Medicaid State Plan - Attachment 3

Services: General Provisions

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1. Inpatient hospital services other than those provided in an institution for mental diseases.

_X__ Provided: ____ No limitations __X__ With limitations*

2. a. Outpatient hospital services.

_X__ Provided: ____ No limitations __X__ With limitations*

b. Rural health clinic services and other ambulatory services furnished.

_X__ Provided: __X_ No limitations ___ With limitations*

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

__X_ Provided: _X_ No limitations ___ With limitations*

3. Other laboratory and x-ray services.

_X__ Provided: ___ No limitations __X_ With limitations*

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

__X__ Provided: ____ No limitations __X__With limitations*

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

c. Family planning services and supplies for individuals of child-bearing age.

__X__ Provided: __X__ No limitations ____ With limitations*

d. Tobacco cessation counseling services for pregnant women

1) Face-to-face tobacco cessation counseling services

_X_ Provided ___ No limitations _X_ With limitations

2) Face-to-face tobacco cessation counseling services benefit package for pregnant women

_X_ Provided _X_ No limitations ___ With limitations

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*Limitations described on following pages.

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5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

__X__ Provided: ____ No limitations __X__With limitations*

5.b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

__X__ Provided: ____No limitations __X__With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

__X__ Provided: ____ No limitations __X__With limitations*

Not Provided: ____

b. Optometrists' services.

__X__ Provided: ____No limitations __X__With limitations*

Not Provided: ____

c. Chiropractor's services.

____ Provided: ____No limitations ____With limitations*

Not Provided: __X__

d. Other practitioners' services. Identified on attached sheet with description of limitations, if any.

__X__ Provided: ____No limitations __X__With limitations*

Not Provided: ____

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7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

__X__ Provided: ____No limitations __X__With limitations*

b. Home health aide services provided by a home health agency.

__X__ Provided: ____No limitations __X__With limitations*

c. Medical supplies, equipment, and appliance suitable for use in the home.

__X__ Provided: ____ No limitations __X__ With limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

__X__ Provided: ____ No limitations __X__ With limitations*

e. Other Medical services, supplies, equipment and appliances.

__X__ Provided: ____ No Limitations __X__ With limitations*

8. Private duty nursing services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

9. Clinic services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

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10. Dental services.

__X__ Provided: _____ No limitations __X__ With limitations*

Not Provided: _____

11. Physical therapy and related services.

a. Physical therapy.

__X__ Provided: _____ No limitations __X__ With limitations*

Not Provided: _____

b. Occupational therapy.

__X__ Provided: _____ No limitations __X__ With limitations*

Not Provided: _____

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

__X__ Provided: _____ No Limitations __X__ With limitations*

Not Provided: _____

12. Prescription drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

__X__ Provided: _____ No limitations __X__ With limitations*

Not Provided: _____

b. Dentures.

__X__ Provided: _____ No limitations __X__ With limitations*

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12. Prescription drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist. (continued)

c. Prosthetic devices.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

e. Eyeglasses.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

____ Provided: ____ No limitations ____ With limitations*

Not Provided: _X___

b. Screening services.

____ Provided: ____ No limitations ____ With limitations*

Not Provided: __X__

c. Preventive services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

d. Rehabilitative services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

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14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

b. Nursing facility services.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

c. Intermediate care facility services.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

15. a. Intermediate care facility services for individuals with developmental disabilities who are determined in accordance with section 1902(a)(31) of the Act, to be in need of such care.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

b. Including such services in a public institution (or district part thereof) for the mentally retarded or persons with related conditions.

____ Provided: ____ No limitations ____ With limitations*

Not Provided: __X__

16. Inpatient psychiatric facility services for individuals under 21 years of age.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

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17. Nurse -midwife services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

18. Hospice care (in accordance with section 1905(o) of the Act.

__X__ Provided: ____ No limitations

__X__ Provided in accordance with secion 2302 of the Affordable Care Act

__X__ With limitations* Not Provided: ____

19. Case management services and Tuberculosis related services.

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

__X__ Provided: ____ With limitations*

Not Provided: ____

b. Special tuberculosis (TB) related services under section 1902(z)(2) of the Act.

____ Provided: ____ With limitations*

Not Provided: _X__

20. Special sickle-cell anemia-related services in accordance with section 1905(a) and section 1903(a)(3)(E) of the Act.

____ Provided: ____ With limitations*

Not Provided__X_

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20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

__X__ Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

__X__ Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

____ Provided ____ No limitations ____ With limitations*

Not Provided: __X__

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act.

__X__ Provided: ____ No limitations __X__ With limitations

Not Provided: ____

23. Certified pediatric or family nurse practitioners' services.

__X__ Provided: __X__ No limitations ____ With limitations*

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24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

b. Services provided in religious non-medical health care facilities.

____ Provided: ____ No limitations ____ With limitations*

Not Provided: __X__

c. Reserved.

____ Provided: ____ No limitations ____ With limitations*

Not Provided: __X__

d. Nursing facility services for residents under 21 years of age.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

e. Emergency hospital services.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

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25. Home and Community Care for Functionally Disabled elderly individuals, as defined, described and limited in Supplement 2 to attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

____ Provided: __X__ Not Provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are: (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

__X__ Provided

__X__ State-Approved (Not Physician's) Service Plan Allowed
__X__ Services Outside the Home also Allowed.
__X__ Limitations Described in Attachment 3.1-A, Page 65

____ Not Provided

27. An alien who is a non-qualified alien or a qualified alien subject to the five-year ban and is otherwise eligible for Medicaid is eligible only for care and services necessary to treat an emergency medical condition as defined in section 1903(v) of the Act.

28. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

_X_ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

___ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

29. Licensed or Otherwise State-Approved Freestanding Birthing Center

_X_ Provided ___ No limitations _X_ With Limitations*

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Description of Service Limitations

I. Inpatient hospital services

a. Chronic pain management is limited to inpatient services provided by an agency-approved pain center in a hospital.

c. Long-term acute care services are provided in agency approved hospitals and require prior authorization. This is not sub-acute care; rather this is intensive acute inpatient care provided to patients who would otherwise remain in intensive care or a similar level of care outside of a hospital's intensive care unit.

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2. a. Outpatient hospital services

(1) Hospital-owned institutional facilities that are hospital-based may provide outpatient hospital services to eligible clients when authorized by the agency to do so.

(2) Freestanding hospital-owned institutional facilities that are nonhospital-based may provide outpatient services to eligible clients when authorized by the agency to do so.

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2.b. Rural Health Clinic (RHC) services and other ambulatory services that are covered under the plan and furnished by an RHC.

I. Rural Health Clinics (RHC)

A rural health clinic (RHC) is:

- A provider-based or freestanding facility certified by the secretary under Code of Federal Regulations (CFR), title 42, part 491.
- Located in a rural area designated as a shortage area as defined by the U.S. Census Bureau.
- An RHC may be a permanent or mobile unit.

II. Covered services

Covered services in accordance with 1905(a)(2)(B).

III. Other ambulatory services

In addition to all Medicaid-covered core services, RHCs will furnish other ambulatory services included in the state plan.

III. Core Service Providers

RHC services include services provided by physicians, nurse practitioners, physician assistants, nurse midwives, clinical psychologists, clinical social workers and other ambulatory services included in the state plan. RHC services also include services and supplies that are furnished incidental to professional services furnished by a physician, physician assistant, nurse practitioner, or nurse midwife, and, for visiting nurse care, related medical supplies other than drugs and biologicals.

IV. Additional providers

Providers who meet the qualifications in 3.1-A, 5a “Physicians’ Services,” 6d “Other Practitioners’ Services,” and 10. “Dental services and dentures (440.100) may provide services in an RHC.

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2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC.

Federally qualified health centers (FQHC)

I. An FQHC is a facility that is any of the following:
- Receiving grants under Title 42, Chapter 6A, Subchapter II, Part D, subpart I, section 254b of the U.S. Code
- Receiving a Section 330 of the Public Health Service Act (PHS) grant based on the recommendation of the Health Resources and Services Administration within the Public Health Service, as determined by the secretary, to meet the requirements for receiving such a grant
- A tribe or tribal organization operating outpatient health programs or facilities under the Indian Self-Determination Act that elects to be designated as an FQHC

II. Covered services

Covered services in accordance with 1905(a)(2)(c)

III. Other ambulatory services

In addition to all Medicaid-covered core services, FQHCs will furnish other ambulatory services included in the state plan.

IV. Core service providers

FQHC services include services provided by physicians, nurse practitioners, physician assistants, nurse midwives, clinical psychologists, clinical social workers and other ambulatory services included in the state plan. FQHC services also include services and supplies that are furnished incidental to professional services furnished by a physician, physician assistant, nurse practitioner, or nurse midwife, and, for visiting nurse care, related medical supplies other than drugs and biologicals.

V. Additional providers

Providers who meet the qualifications in 3.1-A, 5.a “Physicians’ Services” and 6.d. “Other Practitioners’ Services” and 10. “Dental services and dentures” may provide services in an FQHC.

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3. Other laboratory and x-ray services

a. Laboratory services

Pathology services are considered to be the same as laboratory services. The department covers all these services that are inpatient hospital. Limitations shown below are for outpatient.

Drug screens only when medically necessary and when:

- Ordered by a physician as part of a medical evaluation; or
- As drug and alcohol screens required to assess suitability for medical tests or treatment. For opiate substitution and pregnant women clients in the department's contracted treatment programs, drug screens for monitoring alcohol/drug use are reimbursed through a contract issued by the department.

One each of the following, per client per day:

- Blood draw fee; and
- Catheterization for collection of urine specimen.

b. Radiology services

The department covers all these services that are inpatient hospital. Limitations shown below are for outpatient.

The following services require prior approval through the Expedited Prior Authorization (EPA) process:

- Outpatient magnetic resonance imaging (MRI);
- Positron Emission Tomography (PET) scans;
- More than one annual screening mammogram for clients forty (40) years of age and older (based on the National Cancer Institute (NCI) recommendations regarding screening mammograms); and
- General anesthesia for radiological procedures. Allowed only when the medically necessary procedures cannot be performed unless the client is anesthetized.

Portable x-ray services furnished in the client's home or a nursing facility are limited to films that do not involve the use of contrast media.

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4. a. Nursing facility services.

Prior approval of admission is required.

Nursing facility (NF) services are available to eligible individuals in accordance with 42 CFR §440.42 and §440.155.

Specialized add-on services for certain NF residents

Specialized add-on services require pre-authorization. Specialized add-on services are paid as add-on payments to the provider of the specialized add-on service, as described in Attachment 4.19-D, Part 1. Specialized add-on services are not provided by the NF. No services will be paid for as specialized add-on services if such services could be covered under other sections of the Plan (e.g., 3.1-A, 7(c) or 3.1-A, 11), within the limitations of those services. If a covered specialized add-on service is also covered under other sections of the Plan but is in excess of the limitations described in those sections, it may be paid as a specialized add-on service.

Covered specialized add-on services include habilitative services. Habilitative services are medically necessary services intended to assist the resident in partially or fully attaining, learning, maintaining, or improving developmental-age appropriate skills that were not fully acquired as a result of a congenital, genetic, or early acquired health condition, and are required to maximize, to the extent practical, the client's ability to function in his or her environment. Habilitative services are provided only upon prior approval and recommendation of the individual's Interdisciplinary Team (IDT), as reflected in the individual's Individual Plan of Care (IPOC).Habilitative services, limitations, and the providers who may furnish the services are as follows.

Specialized add-on services may be provided remotely when appropriate. During a state or federal emergency, or when necessary to protect the health of nursing facility residents, specialized add-on services may be temporarily modified.

I. Assistive technology
   A. Assistive technology consists of items, equipment, or product systems used to develop the functional capabilities or to increase the community involvement of NF residents who require habilitation. Such services also directly assist the participant and caregivers to select, acquire, and use the technology. Assistive technology includes:
      1. The evaluation of the needs of the nursing facility (NF) resident, including a functional evaluation of the individual.
      2. Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices.
      3. Selecting, designing, fitting, customizing, adapting, applying, retaining, repairing, or replacing assistive technology devices.
      4. Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing care, service, and rehabilitation plans and programs.
      5. Training or technical assistance for the individual and/or if appropriate, the individual's staff and other support people.
      6. Training or technical assistance for professionals, including NF staff or other individuals who provide services to, employ, or are otherwise involved in the assistive technology-related life functions of individuals with disabilities.

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4. a. Nursing facility services (cont)

B. Limitations
1. Assistive technology must have generally accepted therapeutic value as determined by licensed professionals in the field of the treating professional and may not be experimental.

II. Habilitative behavior support and consultation
A. Habilitative behavior support and consultation includes the development and implementation of individualized strategies for helping an individual effectively relate to caregivers and other people in the individual's life; and direct interventions with the individual to decrease aggressive, destructive, and sexually inappropriate or other behaviors that compromise the individual's ability to remain in the community.

B. Limitations
1. Habilitative behavior support and consultation must include the following characteristics:
a. Treatment must be evidence-based and driven by individual outcome data, and consistent with DDA's positive behavior support guidelines.
b. Treatment goals must be objective and measurable. The goals must relate to an increase in skill development and/or a decrease in challenging behaviors that impede quality of life for an individual.
c. The following written components will be developed in partnership with the individual and his or her family (as appropriate) by the treating professional:
i. Functional behavioral assessment; and
ii. Positive behavior support plan based on functional behavioral assessment.

III. Community access services
A. Community access is an individualized habilitative service that provides individuals with opportunities to engage in community-based activities that support socialization, education, recreation, and personal development for the purpose of:
1. Building and strengthening relationships with others in the local community who are not paid to be with the person.
2. Learning, practicing, and applying skills that promote greater independence and inclusion in the individual's community.

B. Limitations
1. Community access services can supplement, but cannot replace, activities that would otherwise be available as part of the NF activities program.

IV. Community guide
A. Community guide services provide short term instruction and support in order to increase access to the community when other supports are not available. Services are designed to develop creative, flexible, and supportive community resources for individuals with developmental disabilities.

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4. a. Nursing facility services (cont)

V. Habilitative therapy services

A. Habilitative therapy services are physical therapy, occupational therapy, and speech, hearing and language services that are intended to address habilitative goals. These therapies are in addition to any rehabilitative therapy services the individual may require.

B. Limitations

1. Habilitative therapy services must have generally accepted therapeutic value as determined by licensed professionals in the field of the treating professional and may not be experimental.

VI. Staff/family consultation and training

A. Staff/family consultation and training is professional assistance to families, NF staff, or direct service providers to help them better meet the habilitative goals of the NF resident. Topics on which consultation and training are provided include:

1. Health and medication monitoring
2. Positioning and transfer
3. Basic and advanced instructional techniques
4. Positive behavior support
5. Augmentative communication systems
6. Diet and nutritional guidance
7. Disability information and education
8. Strategies for effectively and therapeutically interacting with the participant
9. Environmental consultation
10. Individual and family counseling

B. Limitations

1. Staff/family consultation and training does not include any expenses related to conferences (e.g., room and board, attendance, tuition).

