are already enrolled in that service area, but may not gain enrollment until its network is more compliant with contractual requirements.*

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

APPLE HEALTH MANAGED CARE

Citation	Condition or Requirement

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 Apple Health client handbook, which provides information about benefits and enrollment options, including tribal health programs and PCCM for AI/AN clients, and describes recipient options to enroll in an MCO or PCCM program for receipt of services.

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 – Apple Health 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.)

- *The State has two methods of enrolling beneficiaries into MCO managed care:*
  - *Proactive enrollment by the beneficiary*
  - *Assignment of beneficiaries by the State, as described below*

- *Assignments are distributed as follows: Washington has two "legacy" MCOs - Molina Healthcare of Washington, and Community Health Plan of Washington, both of whom have large managed care populations. They also receive a number of family connects and reconnects (defined as enrollees who lost and then regained eligibility – they are re-enrolled into the plan they were enrolled with prior to losing eligibility). Washington also has three new (as of July 2012) MCOs – Coordinated Care, United Healthcare Community Plan, and Amerigroup, who are working to build enrollment.*

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

APPLE HEALTH MANAGED CARE

Citation	Condition or Requirement

- *Washington's current assignment process is: If Molina and CHPW are the only two MCOs in a service area, they split assignments 50/50.*

- *If one or more of the new MCOs is in a service area with Molina/CHPW, the new MCOs are assigned 100% of new enrollment – division of the new enrollees depends on whether one, two ,or three of the new MCOs are in the service area.*
  - *For example, if Molina, Coordinated Care and United Healthcare are the three participating MCOs in a county, Coordinated Care and United Healthcare would split the assignments 50/50*
  - *If Coordinated Care, United Healthcare and Amerigroup were participating in a county, the assignments would be split in thirds.*

- *Beginning with July 2014, assignments, assignment will be made based on the percentage of Initial Health Screens conducted for new enrollees by each MCO.*

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 ProviderOne data.

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

APPLE HEALTH MANAGED CARE

Citation	Condition or Requirement

Apple Health managed care enrollees in counties with mandatory enrollment have the choice of at least two MCOs, 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.)

   _X_ 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).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

APPLE HEALTH MANAGED CARE

Citation	Condition or Requirement

Apple Health managed care 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 MCO managed care. The Medicaid Agency will make the first determination, subject to a state administrative hearing.

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)

- *Ancillary services resulting from or ordered in the course of non-contracted services*
- *Complications resulting from an excluded service are excluded for a period of 30 days following the excluded service*
- *Eyeglass frames lenses and fabrication services*
- *Voluntary termination of pregnancy*
- *Non-emergency transportation services*
- *Air-ambulance*
- *Dental services*
- *Hearing aids*
- *Maternity Support Services/Infant Case Management*
- *Sterilizations for enrollees under age 21*
- *Inpatient psychiatric services*
- *Services received from a neurodevelopmental center recognized by the Washington State Department of Health*
- *Pharmaceutical products prescribed by any provider related to services provided under a separate contract with the Health Care Authority*
- *Lab services required for medication management of drugs prescribed by a Regional Support Network community mental health provider*
- *Surgical procedures for weight loss or reduction*
- *Prenatal diagnosis genetic counseling provided to enrollees to allow enrollees and their PCP to make informed decisions regarding current genetic practices and testing*
- *Substance abuse treatment services covered by DSHS*
- *Nursing facility stays covered by DSHS/Aging and Long Term Support Administration*
- *Mental health services provided under contract with DSHS*

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

APPLE HEALTH MANAGED CARE

Citation	Condition or Requirement

- *Infant formula provided under the Women, Infants and Children program*
- *Any service provided to an enrollee while the enrollee is an inmate of a correctional facility*
- *Hemophiliac blood product – blood factors VII, VIII, IX and the anti-inhibitor indicated for use in treatment of hemophilia and Von Willebrand disease distributed for administration in the enrollee's home*

932 (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 X /will not____ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. X 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 conducted a competitive process in 2011 and 2012 and selected five MCOs as contractors.

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