VII. Supported employment services

A. Supported employment services assist individuals with habilitative needs to obtain and maintain integrated gainful employment. These services provide intensive ongoing support and individualized assistance to gain and/or maintain employment. These services are tailored to individual needs, interests, and abilities, and are provided in individual or group settings.

Individual supported employment services include activities needed to sustain minimum wage pay or higher. These services are conducted in integrated business environments and include the following:

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4. a. Nursing facility services (cont)

1. Intake: An initial meeting to gather and share basic information and a general overview of employment supports, resources in the community and the type of available supports that the individual may receive
2. Discovery: A person-centered approach to learn the individual's likes and dislikes, job preferences, employment goals and skills
3. Job preparation: Includes activities of work readiness resume development, work experience, volunteer support transportation training
4. Marketing: A method to identify and negotiate jobs, building relationships with employers and customize employment development
5. Job coaching: The supports needed to keep the job
6. Job retention: The supports needed to keep the job, maintain relationship with employer, identify opportunities, negotiate a raise in pay, promotion and/or increased benefits

Group supported employment services include:
1. Supports and paid training in an integrated business setting
2. Supervision by a qualified employment provider during working hours
3. Groupings of no more than eight workers with disabilities
4. Individualized supports to obtain gainful employment

B. Limitations
1. Payment is made only for the employment support required as a result of the individual’s disabilities.
2. Payment for individual supported employment excludes the supervisory activities rendered as a normal part of the business setting.
3. The individual’s service hours are determined by the assistance needed to reach employment outcomes as determined by an assessment and might not equal the number of hours spent on the job or in job-related activities.

VIII. Transportation Services

A. Transportation services provide reimbursement for transportation required to facilitate the provision of authorized habilitative services when transportation is not already included in the service provider's contract and payment.

B. Limitations
1. Transportation is limited to travel to and from a habilitative service.
2. Reimbursement for provider mileage requires prior approval.
3. Purchase or lease of vehicles is not covered under this service.
4. Reimbursement for provider travel time is not included in this service.
5. Reimbursement to the provider is limited to transportation that occurs when the NF resident is with the provider.
6. The resident is not eligible for transportation services if the cost and responsibility for transportation is already included in the service provider's contract and payment

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4. a. Nursing facility services (cont)

IX. Other habilitative services and supplies

A. Other habilitative services and supplies are services and supplies that meet habilitative goals but that are not included in specialized add-on service categories above.

B. Limitations

The habilitative goal(s) of the service or supply must be clearly defined in writing, by the individual recommending the service or supply. In particular, the recommendation must describe how the service or supply will assist the resident in partially or fully attaining, learning, maintaining, or improving developmental-age appropriate skills that were not fully acquired as a result of a congenital, genetic, or early acquired health condition, and are required to maximize, to the extent practical, the client's ability to function in his or her environment

X. Providers

The following licensed, registered, or certified providers, or appropriately qualified providers who participate in one of the home and community-based services programs, or providers who are employed by a Regional Support Network may furnish the items, equipment, systems, or services described above in accordance with relevant state law and within their scope of practice:

- Audiologist
- American Sign Language instructor
- Community access service provider
- Community engagement service provider
- Community guide
- Counselor, mental health counselor, marriage and family therapist, or social worker.
- Music therapist
- Occupational therapist
- Person-centered plan facilitator
- Peer mentor
- Physical therapist
- Physician assistant working under the supervision of a psychiatrist
- Psychiatric advanced registered nurse practitioner (ARNP
- Psychiatrist
- Psychologist
- Recreation therapist
- Registered nurse or licensed practical nurse
- Sex offender treatment provider
- Speech and language pathologist
- Supported employment services provider
- Transportation services provider

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4. b. Early and periodic screening, diagnosis, and treatment

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a program providing EPSDT to persons under age 21 who are eligible for Medicaid. In conformance with 1905(r) of the Act, all medically necessary diagnosis and treatment services are provided regardless of whether the service is included in the plan. Limitations to EPSDT and all services provided to children do not apply other than based on medical necessity.

EPSDT health screening visits (well child checks) are provided based on the periodicity schedule described in the agency's provider guides.

Covered services available for children include, but are not limited to:

1. Dental services as described in 3.1-A. 10. II.

2. Eye examinations, refractions, eyeglasses (frames and glasses) and fitting fees:
   (A) Medically necessary eye examinations, refractions, and fitting fees are covered every 12 months.
   (B) Frames, lenses, and contact lenses must be ordered from the Medicaid agency's contractor.

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4. b. EPSDT (cont)

3. Hearing aids are covered on the basis of minimal decibel loss

4. Outpatient physical therapy, occupational therapy, and services for children with speech, hearing and language disorders are provided in accordance with 42 CFR 440.110.

   Duplicate services for occupational, physical, and speech therapy are not allowed for the same client when providers are performing the same or similar procedure(s).

5. Home health services;

   Outpatient occupational therapy, physical therapy, and services for individuals with speech, hearing and language disorders are limited to:
   (A) Clients who are not able to access their care in the community; and
   (B) Medically necessary care.

   When physical therapy and occupational therapy are both medically necessary during the same certification period in order to meet the client's physical or occupational therapy needs, the physician must document on the plan of care that the services are distinctly different and not duplicated.

   - Physical therapy services may be provided by a licensed physical therapist or a physical therapist assistant supervised by a licensed physical therapist. Physical therapist assistants must meet the requirements in chapter 18.74 RCW in effect as of July 1, 2009. Chapter 18.74 RCW specifies required education, experience, and the state's application and examination process for these providers.
   - Occupational therapy services may be provided by a licensed occupational therapist or a licensed occupational therapy assistant supervised by a licensed occupational therapist trained and supervised by a licensed occupational therapist. Licensed occupational therapy assistants must meet the requirements in chapter 18.59 RCW in effect as of July 1, 2009. Chapter 18.59 RCW specifies required education, experience, and the state's application and examination process for these providers.
   - Services for clients with speech, hearing, and language disorders must be provided by or under the supervision of a speech pathologist or audiologist. Speech pathologists, audiologists, and individuals providing services under their supervision must meet the requirements in chapter 18.35 RCW in effect as of July 1, 2009. Chapter 18.35 RCW specifies required education, experience, and the state's application and examination process for these providers.

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4. b. EPSDT (cont)

6. Hospice care, including palliative care

7. School-based health care services

(1) School-based health care services are provided to a child with a disability. The Medicaid agency reimburses school districts, charter schools and tribal schools for school-based health care services provided to children in Special Education, consistent with Section 1905(c) of the Social Security Act. Covered services must:

- Address the physical and/or mental disabilities of the child;
- Be prescribed by a currently licensed physician or another currently licensed or credentialed practitioner within his or her scope of practice under state law; and
- Be in accordance with the Individuals with Disabilities Education Act (IDEA) by being included in the child's current Individualized Education Program (IEP) for Part B services, or Individualized Family Service Plan (IFSP) for Part C services.
- Be provided in the school setting, the natural environment, or an alternate placement in accordance with IDEA.

(a) Provider qualifications – School-based health care services provided to a child with a disability must be delivered by or under the direction of a qualified provider who meets both federal and state licensing or credentialing requirements. The professional must operate within the scope of his or her license and certification according to state law and professional practice standards.

(i) *Physical Therapist* – A 'licensed physical therapist' is an individual who has met the requirements set forth in 42 CFR 440.110(a). Physical therapy services may be provided by a 'licensed physical therapy assistant' or non-licensed personnel under the direction of a physical therapist per federak regulations and professional practice standards.

(ii) *Occupational Therapist* – A 'licensed occupational therapist' is an individual who has met the requirements set forth in 42 CFR 440.110(b). Occupational therapy services may be provided by a 'licensed occupational therapy assistant' or non-licensed personnel under the direction of an occupational therapist per federal regulations and professional practice standards.

(iii) *Speech-Language Pathologist* – A 'licensed speech-language pathologist' is an individual who has met the requirements set forth in 42 CFR 440.110(c)(2), has passed the Speech and Hearing Association examination, and who is is currently licensed according to the Washington State Board of Hearing and Speech. Speech-language pathology services may be provided by a 'certified speech-language

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4. b. EPSDT (cont)

assistant' or non-licensed personnel under the direction of a speech-language pathologist per federal regulations and professional practice standards.

(iv) *Audiologist* – A 'licensed audiologist' is an individual who meets the requirements set forth in 42 CFR 440.110(c)(2). Audiology services may be provided by non-licensed personnel under the direction of a licensed audiologist per federal regulations and professional practice standards.

(v) *Advanced Registered Nurse Practitioner (ARNP), Registered Nurse (RN), or Licensed Practical Nurse (LPN)* – An 'advanced registered nurse practitioner,' 'registered nurse,' or 'licensed practical nurse' is an individual who meets the requirements set forth in 42 CFR 440.60. Nursing and health services may be provided by non-licensed personnel under the direction of an ARNP or RN per professional practice standards.

(vi) *Psychologist* – A 'licensed psychologist' is an individual who meets the requirements set forth in 42 CFR 440.130(d). Mental health services may be provided by non-licensed personnel under the direction of a licensed psychologist per federal regulations and professional practice standards

(vii) *Social Worker* – A 'licensed social worker' is an individual who meets the requirements set forth in 42 CFR 440.130(d). Mental health services may be provided by non-licensed personnel under the direction of a licensed social worker per federal regulations and professional practice standards.

(viii) *Mental Health Counselor* – A 'licensed mental health counselor' is an individual who meets the requirements set forth in 42 CFR 440.130(d). Mental health services may be provided by a 'licensed mental health counselor associate' or non-licensed personnel under the direction of a licensed mental health provider per federal regulations and professional practice standards.

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4. b. EPSDT (cont)

(b) Covered services are provided in accordance with 1905(a) of the Social Security Act including: (4) (B), (6), (11), (13), (28), and subsection (r)(5).

(i) Physical therapy evaluations and treatment services – Assessing, preventing, or alleviating movement dysfunction and related dysfunctional problems.

(ii) *Occupational therapy evaluations and treatment services* – Assessing, improving, developing, restoring functional impairment, loss through illness, injury, or deprivation, and improving the ability to perform tasks toward independence when functions are lost.

(iii) *Speech-language therapy evaluations and treatment services* – Assessment of children with speech and language disorders, and diagnosis and appraisal of specific speech and language disorders. Referral to medical and other professional services necessary for the rehabilitation of speech and language disorders, provision of speech and language services, and for the prevention and improvement of communication disorders.

(iv) *Audiology-hearing evaluations and treatment services* – Assessments of children with hearing loss, determination of the range, nature and degree of hearing loss, including the referral to medical or other professional services for restoration and rehabilitation due to hearing disorders. Provision of rehabilitative activities, such as speech restoration or rehabilitation, auditory training, hearing evaluation and speech conversation, and determination of the child's need for individual amplification.

(v) *Nursing evaluations and treatment services* – Assessment of a child's medical needs ordered by a prescribing physician or other licensed healthcare provider within his or her scope of practice. Treatment services include assessment, treatment, and supervision of delegated health care services provided to prevent disease, disability, or the progression of other health conditions.

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4. b. EPSDT (cont)

(vi) *Mental health services* –Includes diagnostic and treatment services involving mental, emotional, or behavioral problems or dysfunctions. Mental health services include, but are not limited to, mental health evaluations, psychological testing, and individual and group counseling as specified in the child's IEP or IFSP.

c) Medicaid beneficiaries have the freedom to choose their providers. The state, school districts, charter schools and tribal schools may encourage, but may not require, Medicaid eligible children to receive necessary healthcare services in the school setting from school-based providers.

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d. Tobacco cessation counseling services for pregnant women

1) Face-to-face tobacco cessation counseling services provided:

_X_ (i) By or under supervision of a physician.

_X_ (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services. *

___ (iii) By any other health care professional legally authorized to provide tobacco cessation services under State law and who is specifically designated by the Secretary in regulations. (None are designated at this time; this item is reserved for future use).

* Describe if there are any limits on who can provide these counseling services

2) Face-to-face tobacco cessation counseling services benefit package for pregnant women

*Any benefit package that consists of less than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period (eight (8) per year) should be explained below.

Please describe any limitations:

The State's benefit package duplicates the benefits described above. Providers may request a limitation extension according to Washington Administrative Code (WAC).

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5. a. Physicians' services

Exceptions for noncovered services and service limitations are allowed when medically necessary and prior authorized by the department.

(1) Critical care.
- A maximum of three hours of critical care per client per day.
- For inpatient critical care, only the attending physician(s) who assume(s) responsibility for care of the client during a life threatening episode is/are covered to deliver services
- More than one physician may be covered to deliver services if the services are distinctly separate services (i.e., involve multiple organ systems (unrelated diagnosis)).
- In the emergency room, only one physician is covered to deliver services.

(2) Newborn care and neonatal intensive care unit (NICU) services.
- One routine NICU visit per client per day.
- Prolonged care and newborn resuscitation when the physician is present at the delivery (in addition to the one routine visit).

(3) Osteopathic manipulative therapy.
Up to ten osteopathic manipulations per client, per calendar year.

(4) Physical exams:
Routine physical exams are covered in specific instances, including but not limited to:
- EPSDT screening
- Nursing facility placement exams
- Disability determinations for Title XVI-related individuals
- Yearly exams for developmental disability determination (DDD) clients

(5) Physician care plan oversight.
Provided once per client, per month. A plan of care must be established by the home health agency, hospice, or nursing facility, and the physician must provide 30 minutes or more of oversight each calendar month to the client.

(6) Physician standby services.
Must be:
- Requested by another physician;
- Involve prolonged physician attendance without direct (face-to-face) patient contact; and
- Exceed 30 minutes.

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5. a. Physicians' services (continued)17

(7) Physician visits.

Limited to:

- Two physician visits per month for a client residing in a nursing facility or an intermediate care facility.
- One inpatient hospital visit per client, per day, for the same or related diagnosis.
- One office or other outpatient visit per non-institutionalized client, per day, for an individual physician, except for return visits to an emergency room.

Professional inpatient services that are provided during the follow-up period for a surgery are covered only if the services are performed on an emergency basis and are unrelated to the original surgery.

(8) Psychiatric services.

Limited to:

Inpatient care

- One hospital call per day for direct psychiatric care

Outpatient care

- One psychiatric diagnostic interview examination per provider in a calendar year unless an additional evaluation is medically necessary.
- Medically necessary individual or family/group psychotherapy visit, with or without the client
- One psychiatric medication management service per day in an outpatient setting unless more is medically necessary

Prior authorization is required for additional services that are medically necessary.

See section 6.d.(8) for collaborative care (integrated medical and behavioral health services) provided in primary care settings

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5. a. Physicians' services

(9) Clients participating in the department-approved smoking cessation program may receive prescription medications.

(10) Physiatry services

- The Department does not cover duplicate services for occupational and physical therapy for the same client when both providers are performing the same or similar procedure(s).
- The Department does not pay separately for physical therapy services that are included as part of the payment for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.
- The Department does not limit covered physical therapy services for clients 20 years of age and younger.
- For adults:
- 1 physical therapy evaluation (in addition to the 48 program unit limitation below) per calendar year
- 48 physical therapy program units per calendar year
- 2 DME needs assessments (in addition to the 48 program unit limitation) per calendar year
- 1 wheelchair needs assessment (in addition to the DMS needs assessments) per calendar year
- Prior authorization is required for additional program units that are medically necessary

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5. a. Physicians' services (continued)

(11) All physician services that an optometrist is legally authorized to perform are included in physicians' services under this plan and are reimbursed whether performed by a physician or an optometrist in accordance with 42 CFR 441.30.

Optometric physicians are subject to Washington scope of practice laws and are held to the same standards as are people licensed as physicians to practice medicine and surgery by the Washington Medical Board.

Optometric physicians are eligible providers for the Electronic Health Records (EHR) incentive program to the extent they provide services to children under age 21 and meet EHR participation criteria.

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5. b. Medical and surgical services furnished by a dentist.

Services may be provided by a physician, doctor of dentistry, or Doctor of Dental Surgery.

Short stay procedures may also take place in ambulatory surgery settings.

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6. Other practititioners' services

Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law

a. Podiatrists' services
   (1) Foot care is covered only for specific medical conditions that must be treated by a podiatrist.

b. Optometrists' services
   (1) The Medicaid agency covers medically necessary eye examinations, refractions, and fitting fees every 24 months for asymptomatic adults 21 years or older.
   (2) Exceptions will be considered for all individuals based on medical necessity.
   (3) For clients under 21 years of age, services will be provided in accordance with EPSDT requirements at 1905(r), subject to determination of medical necessity and prior authorization by the Medicaid agency.

d. Other practitioners' services
   (1) All other practitioners covered by the Medicaid agency include, but are not limited to, the following licensed practitioners. These practitioners are limited to services within their scope of practice and specialty area.
      - Advanced registered nurse practitioners including certified registered nurse anesthetists
      - Certified behavior support specialists under the supervision of a licensed practitioner covered under this benefit whose scope of practice includes assessment, diagnosis, and treatment of identifiable mental and behavioral health conditions.
      - Chiropractors (for EPSDT only)
      - Dental health aide therapists* (under the supervision of a dentist within the scope of practice as defined under state law. The supervising licensed practitioner assumes professional responsibility for the services provided by the unlicensed practitioner and the licensed practitioner bills for services furnished by unlicensed practitioners.) **Technical correction: Dental health aide therapists added per SPA 17-0027 approved 6/21/2023 effective 7/23/2017*.
      - Dental hygienists
      - Denturists
      - Licensed non-nurse midwives
      - Naturopathic physicians (services are limited to physician-related primary care services)
      - Opticians
      - Pharmacists
         - Pharmacy interns and pharmacy technicians may furnish services in accordance with their professional scope of practice in accordance with state law.
         - Pharmacies are qualified providers of COVID-19 vaccinations per the HHS COVID-19 PREP Act Declaration and authorizations.

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6. Other practitioners' services (cont)

- Physician assistants
- Psychologist
- Certified substance use disorder professionals

(2) Other practitioners are covered as specified in other sections of the State Plan and as approved by the Medicaid agency.

(3) Mental health outpatient services may be provided by the following providers licensed by the state under 42 CFR 440.060(a):

- Licensed Advance Social Workers
- Licensed Advance Social Worker Associates
- Licensed Independent Clinical Social Workers
- Licensed Independent Clinical Social Worker Associates
- Licensed Marriage and Family Therapists
- Licensed Mariage and Family Therapist Associates
- Licensed Mental Health Counselors
- Licensed Mental Health Counselor Associates
- Licensed Psychiatric Advanced Nurse Practitioner
- Licensed Psychologist

To diagnose and treat clients eighteen years of age and younger, the practitioner must be listed above and must:

a. Meet state requirements for a Children's Mental Health Specialist; or
b. Be working under the supervision of a licensed practitioner listed above who meets the state requirement for a Children's Mental Health Specialist.

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d. Other practitioners' services (cont.)

(4) Reserved

(5) Licensed non-nurse midwives
To participate in home births and in birthing centers, midwives must be an agency-approved provider.

(6) Psychologists
- Psychological testing must be medically necessary, prior authorized, in an outpatient setting, and is limited to 2 units per client.
- Neurobehavioral status examinations require prior authorization.
- Neuropsychological testing requires prior authorization.
- Prior authorization is required for additional services that are medically necessary.

(7) Intensive behavior services (applied behavior analysis (ABA) provided by:

A. A lead behavior analysis therapist (LBAT) who under Washington State law is licensed under one of the following provisions:

- A licensed behavior analyst (LBA) practicing under the scope of state law as defined in Department of Health (DOH) RCW and WAC (may bill independently)

- A licensed psychiatrist, psychiatric advanced nurse practitioner, psychologist, mental health counselor, marriage or family therapist, or clinical social worker practicing under the scope of state law as defined in DOH RCW and WAC who is licensed as an LBA (may bill independently)

- A licensed assistant behavior analyst (LABA) practicing under the scope of state law as defined by DOH RCW and WAC and supervised by an LBA practicing under the scope of state law as defined in DOH RCW and WAC (may not bill independently)

Note: When licensed as an LBA, these professionals 8 in applicable DOH RCW and WAC. All licensed supervising practitioners will bill for services performed by unlicensed practitioners.

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6. d. Other practitioners' services (cont)

B. A licensed certified behavior technician (CBT) practicing under the scope of state law as defined in DOH RCW and WAC and supervised by an LBAT practicing under the scope of state law as defined in DOH RCW and WAC (may not bill independently)

C. A licensed psychiatrist, psychiatric advanced nurse practitioner, psychologist, mental health counselor, marriage or family therapist, or clinical social worker practicing under the scope of state law as defined by DOH RCW and attesting to having the training and experience to provide applied behavior analyst services in accordance with state law as defined in WAC (may bill independently)

The State provides assurance that these licensed providers:

- Provide services consistent with §440.60 and the State's Scope of Practice Act.
- Supervise according to the State's Scope of Practice Act for licensed practitioners.
- Assume professional responsibility for the services provided by the unlicensed practitioner

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6. d. Other practitioners' services (cont)

(8) Collaborative care

The following health care professionals are eligible to participate on the collaborative care team to provide collaborative care and will furnish services in accordance with their scope of practice as defined by state law:

1. State-licensed advanced registered nurse practitioners
2. State certified behavioral health support specialists under the supervision of a licensed practitioner covered under this benefit whose scope of practice includes assessment, diagnosis, and treatment of identiable mental and behavioral health conditions.
3. State-certified substance use disorder professionals
4. Substance use disorder professional trainees under the supervision of a state-certified chemical dependency professional
5. State-licensed marriage and family therapists
6. State-licensed marriage and family therapist associates under the supervision of a state-licensed marriage and family therapist or equally qualified mental health practitioner
7. State-licensed mental health counselors
8. Mental health counselor associates under the supervision of a state-licensed mental health counselor, psychiatrist, or physician
9. State-licensed physicians
10. State-licensed physician assistants under the supervision of a licensed physician
11. State-licensed psychiatrists
12. State-licensed psychiatric advanced registered nurses
13. State-licensed psychologists
14. State-licensed registered nurses
15. State-licensed social workers
16. State-licensed social worker associate independent clinical, under the supervision of a state-licensed independent clinical social worker or equally qualified mental health practitioner.
17. State-licensed social worker associate advanced, under the supervision of a state-licensed independent clinical social worker, state-licensed advanced social worker, or equally qualified mental health practitioner.

For unlicensed practitioners that require supervision to furnish services, Washington assures that the supervising state-licensed or state-certified practitioner assumes professional responsibility for the services provided by the unlicensed practitioner.

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6.d. Other licensed practitioners (cont)

(9) Emergency Medical Services (EMS) providers

EMS providers furnish services within their scope of practice as defined by state law. EMS practitioner certification is equivalent to licensure in the state.

(10) Social Work Services to Enhance the Effectiveness of Home Health Services

Licensed social workers are covered within their scope of practice in accordance with state law. Medical Social Services are provided as part of an authorizing practitioner-ordered Home Health service.

(11) Certified Community Health Aide Program (CHAP) providers, supervised by any licensed practitioner covered under this benefit within their scope of practice as defined under state law.

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7. Home health care services

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

1) Applies to home health agency and to services provided by a registered nurse when no home health agency exists in the area.
2) Approval required when period of service exceeds limits established by the single state agency.
3) Nursing care services are limited to:
   (a) Services that are medically necessary;
   (b) Services that can be safely provided in the home setting;
   (c) Two visits per day (except for the services listed below);
   (d) Three high risk obstetrical visits per pregnancy; and
   (e) Infant home phototherapy that was not initiated in the hospital setting.
4) Services must be ordered by a physician, physician assistant (PA), or advanced registered nurse practitioner (ARNP) as part of a written plan of care.
5) Exceptions are made on a case-by-case basis.

b. Home health care services provided by a home health agency

Home health aide services must be:
1) Intermittent or part time;
2) Ordered by a physician, physician assistant (PA), or advanced registered nurse practitioner (ARNP) on a plan of care established by the nurse or therapist;
3) Provided by a Medicare-certified home health agency;
4) Limited to one medically necessary visit per day; and
5) Supervised by the nurse or therapist biweekly in the client's home.

Exceptions are made on a case-by-case basis.

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7. Home health care services (cont.)

c. Medical supplies, equipment and appliances suitable for use in accordance with 42 CFR 440.70.

Medical supplies, equipment and appliances must be:
- Medically necessary;
- In the client's plan of care; and
- Ordered by the treating physician, physician assistant (PA), or advanced registered nurse practitioner (ARNP) and renewed annually.

All of the following apply to medical equipment supplies, appliances, and related services:
- Purchase of equipment and appliances and rental of medical equipment require prior approval.
- All appliances: prosthetics meeting the definition of home health appliances that replace a body part and orthotics supporting a body part are limited to one (1) per upper limb, lower limb, cranium or spine per year. Prior authorization is required to exceed the limitation.

Home infusion-parenteral nutrition equipment and supplies are provided when medically necessary.

The Medical Nutrition Program provides medically necessary nutrition and related equipment and supplies, when the client is unable to meet daily nutritional requirements using traditional foods alone, due to injury or illness.

Limitations described below do not apply to the Medical Nutrition Program for clients under age 21 under EPSDT. All other exceptions to these limitations require prior authorization on a case-by-case basis and are based on medical necessity.
- Initial assessments limited to 2 hours (or 8 units) per year.
- Reassessments limited to no more than 1 hour (or 4 units) per day.
- Training and education provided to groups limited to 1 hour (or 4 units) per day

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility

Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders are provided in accordance with 42 CFR 440.110.

When physical therapy and occupational therapy are both medically necessary during the same certification period in order to meet the client's physical or occupational therapy needs, the physician must document on the plan of care that the services are distinctly different and not duplicated.

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7. Home health care services (cont.)

Limitations for physical, occupational, and speech therapy
The following therapy units are limited as follows, per client per year:

- Physical and occupational therapy – 24 units (approximately 6 hours)
- Occupational therapy – 24 units (equals approximately 6 hours)
- Speech therapy – 6 units (approximately 6 hours)

All of the following are limited to 1 per client per calendar year:

- Physical and occupational therapy
  - Evaluations
  - Re-evaluation at time of discharge
  - Wheelchair management. Assessment is limited to 4 15-minute units per assessment.
- Speech therapy
  - Evaluations of speech fluency, speech sound production, swallowing function, and oral speech device
  - With language comprehension and expression
  - Behavioral and qualitative analysis of voice and resonance
  - Speech language pathology re-evaluation at time of discharge

Limitations do not apply for clients under age 21 under EPSDT.

Additional services are covered with prior authorization on a case-by-case basis when medically necessary.

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8. Private duty nursing services

The purpose of the Private Duty Nursing (PDN) Program is to reduce the cost of healthcare services through equally effective, more conservative, and/or less costly treatment in a client's home. The department's Health and Recovery Services Administration has oversight for the program for clients 17 years of age or younger. Eligible clients must meet all of the following: be 17 years of age or younger; need continuous skilled nursing care that can be provided safely outside an institution; and have prior authorization from the department. PDN program services for those age 18 and older are administered by the department's Aging and Disability Services Administration and are indistinguishable from services for those under age 18.

The department contracts with state licensed home health agencies to provide PDN services. These agencies are not required to obtain Medicare certification to provide PDN services. Within the home health agency, private duty nursing services must be performed by a licensed and appropriately trained registered nurse and/or a licensed practical nurse. For persons 18 years and older with an approved exception to policy, a private (non-home health agency) RN or LPN under the direction of the physician can provide PDN services only when the geographic location precludes a contracted home health agency from providing services, or when no contracted home health agency is willing to provide PDN services.

PDN services meet complex medical needs for persons who require at least four continuous hours of skilled nursing care on a day-to-day basis. Services provide alternatives to institutionalization in a hospital or nursing facility and are not intended to supplant or replace other means of providing the services.

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9. Clinic Services

a. Freestanding kidney centers

(1) Description of facility: A center devoted specially to treating End Stage Renal Disease (ESRD)

(2) Description of service: Peritoneal dialysis or hemodialysis for ESRD.

(3) Program coverage: Covered as an outpatient service when provided by a freestanding renal dialysis center or a freestanding community hemodialysis unit. includes physician services, medical supplies, equipment, drugs, and laboratory tests.

(4) Prior authorization: Required for the facility but not the physician. Initial authorization may be granted for up to three months. Reauthorization may be granted for up to twelve months.

(5) Reimbursement: This service is reimbursed according to attachment 4.19-B.

b. Freestanding ambulatory surgery centers

Allowed procedures are covered when they:

- Are medically necessary; and
- Are not for cosmetic treatment surgery.

Some procedures are covered only when they:

- Meet certain limitation requirements; and
- Have been prior authorized by the department.

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10. Dental services and dentures

The Medicaid Agency covers the services listed below for eligible clients as indicated. Some of these services may require prior authorization. Limitations do not apply for children age 20 and under for EPSDT purposes and may be exceeded based on documented medical necessity with prior authorization. Beneficiaries who have a developmental disability, identified with an indicator provided by the Developmental Disabilities Administration (DDA), or clients who reside in a skilled nursing facility (SNF) or alternative living facility (ALF) qualify for services that may exceed service limitations.

When medically necessary, dental services may be provided in ambulatory surgery centers, inpatient settings, and outpatient settings, including emergency departments.

I. For clients age 21 and over

A. Diagnostic
- Biopsy
- Examinations
- Pulp vitality test
- Radiographs (x-rays)

B. Preventive care
- Behavior management (only for adults identified by DDA)
- Fluoride
- Prophylaxis
- Sealants (only for adults identified by DDA)

C. Treatment
- Aveoloplasty
- Endodontic treatment for permanent anterior teeth
- Extractions/oral surgery
- Periodontic therapy
- Resin and amalgam restorations
- Non-emergency oral surgeries performed in an inpatient setting are not covered. The exception is for clients of DDA whose surgery cannot be performed in an office setting. Documentation must be maintained in the client's record.

D.. Prosthodontics
- Complete and overdentures
- Denture repair, rebase, or reline
- Resin partial dentures

E. Sedation
- Nitrous oxide
- General sedation for adults identified by DDA
- Conscious sedation for adults identified by DDA
- Office-based/mobile anesthesia for adults identified by DDA

F. Teledentistry

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10. Dental services and dentures (cont)

II. For clients age 20 and under

A. Diagnostic
- Biopsy
- Examinations
- Pulp vitality test
- Radiographs (x-rays)

B. Preventive care
- Behavior management
- Fluoride
- Oral hygiene instruction
- Prophylaxis
- Sealants
- Space maintenance

C. Treatment
- Amalgam and composite restorations
- Apexification/apicoectomy
- Crowns
- Endodontic treatment for permanent teeth
- Extractions/oral surgery
- Gingivectomy
- Periodontic therapy
- Pulpotomy

D. Orthodontics
- Limited to medically necessary treatment
- Occlusal orthotic devices for clients age 12 through 20 with prior authorization.

E Prosthedontics
- Complete and overdentures
- Denture repair, rebase or reline
- Resin partial dentures

F. Teledentistry

G. Sedation
- Nitrous oxide
- General sedation
- Conscious sedation
- Office-based/mobile anesthesia; prior authorization required for clients age 9 through 20

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10. Dental services and dentures (cont)

III. For clients age 5 and under and all clients age 20 and under based on the determination of medical necessity

A. In addition to the services described in section II, services include:
- Preventive care: family oral health education
- Treatment: interim therapeutic restorations (ITR)

B. Services must be furnished by a state licensed dentist or primary care provider who has completed an agency-approved training to provide these services.

C. Limitations do not apply for children age 20 and under for EPSDT purposes and may be exceeded based on documented medical necessity, with prior authorization.

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11. Physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders.

a. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders are provided in accordance with 42 CFR 440.110.

b. Duplicate services for occupational, physical, and speech therapy are not allowed for the same client when providers are performing the same or similar procedure(s).

c. Limitations do not apply for clients under the age of 21 under EPSDT.

d. Prior authorization is required to exceed set limits for clients twenty-one (21) years of age and older as follows:

(1) For physical therapy (PT) services beyond one PT evaluation and 24 units (approximately 6 hours) PT per calendar year, per client.

(2) For occupational therapy (OT) services beyond one OT evaluation and 24 OT units (approximately 6 hours) per calendar year, per client.

(3) For speech therapy (ST) services beyond one speech evaluation and 6 units/visits of speech therapy per calendar year, per client.

e. Under 42 CFR 440.110(a), physical therapy services may be provided by a licensed physical therapist or a physical therapist assistant supervised by a licensed physical therapist. Physical therapist assistants must meet the requirements in chapter 18.74 RCW in effect as of July 1, 2009. Chapter 18.74 RCW specifies required education, experience, and the state's application and examination process for these providers.

f. Under 42 CFR 440.110(b), occupational therapy services may be provided by a licensed occupational therapist, a licensed occupational therapy assistant supervised by a licensed occupational therapist, or an occupational therapy aide, in schools, trained and supervised by a licensed occupational therapist. Licensed occupational therapy assistants and occupational therapy aides must meet the requirements in chapter 18.59 RCW in effect as of July 1, 2009. Chapter 18.59 RCW specifies required education, experience, and the state's application and examination process for these providers.

g. Under 42 CFR 440.110(c), services for individuals with speech, hearing, and language disorders must be provided by or under the supervision of a speech pathologist or audiologist. Speech pathologists, audiologists, and individuals providing services under their supervision must meet the requirements in chapter 18.35 RCW in effect as of July 1, 2009. Chapter 18.35 RCW specifies required education, experience, and the state's application and examination process for these providers.

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12. a. Prescribed drugs

Drug Coverage

(1) Covered outpatient drugs as defined in Section 1927 (k)(2) of the Act are those which are prescribed for a medically accepted indication and produced by any manufacturer, which has entered into and complies with an agreement under Section 1927(a) of the Act.

(2) Prescriptions written as a result of an EPSDT visit will be approved as ordered by the prescriber.

(3) Drugs excluded from coverage as provided by Section 1927(d) (2) of the Act are designated in Attachment 3.1-A and 3.1-B, pages 32a and 32b of this plan. Experimental drugs are excluded from coverage.

(4) Drug shortages. Prescribed drugs that are not covered outpatient drugs (including drugs authorized for import by the Food and Drug Administration) are covered when medically necessary during drug shortages identified by the Food and Drug Administration (FDA).

Prior Authorization

(5) Prescription drugs may be subject to prior authorization by the agency to ensure that drugs are prescribed and dispensed appropriately.

(6) The agency determines which prescription drugs may require prior authorization by reviewing the drug(s) for the following:

- Safety
- Potential for abuse or misuse
- Narrow therapeutic index
- High cost when less expensive alternatives are available

(7) Prior authorization programs for covered outpatient drugs provide for a response within 24 hours of a request for prior authorization and provides for the dispersing of at least a 72-hours supply of medications in emergency situations.

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12. a. Prescribed drugs (continued)

Supplemental Rebate Program

(7) The state is in compliance with Section 1927 of the Act. Based on the requirements for Section 1927 of the Act, the state has the following policies for the supplemental rebate program for Medicaid recipients:

a) All covered drugs of federal participating manufacturers remain available to the Medicaid program but may require prior authorization.

b) The current state supplemental rebate agreement between the state and a drug manufacturer for drugs provided to Medicaid recipients, submitted to CMS on July 15, 2008, and entitled “State of Washington Supplemental Rebate Contract” has been authorized by CMS remains in effect.

c) The state will continue the ability to have state-specific supplemental rebates and will also participate in a multi-state pooling program that will negotiate supplemental rebates in addition to federal rebates provided for in Title XIX. This multi-state pooling program is known as TOP$sm The Optimal PDL $olution (TOP$). TOP$ rebates will be separate from federal rebates.

d) A TOP$ rebate agreement, submitted to CMS on December 13, 2017, for drugs provided to the Medicaid program has been authorized by CMS.

e) TOP$ supplemental rebate agreements would apply to the drug benefit, both fee-for-service and those paid by contracted managed care organizations (MCOs), under prescribed conditions in Attachment A-2 to the TOP$ Supplemental Rebate Agreement.

f) Supplemental rebates received by the state in excess of those required under the federal drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the federal rebate agreement. The non-federal share of supplemental rebates received by the state will not be subject to the increased offset described in the Affordable Care Act.

g) The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification, in accordance with Section 1927(b)(3)(D).

h) Rebates paid under the CMS-authorized TOP$sm agreement for Washington State Medicaid population do not affect AMP or best price under the Medicaid program.

i) The CMS-authorized TOP$sm agreement for the Washington State Medicaid population only provides supplemental rebates for Medicaid programs eligible for federal rebates. It does not cover non-Medicaid programs.

j) Pharmaceutical manufacturers are allowed to audit utilization rates.

k) The state may enter into value-based contracts with manufacturers on a voluntary basis. The contracts will be executed on the model agreement entitled “Value-Based Supplemental Rebate Agreement” submitted to CMS on March 14, 2019, and authorized for use beginning January 1, 2019.

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12. a. Prescribed drugs (continued)

Preferred Drug List

a. Pursuant to 42 U.S.C. section 1396r-8, the State is establishing a preferred drug list with prior authorization for drugs not included on the preferred drug list. Prior authorization programs for covered outpatient drugs provide for a response within 24 hours of a request for prior authorization, and provides for the dispensing of at least a 72-hour supply of medications in emergency situations, in accordance with provisions of section 1927(d)(5) of the Social Security Act. The prior authorization process is described in chapter 182-530 WAC.
b. The preferred drug list will be used by all contracted Medicaid managed care organizations and the Medicaid fee-for-service program.
c. Prior authorization will be established for certain drug classes or particular drugs in accordance with Federal law. All drugs covered by the program, irrespective of a prior authorization requirement, will comply with the provisions of the national drug rebate agreement.
d. A preferred drug list does not prevent Medicaid beneficiaries from obtaining access to medically necessary drugs of manufacturers that participate in the national drug rebate program.
e. The State will utilize the Drug Utilization Review board to assure, that in addition to pricing consideration, preferred drugs are clinically appropriate.

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12. a. Prescribed Drugs (continued)

Citation	Provision
1935(d)(1)	In January 2006, the Medicaid agency ceased covering any Part D drug for full-benefit dual eligible e individuals who are entitled to receive Medicare benefits under Part A or Part B.
1927(d)(2) and 1935(d)(2)	(a) The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D. **_X_ The following excluded drugs are covered:** Select (i) Agents when used for anexoria, weight loss, or weight gain as listed on the Washington Apple Health Preferred Drug List located on the agency's website. _no_ (ii) Agents when used to promote fertility select (iii) Agents when used for the symptomatic relief cough and colds as listed on the Washington Apple Health Preferred Drug List located on the agency's website. _X_ (iv) Prescription vitamins and mineral products, except prenatal vitamins and fluoride, for documented deficiency. select (v) Nonprescription (OTC) drugs when determined by the department to be the least costly therapeutic alternative for a medically accepted indication. . OTC product coverage is listed within a product's therapeutic class on the Washington Apple Health Preferred Drug List located on the agency's website.

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12. a. Prescribed Drugs (continued)

none (vii) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee

____ No excluded drugs are covered

(b) Agents when used for cosmetic purposes or hair growth are noncovered. Exceptions for noncovered services are allowed when medically necessary and prior authorized by the state

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12. b. Dentures

These services have been moved under “Dental Services” based on CMS recommendation.

12. c. Prosthetic devices

Prosthetics and orthotics must be:
- Medically necessary;
- In the client’s plan of care; and
- Ordered by the treating physician, physician assistant (PA), or advanced registered nurse practitioner (ARNP) and renewed annually.

All of the following apply to prosthetics and orthotics and related services:
- Purchase of equipment and appliances and rental of medical equipment require prior approval.
- Prosthetics replacing a body part and orthotics supporting a body part are limited to one (1) per upper limb, lower limb, cranium, or spine per year. Prior authorization is required to exceed the limitation.

Hearing aids provided on the basis of minimal decibel loss

12. d. Eyeglasses (Included under “Optometrists’ Services”, section 6.b.)

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13. c. Preventive services

Screening, Brief Intervention, and Referral to Treatment (SBIRT) services

In accordance with 42 CFR 440.130(c), the Medicaid agency covers alcohol and substance misuse counseling through screening, brief interventions, and referral to treatment (SBIRT) when provided by a physician or other licensed practitioner within the scope of their practice as defined in state law, and when provided by or under the supervision of, a physician or other licensed practitioner within the scope of their practice as defined in state law.

A. PROVIDERS

To qualify as a qualified SBIRT provider, eligible state-licensed or state-certified health care professionals must complete an agency-approved SBIRT training.

The following health care professionals are eligible to become qualified SBIRT providers to deliver SBIRT services within their scope of practice as defined in state law:

- Licensed advanced registered nurse practitioners (ARNP)
- Licensed dentist
- Licensed dental hygienists
- Licensed marriage and family therapists
- Licensed marriage and family therapist associates
- Licensed mental health counselors
- Licensed mental health counselor associates
- Licensed practical nurse
- Licensed psychologist
- Licensed physician
- Licensed physician assistant
- Licensed registered nurse
- Licensed advance social workers
- Licensed advance social worker associates
- Licensed independent social workers
- Licensed independent social worker associates
- Certified substance use disorder professionals (SUDP)
- Certified behavioral health support specialists

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13. c. Preventive services
Screening, Brief Intervention, and Referral to Treatment (SBIRT) services (cont.)

B. SERVICES

SBIRT services are covered for determining risk factors that are related to alcohol and other drug use disorders. SBIRT services are:

- *Screening and assessment* (Occurs during an Evaluation and Management (E/M) exam which involves client history, a physical exam, and medical decision-making): The health care professional uses a standardized screening tool to assess a client's substance use behaviors.
- *Brief intervention* in the form of counseling (Limited to 4 sessions per client per provider per calendar year; additional sessions are allowed with prior authorization when medically necessary. In accordance with EPSDT requirements at 1905(r), clients under 21 years of age will receive all medically necessary services to which they are entitled): The health care professional engages the client in a short conversation, providing health information, feedback, motivation, and advice.
- *Referral for treatment*, if indicated: The health care professional provides a referral to a licensed and certified behavioral health agency for assessment and treatment as appropriate.

Washington covers and reimburses all United States Preventive Services Task Force (USPSTF) grade A and B preventive services and approved adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), and their administration, without cost-sharing. Changes to ACIP recommendations are incorporated into coverage and billing codes as necessary.

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13.c Preventive Services

Doula Services

Pursuant to 42 CFR 440.130(c), doula services are provided as preventive services and must be recommended by a physician or other licensed practitioner acting within their scope of practice under state law.13.c. Preventive Services

A doula is a nonmedical support person trained to provide physical, emotional, and informational support to birthing persons. A doula advocates for and supports the birthing person and their family to self-advocate by helping them to know their rights and make informed decisions. Doula services are provided during pregnancy, childbirth or end of pregnancy, and the postpartum period (the 12-month period after the last day of pregnancy). These services are inclusive of all pregnancy outcomes.

Services include:

- Prenatal intake visit – one per pregnancy
- Labor and delivery support – as needed (no limit but may be billed only once per pregnancy)
- Comprehensive postpartum visit – one per pregnancy
- Additional prenatal and postpartum visits – limited to 20 hours

Limitations may be exceeded based on medical necessity.

Birth doulas must be at least 18 years old and possess current certification as a birth doula with Washington State Department of Health.

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13.c. Preventive Services

Community Health Worker Services

Per 42 CFR Section 440.130(c), Community Health Worker services are provided as preventive services and must be recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law.

I. Services
Community Health Worker (CHW) services are preventive health service to prevent disease, disability, and other health conditions or their progression, to prolong life and/or to promote physical and mental health and efficiency. CHW services leverage lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.

The following component services are covered when performed by CHWs:

1) Person-centered assessment, performed to better understand the individual context and needs, facilitate patient-driven goal setting, and establish a care plan.

2) Care coordination and health system navigation
   a. Communicate with practitioners, home- and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding:
      i. patient's psychosocial strengths and needs,
      ii. functional deficits,
      iii. goals,
      iv. preferences, and
      v. desired outcomes, including cultural and linguistic factors.
   b. Provide coordination of receipt of needed services and care transitions between and among health care practitioners and settings, including:
      i. access/health system navigation involving referral to other healthcare services, including identifying appropriate providers and helping secure appoints.
      ii. follow-up after discharges from emergency departments, hospitals, skilled nursing facilities or other health care facilities.
      iii. facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) to address the social determinates of health (SDOH) need(s).

3) Facilitating behavior change
   a. Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals.
   b. Facilitating and providing social and emotional support to help the patient cope with the problem(s) addressed in the initiating visit, the principal illness, facilitating access to community-based social services (E.g., housing, utilities, transportation, food assistance) to address social determinant of health (SDOH) need(s), and adjusting daily routines to better meet diagnosis and treatment goals

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13.c. Preventive Services (cont)

Community Health Worker Services (cont)

4) Health education and promotion
   a. Help patients to contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, and preferences, in the context of the principal illness and/or SDOH need(s) and educating the patient on how to best participate in medical decision-making.
   b. Build patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services addressing the principal illness and SDOH need(s), in ways that are more likely to promote personalized and effective diagnosis or treatment.

II. Providers

Community Health Workers (CHWs) are frontline public health workers who are trusted members of and/or have a close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

Community Health Representatives (CHRs) are well-trained, medically guided, tribal and Native community people, who provide a variety of health services within American Indian and Alaska Native communities. CHRs are recognized as CHWs for the purposes of CHW services.

1) CHWs must deliver services under the supervision of any licensed practitioner within the scope of their licensure as described in state law.

2) CHWs must have lived experience that aligns with and provides a connection between the CHW and the community being served.

3) CHWs must meet the following requirements:
   a. Have 2,000 supervised hours working as a CHW in paid or volunteer positions within the previous three years and demonstrated skills and practical training in the following areas:
      i. Communication
      ii. Interpersonal and relationship-building
      iii. Service coordination and navigation
      iv. Advocacy
      v. Capacity building
      vi. Professional conduct
      vii. Outreach
      viii. Individual and community assessment
      ix. Knowledge base in public health principles and social determinants of health
      x. Education and facilitation
      xi. Evaluation and research

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13.c. Preventive Services (cont)

Community Health Worker Services (cont)

b. Demonstrate minimum qualifications through one of the following:
   i. CHW/CHR Certificate: A certificate of completion, including but not limited to any certificate issued by Washington State Department of Health or designee, or Indian Health Services of a curricula that attests to demonstrated skills and/or competencies in the list above.
   ii. Supervision Attestation**:** Medicaid-enrolled licensed supervisors may conduct a CHW assessment and attest to CHW skills and proficiencies to demonstrate the CHW's skills and competencies. The supervising provider must maintain documentation of the CHW assessment.

4) CHWs that do not meet any of the identified skills and/or practical training areas must obtain the necessary training within 18 months of employment.

5) All CHWs must complete a minimum of six hours of additional training annually. The supervising provider must maintain documentation of the CHW's completion of continuing education requirements.

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13. d. Rehabilitative services

1) Behavioral health (substance use disorders (SUD), mental health (MH), and MH/SUD co-occurring disorder (COD)) treatment services recommended by a physician or other licensed practitioner within their scope of practice, for the maximum reduction of physical or mental disability and restoration of a beneficiary to their best possible functional level.

Substance Use Disorder Case Management is covered under the Targeted Case Management benefit as described in Supplement 1F to Attachment 3.1-A.

(a) Provider Types:
The following state-credentialled provider types, working within a state-licensed behavioral health agency, may furnish services in accordance with their scope of practice as defined by state law or exempt from such licensure pursuant to Title 25 U.S.C. Sec. 1621t of the Indian Health Care Improvement Act:

i. An individual who has one of the following credentials is considered a **Mental Health Professional**:
- Licensed Advanced Registered Nurse Practitioner working as a Psychiatric Advanced Registered Nurse Practitioner
- Certified Agency Affiliated Counselor
- Licensed Agency Affiliated Counselor
- Licensed Marriage and Family Therapist
- Licensed Marriage and Family Therapist Associate
- Licensed Mental Health Counselor
- Licensed Mental Health Counselor Associate
- Licensed Osteopathic Physician, working as a psychiatrist
- Licensed Physician Assistant working under the supervision of a Psychiatrist
- Licensed Physician, working as a Psychiatrist
- Licensed Physician, working as a Child Psychiatrist
- Licensed Psychologist
- Licensed Registered Nurse, working as a Psychiatric Nurse
- Licensed Social Worker (Advanced, Independent Clinical, or Associate)

Within the list of Mental Health Professionals above, the following definitions apply:
- "Psychiatrist" means a physician licensed by the state who has in addition completed four years of graduate training in psychiatry in a program approved by the American Board of Medical Specialties or the American Osteopathic Board and is certified or eligible to be certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.
- "Child psychiatrist" means a person having a license as a physician in this state, who has had graduate training in child psychiatry in a program approved by the American Board of Medical Specialties or the American Osteopathic Association, and who is board eligible or board certified in child psychiatry.

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13. d. Rehabilitative Services (cont)

- "Psychiatric nurse" means a registered nurse who has a bachelor's degree from an accredited college or university, and who has had, in addition, at least two years' experience in the direct treatment of mentally ill or emotionally disturbed persons, such experience gained under the supervision of a Mental Health Professional. "Psychiatric nurse" also means any other registered nurse who has three years of such experience.
- "Psychiatric advanced nurse practitioner" means person who is licensed as an advanced registered nurse practitioner according to state law; who is board-certified in advance practice psychiatric and mental health nursing.

ii. **Licensed Practical Nurse**
iii. **Nursing Assistant Registered/Certified**
iv. **Medical Assistant - Certified**
v. **Licensed Pharmacist**
vi. **Licensed Osteopathic Physician Assistant**
vii. **Licensed Registered Nurse**
viii. **Certified Substance Use Disorder Professional**
ix. **Certified Substance Use Disorder Professional Trainee**
x. **Certified Peer Counselor** who has self-identified as in recovery from mental health conditions and or substance use disorders or is the parent or legal guardian of a person who has applied for, is eligible for, or has received mental health or substance use services; has received specialized training provided or contracted by the Health Care Authority; has passed a test, which includes both written and oral components of the training; has passed a Washington State background check; has been certified by the Health Care Authority and is working under an Agency Affiliated registration. Certified Peer Counselors work under the supervision of a Mental Health Professional or a Substance Use Disorder Professional.
xi. **Mental Health Care Provider**, means an individual working in a Behavioral Health Agency, under the supervision of a Mental Health Professional, who has primary responsibility for implementing an individualized plan for mental health rehabilitation services. To provide services as a Mental Health Care Provider, this person must be a Registered Agency Affiliated Counselor and have a minimum of one year of education or experience in mental health or a related field.
xii. **Behavioral Health Specialist** is a Mental Health Professional who meets state requirements as:

- A "child mental health specialist"
- A "geriatric mental health specialist"
- An "ethnic minority mental health specialist"
- A "disability mental health specialist"
- A "co-occurring disorder specialist – enhancement"

xii. **Certified Behavioral Health Support Specialist (BHSS)** means an individual certified by the state to deliver brief behavioral health services under the supervision of a Mental Health Professional or a licensed practitioner covered under this benefit whose scope of practice includes assessment, diagnosis, and treatment of identifiable mental and behavioral health conditions. To provide services as a Certified Behavioral Health Support Specialist, this person must have a bachelor's degree and have completed the BHSS educational program approved by the state.

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xiii. **Certified Gambling Counselor** is an individual that holds a state license as a Marriage and Family Therapist, a Marriage and Family Therapist Associate, A Mental Health Counselor, a mental Health Counselor Associate, a Social Worker (Advanced, Independent Clinical, or Associate), Psychologist or a state certification as a Substance Use Disorder Professional or Substance Use Disorder Professional Trainee and also holds a state certification as a Certified Gambling Counselor.

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13. d. Rehabilitative Services (cont)

(b) Services:

i. Crisis Intervention

Screening, evaluation, assessment, and clinical intervention are provided to all Medicaid enrolled persons experiencing a behavioral health crisis. A behavioral health crisis is defined as a significant change in behavior in which instability increases and/or risk of harm to self or others increases. The reasons for this change could be external or internal to the person. If the crisis is not addressed in a timely manner, it could lead to significant negative outcomes or harm to the person or others. Crisis intervention services are available on a 24-hour basis, 365 days a year. Crisis intervention services are intended to stabilize the person in crisis, prevent further deterioration, and provide immediate treatment and intervention, de-escalation, and coordination/referral efforts with health, social, and other services and supports as needed to affect symptom reduction, harm reduction, and/or to safely transition persons in acute crisis to the appropriate environment for continued stabilization. Crisis intervention should take place in a location best suited to meet the needs of the person and in the least restrictive environment available. Crisis intervention services may be provided prior to completion of an intake evaluation.

The following practitioners may furnish crisis intervention services within their scope of practice as defined by state law:

- Mental Health Professional (MHP)
- Mental Health Care Provider, under the supervision of an MHP
- Certified Behavioral Health Support Specialist under the supervision of an MHP

Additional Information:
In order to claim increased FMAP for services using the ‘community-based mobile crisis intervention services’ model, the requirements described in section 1947(b) of the Act must be met, including providing services to persons outside of a hospital or other facility setting, through a multidisciplinary team, trained in trauma-informed care, de-escalation strategies, and harm reduction. The team must include, at a minimum, at least one individual who may conduct an assessment within their authorized scope of practice under state law and other professionals or paraprofessionals with appropriate expertise in behavioral health care.

ii. Crisis Stabilization

Services provided to Medicaid enrolled persons who are experiencing a behavioral health crisis. This service includes follow-up after a crisis intervention. These services are to be provided in the person's own home or another home-like setting, or a setting which provides safety for the person and the Mental Health Professional. Crisis stabilization services may include short-term assistance with life skills training and understanding medication effects. It may also include providing services to the person’s natural and community supports, as determined by a Mental Health Professional, for the benefit of supporting the person that experienced the crisis. Crisis stabilization services may be provided prior to an intake evaluation for behavioral health services. Crisis stabilization services may be provided by a team of professionals, as deemed appropriate and under the supervision of a Mental Health Professional.

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13. d. Rehabilitative Services (cont)

The following practitioners may furnish crisis stabilization services within their scope of practice as defined by state law:

- Mental Health Professional (MHP)
- Mental Health Care Provider, under the supervision of an MHP
- Certified Peer Counselor, under the supervision of an MHP
- Substance Use Disorder Professional, under the supervision of an MHP
- Certified Behavioral Health Support Specialist under the supervision of an MHP

iii. Intake evaluation, assessment, and screenings (Mental Health)

This service is an evaluation of a person's behavioral health, along with their ability to function within a community, to establish the medical necessity for treatment, determine service needs, and formulate recommendations for treatment. Intake evaluations must be initiated prior to the provision of any other behavioral health services, except those specifically stated as being available prior to an intake. Services may begin before the completion of the intake once medical necessity is established.

Mental health intake evaluation, assessment, and screening services may be provided by a Mental Health Professional within their scope of practice as defined by state law. Psychological assessment and tests must by performed by or under the supervision of a licensed psychologist or psychiatrist.

iv. Intake evaluation, assessment, and screenings (Substance Use or Problem Gambling Disorder)

This service is a comprehensive evaluation of a person's behavioral health, along with their ability to function within a community, to determine current priority needs and formulate recommendations for treatment. The intake evaluation for substance use disorder includes a review of current intoxication and withdrawal potential; biomedical complications; emotional, behavioral, and/or cognitive complications; readiness to change; relapse potential; and recovery environment. Intake evaluations for problem gambling disorders include a biopsychosocial clinical assessment. Information from the intake is used to work with the person to develop an individualized service plan to address the identified issues.

Intake evaluations must be initiated prior to the provision of any other substance use or problem gambling disorder services. Services may begin before the completion of the intake once medical necessity is established.

Intake evaluations, assessments, and screenings may be provided by the following practitioners within their scope of practice as defined by state law:

- Certified Substance Use Disorder Professional (SUDP)
- Certified Substance Use Disorder Professional Trainee (SUDPT), under the supervision of a SUDP
- Licensed Advanced Registered Nurse Practitioner
- Licensed Marriage and Family Therapist
- Licensed Marriage and Family Therapist Associate
- Licensed Mental Health Counselor
- Licensed Mental Health Counselor Associate
- Certified Behavioral Health Support Specialist under the supervision of an MHP

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13. d. Rehabilitative services (cont.)

- Licensed Osteopathic Physician
- Licensed Osteopathic Physician Assistant
- Licensed Physician
- Licensed Physician Assistant
- Licensed Psychologists
- Licensed Social Worker (Advanced, Independent Clinical, or Associate)
- Persons with a Co-occurring Disorder Specialist-Enhancement, as described in 13.d.1(a) above

Additional Information:
Assessments related to gambling disorders must be performed by or under the supervision of a licensed/certified practitioner, who holds a Certified Gambling Counselor Certification, as defined in state law.

v. Medication Management

Medication management is the prescribing and/or administering of psychiatric medications and reviewing of their side effects. This service may be provided in consultation with primary therapists, case managers, and/or natural supports, without the person present, but the service must be for the benefit of the person.

Medication management may be provided by the following practitioners within their scope of practice as defined by state law:

- Licensed Advanced Registered Nurse Practitioner
- Licensed Advanced Registered Nurse Practitioner/Psychiatric Advanced Registered Nurse Practitioner
- Medical Assistant – Certified
- Licensed Osteopathic Physician
- Licensed Osteopathic Physician/Psychiatrist
- Licensed Pharmacist
- Licensed Practical Nurse
- Licensed Physician Assistant
- Licensed Physician
- Licensed Physician/Psychiatrist
- Licensed Registered Nurse

vi. Medication Monitoring

Medication monitoring is one-on-one cueing, observing, and encouraging a Medicaid enrolled person to take their psychiatric medications as prescribed. Also includes reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid enrolled person. This service is designed to facilitate medication compliance and positive outcomes.

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13. d. 7 Rehabilitative services (cont.)

Medication monitoring may be provided by the following practitioners within their scope of practice as defined by state law:

- Mental Health Professional (MHP)
- Mental Health Care Provider, under the supervision of an MHP
- Certified Peer Counselor, under the supervision of an MHP
- Medical Assistant-Certified
- Licensed Osteopathic Physician/Psychiatrist
- Licensed Osteopathic Physician Assistant
- Licensed Pharmacist
- Licensed Physician Assistant
- Licensed Physician/Psychiatrist
- Licensed Practical Nurse
- Licensed Registered Nurse
- Nursing Assistant Registered/Certified
- Certified Behavioral Health Support Specialist under the supervision of an MHP

vii. Mental Health Treatment Interventions

Services delivered in a wide variety of settings that promote recovery using therapeutic techniques. These services are provided, as medically necessary, along a continuum from outpatient up through residential and inpatient levels of care, and include evaluation, stabilization, and treatment. Services provided in facility settings must have the appropriate state facility licensure.

Treatment services include the use of planned interventions to achieve and maintain maximum level of functioning for the person.

Treatment interventions include cognitive and behavioral interventions designed with the intent to stabilize the individual and return them to more independent and less restrictive treatment. Services are conducted with the person, their family, or others at their behest, for the direct benefit of the person. Services may include individual, family, and group therapy, as well as skill building/self-care necessary to maintain/restore functioning. Services may also include therapeutic psychoeducation, which focuses on assisting the individual and their identified supports in increasing knowledge of mental health and recovery, use and efficacy of medication, symptom reduction and management, effective problem solving, and emotional/behavioral regulation skills. Intensive or brief intervention treatment models may be utilized, as well as using a multi-disciplinary team-based approaches.

Mental health treatment interventions may be provided by the following practitioners within their scope of practice as defined by state law:

- Mental Health Professional (MHP)
- Mental Health Care Provider, under the supervision of an MHP
- Certified Peer Counselor, under the supervision of an MHP
- Certified Behavioral Health Support Specialist under the supervision of an MHP

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13. d. 7 Rehabilitative services (cont.)

Additional information:
Individual and Family treatment may take place without the person present, with their consent, as required by law. However, the service must be for the benefit of attaining the goals identified by the person in their individualized service plan.

viii. Peer Support

This service provides scheduled activities that promote wellness, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Services provided by certified peer counselors as noted in the individuals' Individualized Service Plan, or without an Individualized Service Plan when provided during/post crisis episode.

Certified Peer Counselors work with their peers (adults and youth) and the parents/caregiver of children receiving or who have received behavioral health services They draw upon their experiences to help peers find hope and make progress toward recovery and wellness goals. Certified Peer Counselors model skills in recovery and self-management to help individuals meet their self-identified goals.

Certified Peer Counselors must provide peer counseling services under the supervision of an MHP or SUDP who understands recovery. The peer's and clinical supervisor's expertise should be aligned with the needs of the populations served by the Certified Peer Counselor.

ix. Behavioral Health Care Coordination and Community Integration

A range of activities furnished to engage persons in treatment and assist them in transitioning from a variety of inpatient, residential, or non-permanent settings back into the broader community. To be eligible, the person must need transition support services in order to ensure timely and appropriate behavioral health treatment and care coordination.

Activities include assessment for discharge or admission to community behavioral health care, integrated behavioral health treatment planning, resource identification and linkage, and collaborative development of individualized service planning that promote continuity of care. These specialized behavioral health community integration activities are intended to promote discharge, maximize the benefits of the transition plan, minimize the risk of unplanned readmission, and increase the community tenure for the person. Services focus on reducing the disabling symptoms of mental illness or substance use disorder and managing behaviors resulting from other medical or developmental conditions that jeopardize the person's ability to live in the community. Services are individualized interventions for the individual or collateral contacts for the benefit of the person and may include skill-building to develop skills promoting community tenure.

This service may be provided prior to an intake evaluation or assessment.

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13. d. 7 Rehabilitative services (cont.)

Behavioral health care coordination and community integration services may be provided by the following practitioners:

- Mental Health Professional (MHP)
- Mental Health Care Provider, under the supervision of an MHP
- Certified Peer Counselor, under the supervision of an MHP or SUDP
- Certified Substance Use Disorder Professional (SUDP)
- Certified Substance Use Disorder Professional Trainee, under the supervision of an SUDP
- Licensed Practical Nurse
- Licensed Pharmacist
- Licensed Physician Assistant
- Licensed Registered Nurse
- Certified Behavioral Health Support Specialist under the supervision of an MHP

x. Substance Use Disorder Brief Intervention

A time limited, structured behavioral intervention designed to address risk factors that appear to be related to substance use disorders, using substance use disorder screening tools and brief intervention techniques, such as evidence-based motivational interviewing and referral to additional treatment services options when indicated.

This service may be provided prior to an intake evaluation or assessment.

Substance use disorder brief intervention services may be provided by the following practitioners:

- Certified Substance Use Disorder Professionals (SUDP)
- Certified Substance Use Disorder Professional Trainee under the supervision of an SUDP
- Licensed Advanced Registered Nurse Practitioner
- Licensed Marriage and Family Therapist
- Licensed Marriage and Family Therapist Associate
- Licensed Mental Health Counselor
- Licensed Mental Health Counselor Associate
- Licensed Osteopathic Physician
- Licensed Osteopathic Physician Assistant
- Licensed Physician
- Licensed Physician Assistant
- Licensed Psychologists
- Licensed Social Worker (Advanced, Independent Clinical, or Associate)
- Persons with a Co-occurring Disorder Specialist-Enhancement, as described in 13.d.1(a) above

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13. d. 7 Rehabilitative services/Mental health services (cont.)

xi. Substance Use or Problem Gambling Disorder Treatment Interventions
Services delivered in a wide variety of settings across the continuum that promote recovery, using therapeutic techniques. These services are provided, as medically necessary, along a continuum from outpatient up through residential and inpatient levels of care. Services provided in inpatient levels of care are provided in state-certified facilities.

Treatment interventions include intentional intervention in the health, behavioral health, and personal and/or family life of a person with a substance use or problem gambling disorder. Interventions are designed to facilitate the affected individual to achieve and maintain maximum functional recovery. Treatment interventions include individual treatment, group treatment, family counseling, intensive, and team-based approaches.

Provider Qualification:

- Certified Substance Use Disorder Professionals (SUDP)
- Certified Substance Use Disorder Professional Trainee under the supervision of the SUDP
- Licensed Advanced Registered Nurse Practitioner
- Certified Peer Counselor, under the supervision of an SUDP
- Licensed Marriage and Family Therapist
- Licensed Marriage and Family Therapist Associate
- Licensed Mental Health Counselor
- Licensed Mental Health Counselor Associate
- Licensed Osteopathic Physician
- Licensed Osteopathic Physician Assistant
- Licensed Physician
- Licensed Physician Assistant
- Licensed Psychologists
- Licensed Social Worker (Advanced, Independent Clinical, or Associate)
- Persons with a Co-occurring Disorder Specialist-Enhancement, as described in 13.d.1(a) above

Additional information:

- Counseling services related to gambling disorders must be performed by a licensed/certified practitioner, who holds a Certified Gambling Counselor Certification, as defined in state law, or be performed by a licensed/certified practitioner under the supervision of a Certified Gambling Counselor Supervisor.
- Individual and Family treatment may take place without the person present, with their consent, as required by law. However, the service must be for the benefit of attaining the goals identified by the person in their individualized service plan.

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13. d. 7 Rehabilitative services (cont)

xii. Substance Use Disorder Withdrawal Management

Services required for the care and/or treatment of persons intoxicated or incapacitated by alcohol or other drugs that are provided during the initial period of care and treatment while the person recovers from the transitory effects of acute or chronic intoxication or withdrawal from alcohol or other drugs. Services are provided in state-certified facilities. Services include:

- Screening of persons in need of withdrawal management; and
- The use of different counseling and treatment strategies, such as motivational interviewing and developing an initial service plan for persons admitted to a program. These services are used to refer, stimulate motivation to guide individuals to additional treatment, and sustain recovery.
- Different levels of withdrawal management are provided in a variety of settings, including residential, sub-acute and acute locations.

Substance Use Disorder withdrawal management services may be provided by the following practitioners within their scope of practice as defined by state law:

- Certified Substance Use Disorder Professionals (SUDP)
- Certified Substance Use Disorder Professionals Trainee under the supervision of an SUDP
- Licensed Advanced Registered Nurse Practitioner/Psychiatric Advanced Registered Nurse Practitioner
- Certified Peer Counselor, under the supervision of an SUDP
- Licensed Marriage and Family Therapist
- Licensed Marriage and Family Therapist Associate
- Licensed Mental Health Counselor
- Licensed Mental Health Counselor Associate
- Licensed Medical Assistant
- Nursing assistant registered/certified
- Licensed Osteopathic Physician/Psychiatrist
- Licensed Physician/Psychiatrist
- Licensed Physician Assistant
- Licensed Psychologists
- Licensed Registered Nurse
- Licensed Social Worker (Advanced, Independent Clinical, or Associate)
- Persons with a Co-occurring Disorder Specialist-Enhancement, as described in 13.d.1(a) above

c) Service Limitations

Services outlined within this section that are provided within residential or inpatient settings do not include room and board costs. Services provided within an Institution for Mental Disease (IMD) are not eligible for reimbursement.

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13. d. 8. Therapeutic child-care

Therapeutic child-care to treat psycho-social disorders in children under 21 years of age based on medical necessity. Services Include: developmental assessment using recognized, standardized instruments play therapy; behavior modification; individual counseling; self esteem building; and family intervention to modify parenting behavior and/or the child's environment to eliminate/prevent the child's dysfunctional behavior. Prior approval is required. Payment rates are established per section X of Attachment 4.19-B.

Line staff, responsible or planning and providing these services in a developmentally appropriate manner must have an AA degree in Early Childhood Education or Child-Development or related studies, plus five years' of related experience, including identification, reporting, and prevention of child abuse and/or neglect.

Supervisory staff must have a BA in Social Work or related studies, plus experience working with parents and children at risk of child abuse and/or neglect. Experience can be substituted for education using a 2:1 ratio. Their responsibilities are for development, implementation, and documentation of treatment plans for each child.

Agencies and individual providers must be approved as meeting Medicaid agency criteria and certification requirements under state law as appropriate.

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13. d. 9. Behavior Rehabilitation Services.

Behavior rehabilitative services are health and remedial services provided to children to remediate debilitating disorders, ordered by a physician or other licensed practitioner of the healing arts within the scope of his or her practice within state law, intended for the maximum reduction of mental disability and restoration of the individual to his or her best possible functional level. Prior approval is required.

Service Settings

BRS may be delivered in a group living setting (in the community), in a treatment foster home, or in a small number of cases, in the child's own home. In all setting, BRS is always provided by the credentialed staff of the BRS provider. Natural parents or foster parents do not provide BRS, nor does the State claim for such.

Service Description

Upon assessment and development of an individual service and treatment plan, specific services include milieu therapy, crisis counseling, regularly scheduled counseling and therapy, and health services. Care management and planning are ongoing and may include coordination with other agencies. When the child returns home, after care may be provided for up to six (6) months.

Milieu therapy: Refers to those activities performed with children to normalize their psycho-social development and promote the safety of the child and stabilize his or her behavior in any given environment. The child is monitored in structured activities conducive to interpersonal interaction (e.g., group work assignments), with the aim of promoting living skills development. As the child is monitored, intervention is provided to remediate the dysfunctional behaviors and encourage appropriate responses which the child may then apply in a broad range of settings. Aggression replacement training is provided to teach children to understand and replace aggression and anti-social behavior with positive alternatives. Providers include Social Service and Care Management staff. Child care staff provide assistance to these staff in the form of day-to-day supervision and behavioral feedback to the youth. (*see Provider Qualifications).*

Crisis counseling: Available on a 24 hour basis, providing immediate short term intervention to assist the child in responding to the crisis and/or stabilize the child's behavior until problems can be addressed in regularly scheduled counseling and therapy sessions. Children in the population served by BRS are subject to sudden, escalating disturbed behavior patterns. Crisis counseling is intended to quickly intervene and address escalating behavior, while scheduled counseling and therapy are intended to address the child's problems in the longer term. Example: A short term intervention would include the child having a face-to-face encounter with a counselor to discuss the nature of the child's current emotional/behavioral disturbance and his/her feelings that caused the disturbance. The child has the opportunity to work out a plan to cope with the immediate situation until longer term solutions can be developed. Providers include Social Service staff and Care Management staff (*see Provider Qualifications).*

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13. d. 9. Behavior Rehabilitation Services (cont.)

Service Description (cont)

Regularly scheduled counseling and therapy: May include psychological testing. Each child has an individual services and treatment plan which identifies the child's specific behavioral dysfunctions. Services and treatment are tailored to the child in his/her individual plan. Therapy may be in an individual or group setting, which may include members of the child's peer group or family members, but therapy is directed at the child's behavioral problems. Irrespective of the therapeutic setting, counseling and therapy are provided to, or directed exclusively toward, the treatment of the Medicaid-eligible individual.

Providers include Social Services and Care Management staff. Child care staff may provide assistance to these staff in the form of day-to-day supervision and behavioral feedback to the youth (*see Provider Qualifications).*

Health Counseling: This component includes any service recommended by a licensed practitioner of the healing arts within the scope of his/her practice, aimed at reducing physical or mental disability of the individual and restoring the individual to his/her best possible functional level. Emergency and routine medical services are not claimed as BRS.

An EPSDT examination for the child must be arranged within the first 30 days of entry into BRS, and any recommendations resulting from the examination must be acted upon.

Youth may receive health counseling regarding health maintenance, disease prevention, nutrition, hygiene, pregnancy prevention, and prevention of sexually transmitted infections in a group setting or on a one-on-one basis with BRS social service staff or care management staff.

The population of youth served by BRS are at a higher risk of unsafe behaviors than the general population of youth in the community. They are also less concerned with maintaining personal habits that promote and sustain health such as nutrition, personal hygiene, and the prevention of disease. The counseling they receive reduces their dysfunctional behaviors.

BRS providers are required to provide or arrange for drug and/or alcohol treatment for all youth who require such treatment irrespective of the setting in which the youth resides, i.e., all settings. Drug and/or alcohol treatment may be sought in the community network of providers and paid for with the youth's Medicaid benefit and is not billed for in the BRS provider's rate. A small number of BRS providers have staff members who possess the required credentials to provide substance abuse treatment. In such cases, treatment could be provided within the facility without an increase in the provider's rate. Whether provided by a subcontracting community resource or within the BRS facility, substance abuse treatment is integrated into the youth's treatment plan and supported by the social service staff, the care management staff, and the child care staff.

Milieu therapy, crisis counseling, scheduled counseling and therapy, and health counseling are provided by care management staff and social service staff. The role of the child care staff is a supporting role to the care management and social service staff. (see *Provider Qualifications and Responsibilities)*.

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13. d. 9. Behavior Rehabilitative Services (cont)

Demonstrations by staff of recreational or work activities are not claimed as BRS.

Population to be Served

Children who receive these services suffer from conditions that prevent them from functioning normally in their homes, schools, and communities. Dysfunctional behaviors may include drug and alcohol abuse; anti-social behaviors that require an inordinate amount of intervention and structure; sexual behavior problems; behaviors symptomatic of victims of severe family conflict; and behavioral disturbances resulting from psychiatric disorders of the parents.

Provider Qualifications and Responsibilities

Each provider must be licensed by the state's Division of Licensed Resources. Specific qualifications for all BRS providers' staff are listed below. In all settings, it is the providers' credentialed staff who perform BRS services.

Social Services Staff: The minimum qualification is a Masters Degree in social work or a social science such as psychology, counseling, or sociology. Social workers must meet the requirements in 18.225 RCW and chapter 246-809 WAC and have a Master's or Doctoral level degree from an educational program accredited by the Council on Social Work Education. Licensed/certified staff must successfully complete the Department of Health's examination and supervised/supervisory experience requirements. Social service staff without a Master's Degree must have a Bachelor's Degree in social work or a social science such as psychology, counseling, or sociology, and must consult at least eight hours per month with a person who has a Master's Degree.

Responsibilities include development of service plans; individual, group, and family counseling; and assistance to child care staff in providing appropriate treatment for clients.

The social service staff provides the child care staff with oversight and direction, when necessary, in the provision of appropriate treatment for children, in accordance with each child's specific treatment plan. Because the Social Service staff possess a higher educational credential and greater experience than the child care staff, they provide leadership to the child care staff.

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13. d. 9. Behavior Rehabilitative Services (cont)

Provider Qualifications and Responsibilities (cont)

Care Management Staff: The minimum qualification is a Master's Degree with major study in social work or a social science such as psychology, counseling, or sociology, or a Bachelor's Degree with major study in social work or a social science such as psychology, counseling, or sociology, and two (2) years' experience working with children and families. Mental health counselors must meet the requirements in 18.225 RCW and chapter 246-809WAC and have a Master's or Doctoral level degree in mental health counseling or a related field from an approved college or university. Licensed/certified staff must successfully complete the Department of Health's examination and supervised/supervisory experience requirements.

Responsibilities include case planning, individual and group counseling, assistance to child care staff in providing appropriate treatment for clients, coordination with other agencies, and documentation of client progress.

Care managers are in a leadership role to the child care staff. The care manager is responsible for maintaining oversight and providing direction to child care staff on a day-to-day basis for the child's behavior management, in accordance with each child's specific treatment plan. Care managers coordinate with other agencies to ensure that the child, when returned home, will have adequate supports to enable him/her to remain in the community. Examples of such supports could include ensuring that the child has a medical home, has a community treatment resource for drug and/or alcohol abuse, or has counseling for the treatment of sexually aggressive behavior. Coordination with other agencies depends on the specific problems of a specific child.

Therapeutic interventions are provided by social services staff, care management staff, and subcontracted individuals. All providers must meet the qualifications above, and as required, be licensed or certified by the Department of Health (DOH) according to chapter 18.25 RCW to furnish the service(s) provided by the BRS contractor.

Child Care Staff: Minimum qualifications require that no less than 50% of the childcare staff in a facility have a Bachelor's Degree. Combinations of formal education and experience working with children and families may be substituted for a Bachelor's degree.

Responsibilities include assisting social service staff in providing individual, group, and family counseling; and therapeutic intervention to address behavioral and emotional problems as they arise. Child care staff are responsible for understanding each child's treatment plan and providing day-to-day supervision and behavioral feedback to the child, in accordance with each child's individual treatment plan. These staff may provide input, based on their experience with the child, during case staffing and counseling sessions with the child and/or his/her family.

Master's Level Oversight: In addition to the staffing qualifications listed in this section, the Contractor's program must have Master's level oversight. This requirement may be met through a Master's level Program Director or Social Service staff or by subcontracting with a consultant

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17. Nurse midwife services

Nurse midwife services within the scope of practice in accordance with state law are covered.

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18. Hospice care in accordance with section 1905(o) of the Act.

A. Services

1. Items not included in the daily rate require prior authorization.
2. Covered services
   a. Covered services are intermittent except during brief periods of acute symptom control.
   b. Core services are provided directly by hospice agency staff or contracted through a hospice agency as necessary, and include:
      - Physician services related to administration of the plan of care.
      - Nursing care provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of an RN.
      - Medical social services provided by a social worker under the direction of a physician.
      - Counseling services provided to a client and the client's family members or caregivers.
   c. Additional services, which must be related to the hospice diagnosis, written in the plan of care, identified by the hospice interdisciplinary team, safe and meet the client's needs within the limits of the hospice program, and made available by the hospice agency on a 24-hour basis:
      - A brief period of inpatient care for general or respite care provided in a Medicare-certified hospice care center, hospital, or nursing facility.
      - Drugs, biologicals, and over-the-counter medications used for the relief of pain and symptom control of a client's terminal illness and related conditions.
      - Home health aide, homemaker, and/or personal care services ordered by the client's physician and documented in the plan of care. (Home health aide services must be provided by a qualified home health aide and are an extension of skilled nursing or therapy services).
      - Interpreter services as necessary for the plan of care.
      - Medical equipment and supplies that are medically necessary for the palliation and management of a client's terminal illness and related conditions.
      - Medical transportation services as required by the plan of care related to the terminal illness.
      - Physical therapy, occupational therapy, and speech-language pathology therapy to manage symptoms or enable the client to safely perform activities of daily living and basic functional skills.
      - Skilled nursing care.
      - Other services or supplies documented as necessary for the palliation and management of the client's terminal illness and related conditions.
      - Bereavement counseling

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18. Hospice care in accordance with section 1905(o) of the Act (cont)

B. Hospice Agency and Practitioner Qualifications

1. Hospice agency requirements:
   - Documentation that it is Medicare, Title XVIII-certified by the State's Department of Health; and
   - Has received written notification from the Medicaid Agency of enrollment as an approved hospice care center.

2. Practitioner requirements:
   All practitioners who provide hospice services must be licensed, certified, accredited, or registered according to Washington State's laws and rules, including but not limited to physicians, registered nurses, licensed practical nurses, and social workers.

C. Hospice Election Periods

Hospice coverage is available for two (2) 90-day election periods followed by an unlimited number of 60-day election periods. A client or a client's authorized representative must sign an election statement to initiate or reinstate an election period for hospice care. An election period to receive hospice care continues through the initial election period and subsequent election periods without a break in care as long as the client:
- Remains in the care of a hospice agency; and
- Does not revoke the election.

D. Face-to-face Encounters

Hospice agencies must have a face-to-face encounter with every hospice client prior to the one hundred eightieth-day recertification and prior to each subsequent recertification in order to determine continued eligibility of the client for hospice care. These encounters are not covered separately – they are included in the core services.

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E. Concurrent care for children on hospice in accordance with section 2302 of the Affordable Care Act.

1. Hospice clients 20 years of age and under are eligible.

2. The hospice benefit may be elected without foregoing curative services to which the client is entitled for treatment of the terminal condition.

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20. Extended services for pregnant women, through the sixty days postpartum period. The extended services include:

a. Maternity support services, by a provider approved by the Department of Health and the department, consisting of:

(1) Nursing assessment and/or counseling visits, provided by licensed registered nurses;
(2) Psychosocial assessment and/or counseling visits, provided by licensed or credetialed behavioral health specialists;
(3) Nutrition assessment and/or counseling visit, provided by registered, state-certified dieticians;
(4) Community health worker visit, provided by community health educators; and
(5) Childbirth education, provided by licensed or credentialed child birth educators.

b. Outpatient alcohol and drug treatment for pregnant and postpartum women consisting of a chemical dependency assessment by an Alcohol and Drug Abuse Treatment and Services Act assessment center, parenting education, and chemical dependency treatment. These services are provided by Chemical Dependency Counselors approved by the Division of Alcohol and Substance Abuse (DASA) according to Washington State's law cited in the Revised Code of Washington, rCW 43.24.030.

c. Rehabilitation alcohol and drug treatment services, excluding room and board, for pregnant and postpartum women recommended by a physician or licensed practitioner of the healing arts within the scope of their practice under State law. Services are provided in residential treatment facilities with 16 beds or less certified by the Division of Alcohol and Substance Abuse.

d. Genetic counseling performed by a provider approved by Parent-Child Health Services and Washington State's Department of Health according to Washington State's law cited in the Revised Code of Washington, RCW 43.24.030.

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22. Respiratory care services

As defined in rule, the department covers medically necessary oxygen and/or respiratory therapy equipment, supplies, and services to eligible clients in nursing facilities, community residential settings, and in their homes. The above is prescribed by a health care practitioner authorized by law or rule in the State of Washington. Prior authorization is required for specified equipment, or when a request falls outside of the defined criteria.

Selected contracted nursing facilities are authorized to provide exceptional care needs to ventilaror- and tracheostomey-dependtent clents.

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24. a. Transportation

Ambulance transportation is provided as a medical service for emergencies, for scheduled non-emergencies when medically necessary, or as required by state law. Ambulance transportation is not provided through a brokerage system.

See Attachment 4.19-B, IX.C for reimbursement information.

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24. a. Transportation

Transportation is provided in accordance with 42 CFR 440.170 as an optional medical service, excluding "school-based" transportation.

/ / Not Provided:
/ / Provided without a broker as an optional medical service:

(If state attests "Provided without a broker as an optional medical service" then insert supplemental information.)

Instructions:
Describe how the transportation program operates including types of transportation and transportation-related services provided and any limitations. Describe emergency and non-emergency transportation services separately. Include any interagency or cooperative agreements with other Agencies or programs.

/X/ Non-emergency transportation is provided through a brokerage program as an optional medical service in accordance with 1902(a)(70) of the Social Security Act and 42 CFR 440.170(a)(4).

(If the state attests that non-emergency transportation is being provided through a brokerage program then insert information about the brokerage program.)

Instructions:
/X/ The State assures it has established a non-emergency medical transportation program in accordance with 1902(a)(70) of the Social Security Act in order to more cost-effectively provide transportation, and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36(b)-(i).

Competitive procurement:
The State conducted a competitive procurement process as required by 42 CFR 440.170(a)(4), and in compliance with the requirements of 45 CFR 92.36(b)-(i). The State conducted a rigorous competitive process which included nationally advertised processes. The Request for Proposal (RFP) was released in June 2010 and drew interest from national firms. For profit brokers are not prohibited from competing for brokerage contracts during procurements.

State contracts with regional brokers:
The RFP resulted in contracts with six organizations to provide brokered NEMT services, for trips delivered starting 01/01/2011. There are 13 broker regions (collectively covering the entire state), with each region covering a single-county or multi-county geographic area. The regions coincide with healthcare catchment areas, and the normal travel patterns for individuals obtaining healthcare services.

The contracted brokers are responsible for:
(1) operating a customer service center to provide a gatekeeper function and pre-authorize trips; and
(2) developing a network of transportation providers, and paying the providers.

24. a. Transportation (cont)

Performance-based contracts:
As of 1/1/2011, the contracts with brokers include performance-based provisions:
Per Trip Service Cost Incentive: If a broker achieves service cost decreases (compared year-to-year and computed quarterly), of up to 5%, then the State will award a performance incentive of the same percentage increase in the monthly broker fee. (Details can be found in the contract, Exhibit J.)
Customer Services Center Telephone Response Performance Penalty: If a broker fails to meet telephone response standards, then the State will assess a penalty, of between 1% - 5% of the monthly broker fee (computed monthly and deducted quarterly). (Details can be found in the contract, Exhibit J.)

The State monitors broker operations.
For additional details see both the Payment Methodology section and the final section on broker operations.

(a) Non-governmental entities

(1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a):

/ / (1) state-wideness (indicate areas of State that are covered)

Broker regions covered by SPA 08-028 (approved 08/17/2010 effective 10/01/2008):

1A: Chelan, Douglas, and Okanogan counties
3B: Snohomish County
4: King County
5: Pierce County
6B: Grays Harbor, Lewis, Mason-south, Pacific, and Thurston counties
6C: Clark, Cowlitz, Klickitat, Skamania, and Wahkiakum counties

Broker regions covered by SPA 11-11, effective 01/01/2011:

1B: Ferry, Pend Oreille, and Stevens counties
1C: Adams, Grant, and Lincoln counties
1D: Spokane County
1E: Asotin, Garfield, and Whitman counties
2: Benton, Columbia, Franklin, Kittitas, Walla Walla, and Yakima counties

Broker region covered by SPA 11-11, effective 04/01/2011:

6A: Clallam, Jefferson, Kitsap, and Mason-north counties

/ / (10)(B) comparability (indicate participating beneficiary groups)

/X/ (23) freedom of choice (indicate mandatory population groups)

(2) Transportation services provided will include:

/X/ Wheelchair van
/X/ Taxi
/X/ Stretcher car
/X/ Bus passes
/X/ Tickets
/X/ Secured transportation
/X/ Other transportation

24. a. Transportation (cont)

Instructions:

Describe other transportation: When cost- effective, appropriate, and necessary to ensure access to eligible medical services, will consider using/authorizing gas/fuel vouchers, mileage reimbursement, grouped-ride vehicle, volunteer drivers, parking, tolls, ferries, and air transport, and will provide lodging and meal reimbursement as outlined at 42 CFR 440.170(a)(3)(ii).

[Note: Grouped or shared ride vehicles are a cost-effective method to transport groups of clients with similar trip origins and destinations, or more than one client in a locale similar to an airport shuttle. Brokers pay transportation subcontractors on a contracted mileage-based or time-based system; costs are allocated equitably to the clients' specific medical program account codes.]

Bus fare:
When bus passes are authorized (whether monthly, weekly, etc.) the lowest cost bus pass will be used that is cost effective, and will not exceed the cost of the individual trips for which they will be used. Bus passes will not be purchased in bulk prior to the broker's determination that they are needed, unless the broker is able to obtain full credit for returning unused bus passes.

Assurance that costs are not over-allocated to Medicaid: The State ensures that costs are not over-allocated to Medicaid using the following methods:

- The State provides brokers access to a client eligibility (look-up) record which contains the account code to charge the transportation expenses. The account codes identify whether the client is on a Medicaid-funded or other-funded program, and the client's respective medical assistance program. The eligibility record information is updated daily.
- As a contract requirement, Brokers verify a client's eligibility before authorizing NEMT services.
- Brokers screen clients to ensure that other transportation resources are used first, before Medicaid.
- Brokers screen for the trip purpose, to ensure that the requested trip is to/from a covered service.
- Brokers are contractually required to assign trips to the lowest-cost mode and service provider that can deliver the trip, based on the client's mobility status and personal capabilities.
- Direct Service Costs (subcontracted transportation provider expenses) are direct-charged to the proper account codes for the client's medical assistance program. The expenses for a shared-ride are charged to the respective account codes, in a manner that costs are not over-allocated to Medicaid.
- The Broker's fixed monthly payment is allocated to the respective account codes, using a "percentage of trips" basis.
- State NEMT staff review broker invoices, perform desk reviews of brokers' policies and procedures to ensure they meet requirements, and conduct on-site monitoring of broker processes to be sure that costs are charged appropriately.
- As of 01/01/2011, the State developed a Data Tracking and Utilization System (DTUS) and requires brokers to submit trip-level detail for review. This data has greatly enhanced the monitoring efforts of state staff, and has been used for targeted review of specific areas, and a representative sampling for on-site monitoring.

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24. a. Transportation (cont)

- State staff review, on-site at broker location, a random selection of trips, to include trips where costs are shared with non-Medicaid trips; review broker staff use of the allocation methodology, and test results.
- State staff desk review of cost allocation of shared trips, using the NEMT trips database. Costs assigned to Medicaid will not exceed the cost of the least expensive method of transportation appropriate to the Medicaid beneficiary.

(3) The State assures that transportation services will be provided under a contract with a broker who:

(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, qualifications, and costs;

(ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transportation is timely and transport personnel are licensed, qualified, competent, and courteous;

(iii) is subject to regular auditing and oversight by the State in order to ensure the quality and timeliness of the transportation services provided and the adequacy of beneficiary access to medical care and services;

(iv) complies with such requirements related to prohibitions on referral and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under Section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate.)

(4) The broker contract will provide transportation to the following categorically needy mandatory populations:

/X/ Low-income families with children (section 1931)
/X/ Deemed AFDC-related eligibles
/X/ Poverty-level-related pregnant women
/X/ Poverty-level-related infants
/X/ Poverty-level children 1 through 5
/X/ Poverty-level children 6 through 18
/X/ Qualified pregnant women AFDC-related
/X/ Qualified children AFDC-related
/X/ IV-E foster care and adoption assistance children
/X/ TMA recipients (due to employment)(section 1925)
/X/ TMA recipients (due to child support)
/X/ SSI recipients

(5) The broker contract will provide transportation to the following categorically needy optional populations:

/X/ Optional poverty-level-related pregnant women
/X/ Optional poverty-level-related infants
/X/ Optional targeted low-income children
/X/ Non-IV-E children who are under State adoption assistance agreements
/X/ Non-IV-E independent foster care adolescents who were in foster care on their 18th birthday

24. a. Transportation (cont)

/X/ Individuals who meet income and resource requirements of AFDC or SSI
/X/ Individuals who would meet the income and resource requirements of AFDC if child care costs were paid from earnings rather than by a State agency
/ / Individuals who would be eligible for AFDC if the State plan had been as broad as allowed under Federal law
/X/ Children aged 15 through 20 who meet AFDC income and resource requirements
/X/ Individuals who would be eligible for AFDC or SSI if they were not in a medical institution
/X/ Individuals infected with TB
/X/ Individuals screened for breast or cervical cancer by CDC program
/ / Individuals receiving COBRA continuation benefits
/X/ Individuals in a special income level group, in a medical institution for at least 30 consecutive days, with gross income not exceeding 300% of the SSI income standard
/X/ Individuals receiving home and community based waiver services who would only be eligible under the State plan if in a medical institution (NEMT is provided to 1905(a) services but not to 1915(c) waivered services (e.g.,socialization, work training, etc.)
/X/ Individuals terminally ill if in a medical institution and will receive hospice care
/X/ Individuals aged or disabled with income not above 100% FPL
/X/ Individuals working disabled who buy into Medicaid (BBA working disabled group)
/X/ Employed medically improved individuals who buy into Medicaid under TWWIIA Medical Improvement Group
/ / Individuals disabled aged 18 or younger who would require an institutional level of care (TEFRA 134 kids)

(6) Payment Methodology

(A) The State will pay the contracted broker by the following method:
/ / (i) Risk capitation
/ / (ii) Non-risk capitation
/X/ (iii) Other (e.g., brokerage fee and direct payment to providers)

(B) Who will pay the transportation provider?
/X/ (i) Broker
/ / (ii) State
/ / (iii) Other

Instructions:
Describe who will pay the transportation provider.

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24. a. Transportation (cont)

The State pays the brokers, which in turn pay the subcontracted transportation provider. Here is a description of the payment process:

The State contracts with brokers:
The State contracts with brokers specify a two-part payment:

- Broker payment: the contract term "Administrative Costs", that specify a fixed monthly amount for the broker cost of operations (e.g., operating a customer service center; verifying eligibility; assigning trips to lowest-cost, appropriate mode and provider of transportation; managing subcontracts including vehicle inspections and reviewing driver background checks; reviewing subcontractor invoices for the direct transportation services).

- Transportation provider payment: The State contracts with brokers use the term "Direct Service Costs" to identify the expenses and payments made to the brokers' subcontractors and the reimbursement to clients. The Direct Service Costs are "passed through" to the transportation providers; brokers do not retain any portion.

Brokers subcontract with transportation providers:
Payment methodology and rates are included in the brokers' subcontracts. [Note: The State does not set a fee-for-service rate for brokers' subcontractors because the transportation resource availability varies greatly across the state.] Further, State Department of Licensing rules allow local jurisdictions (e.g., cities) to regulate "for hire" operations, including rates charged to the general public. [State NEMT staff review broker subcontracts as part of the routine monitoring process. Brokers must submit a rate sheet as part of their monthly reports, and a summary of trips and expenses listed by each subcontractor. State NEMT staff review subcontractor rates to assure a competitive, fair process, and to defend against potential abuse.]

Broker payment type/method: With the exception of transit trips, the most common type of payment is made on a per mile basis, with a much smaller percentage of payments being time-based or flat-fee per contract. Brokers report the payment type in the trip-level detail submitted monthly.

Trip assignments: Brokers assign trips to the lowest-cost, available, and appropriate mode and provider of transportation based on each client's mobility status and personal capabilities. (Brokers are not allowed to directly provide transportation services.)

Transportation providers invoice broker:
After completing the trip, the transportation providers invoice the broker (detailed by trip, with the broker's trip control number). Brokers review subcontractor invoices and determine if the trip was invoiced correctly and whether the trip is payable and allowable by the State. The State does not pay for client "no shows" and does not pay for "no load" miles.
[Note (1): Brokers are required to maintain all documentation related to the state contract for brokerage services (e.g., operating a call center; verifying eligibility; assigning trips to lowest-cost, appropriate mode and provider of transportation; managing subcontracts including vehicle inspections and reviewing driver background checks; and reviewing subcontractor invoices for the direct transportation services.]
[Note (2): The brokers' subcontracted transportation providers are required to maintain all documentation related to the provision of the direct transportation service. The transportation providers bill the broker in accordance with the subcontract.]
Shared trips: See the description at the end of this Payment Methodology section regarding shared trips and cost allocation.

24. a. Transportation (cont)

Brokers invoice the State:
The brokers invoice the State; the invoice is due the 20th of the month following the month of service.
(1) The invoices contain separate line item amounts for:
the broker's contracted monthly payment (see description of "Administrative Costs"), which are detailed by accounting codes (allocated based on the number of trips) to funding source (e.g., Medicaid vs. non-Medicaid, and further detailed by specific medical assistance program); and
(2) transportation provider expenses (see description of "Direct Service Costs"), which are detailed by accounting codes to funding source (e.g., Medicaid vs. non-Medicaid, and further detailed by specific medical assistance program).
The invoice includes back-up documentation and comprehensive trip data reports. These reports include, but are not limited to: trips and costs by mode, by program serviced, most costly clients, and by subcontracted transportation provider.

The State pays the brokers, which then pay the transportation providers:
The State pays the broker for the broker "Administrative Costs", which the broker retains. The State pays the brokers for the "pass-through" expenses for payment to the transportation provider (the "Direct Service Costs"). Brokers are required to remit payment to subcontractors no later than ten (10) calendar days after receipt of the reimbursement from the State for allowed claims performed under the NEMT contract.

The State submits the required information for Medicaid-eligible services on the CMS 64 form.

Shared rides and cost allocation:
The trips provided under the State contract with brokers are predominately for Medicaid clients going to Medicaid-covered services (in CY2011, these accounted for 97.6% of trips).

The majority of brokered trips are provided on an "individual" basis, and costs are direct-charged to the client's respective medical assistance program. Shared rides are used when cost-effective, available, and appropriate; in some geographic areas shared rides are the only available resource other than gas vouchers or mileage reimbursement. Most shared rides are with other Medicaid passengers. Non-Medicaid trips, which are shared with others, accounted for less than 0.28% of all brokered trips. Proper accounting is done by coding trips according to the correct funding source, and the client's respective medical assistance program.

The State policy for broker allocation of costs of shared rides, when Medicaid is not the primary payor for all riders, is that Medicaid funds shall not subsidize the cost of non-Medicaid trips, and that the cost to Medicaid shall not increase because of the shared rides.

The State ensures that Medicaid is being appropriately charged for shared rides by requiring a broker to have an allocation methodology, monitoring the broker use/application of the allocation methodology, and testing sample sets of the costs of shared rides (Medicaid vs. non-Medicaid).

Until a consistent statewide allocation methodology is feasible, the State will require brokers submit a proposed allocation methodology for State review/approval. For brokers that use a manual calculation process (or a formula outside the software system), the State will review the various methods, and adopt a methodology to be used by these brokers. For brokers that use a process built into their software systems, the State will review the various methods supported by the software systems, and work with brokers to utilize the methodology which has the best results to prevent Medicaid subsidizing the cost of non-Medicaid trips.
The State will monitor broker application of the approved allocation methodology.

24. a. Transportation (cont)

(C) What is the source of the non-Federal share of transportation payments?

Instructions:
Describe the source of the non-Federal share of the transportation payments proposed under this State plan amendment. If more than one source exists to fund the non-Federal share of the transportation payments, please separately identify each source of non-Federal share funding.

The source of the non-Federal share of the transportation payments is State general funds.

(D) The State assures that no agreement (contractual or otherwise) exists between the State or any form of local government and the transportation broker to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly). This assurance is not intended to interfere with the ability of a transportation broker to contract for transportation services at a lesser rate and credit any savings to the program.

(E) The State assures that payment proposed under this State plan amendment will be made directly to transportation providers and that the transportation provider payments are fully retained by the transportation providers and no agreement (contractual or otherwise) exists between the State or local government and the transportation provider to return or redirect any of the Medicaid payment to the State or form of local government (indirectly or directly).

/X/ (7) The broker is a non-governmental entity:

/X/ The broker is not itself a provider of transportation nor does it refer to or subcontract with any entity with which it has a prohibited financial relationship as described at 45 CFR 440.170(4)(ii).

/ / The broker is itself a provider of transportation or subcontracts with or refers to an entity with which it has a prohibited financial relationship and:

(i) / / Transportation is provided in a rural area as defined at 412.62(f) and there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

(ii) / / Transportation is so specialized that there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

(iii) / / The availability of other non-governmental Medicaid participating providers or other providers determined by the State to be qualified is insufficient to meet the need for transportation.

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24. a. Transportation (cont)

/ / (8) The broker is a governmental entity and provides transportation itself or refers to or subcontracts with another governmental entity for transportation. The governmental broker will:

/ / Maintain an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the Medicaid brokerage will be completely separate from any other program.

/ / Document that with respect to each individual beneficiary's specific transportation needs, the governmental provider is the most appropriate and lowest cost alternative.

/ / Document that the Medicaid program is paying no more for fixed route public transportation than the rate charged to the general public and no more for public paratransit services than the rate charged to other State human services agencies for the same service.

(9) /X/ Please describe how the NEMT brokerage program operates.

Instructions:
Describe how the Brokerage program will operate. Include the services that will be provided by the broker. If applicable, describe any services that will not be provided by the broker and name the entity that will provide these services.

Non-governmental brokers serving the following contract regions are all private non-profit 501(c)3 organizations: Regions:

12. 1A, 3B, 4, 5, 6B and 6C (approved in SPA 08-028, effective 10/01/2008)
13. 1B, 1C, 1D, 1E, and 2 (effective 01/01/2011)
14. 6A (effective 04/01/2011)

24. a. Transportation (cont)

Description:

The State contracts with regional brokers:
The State of Washington operates the non-emergency medical transportation (NEMT) brokerage program through contracts with regional brokers, in accordance with federal regulations.

Brokers operate customer service centers and interact with eligible Medicaid clients requesting transportation access to eligible Medicaid services – trips are authorized only after brokers verify client eligibility and determine that clients do not have other transportation resources/options.

Brokers verify eligibility. The State provides brokers with a means of looking up client eligibility; the data includes the proper account codes to be used for a specific client's medical assistance program (e.g., there are approximately 40 sets of account codes, tied to specific medical assistance programs, and differentiate whether the client is on a Medicaid-funded or state-funded program, has managed care or not, or are dual eligible). This information is retained at the broker level and is not passed to the subcontracted transportation providers. The use of account codes helps ensure that Medicaid is charged only for allowable costs.

To directly save Medicaid medical funds (and as examples), brokers may authorize trips to Veterans' Hospitals and Shriners' Hospitals, and for services where Medicare and/or private insurance is primary and Medicaid coverage is secondary.

Brokers subcontract with transportation providers:
The brokers are responsible to develop a network of providers, using a fair and clear contracting process, through the use of subcontracts, that establish a competitive marketplace with a variety of service providers for each mode of transportation (e.g., ambulatory and nonambulatory trips). The subcontracts must be in writing and must include state requirements (reference contract exhibit for "Subcontracts with Transportation Service Providers"); subcontracts must include payment method, rates, and the State's minimum quality standards (e.g., standards for transport vehicles, drivers, and transportation performance).

Trip assignments:
Brokers assign trips to the most appropriate and cost-effective available transportation services subcontractor based on each client's mobility status and personal capabilities. Brokers utilize low cost options first, such as fixed route tickets/passes, gas reimbursement, mileage reimbursement, and only authorize higher cost options such as taxi and wheelchair lift-equipped vehicles based on the individual needs of clients. The State does not pay for no-load miles.

Monitoring of NEMT program:
State monitoring: The State monitors the NEMT program through multiple efforts:
- Monthly desk audits
- Monthly review of brokers invoices and reports, and backup documentation:
- A rates table for all subcontractors
- The number of trips by mode and total dollar cost, by subcontractor
- A complaints/grievance summary report, by category, by subcontractor
- Ongoing review of NEMT trips – brokers submit a monthly file of trip-level details, including assigned subcontractor, to the State's electronic NEMT trips database (used by NEMT staff as part of daily operations)
- Review broker reports of incidents and accident (part of daily operations)
- Review of brokers' subcontracts with transportation providers (as needed, either by electronic submission or on-site review)

24. a. Transportation (cont)

Review of fleet inventories, by subcontractor – twice annually
Review of an inspection schedule which lists, by subcontractor, the last date inspected and the next scheduled inspection date – twice annually.
Review of financial and operating reports – annually
Reviewed brokers independent audits
Random sample review of trips from the State's NEMT trips database to ensure compliance with Medicaid rules and regulations. Focused review of trips as needed.
On-site monitoring. During 2011 the State conducted an on-site monitoring visit and reviewed the following for a random sample of trips: billing, vehicle insurance documentation, vehicle inspection reports, driver documentation (e.g., background check, driver's license, Department of Licensing "Abstract of Driving Record", training certifications).

In addition, the State contractually requires brokers to conduct a percentage of pre-trip and post-trip verifications of appointments for Medicaid covered services.

The quantity and quality of trip/cost data facilitates State cost containment initiatives, as well as program oversight and management. As a result, Washington NEMT operates at one of the lowest estimated per capita costs in the country.

Complaint resolution and client appeal rights:
All Brokers are required to have staff that provides an ombudsman function, so that clients can get resolution at the broker level.

The State reviews complaints from clients, healthcare providers, and transportation providers. Complaints come in through a state customer service center (toll-free number), the NEMT website, direct phone calls, and inquiries from constituent services liaisons. State NEMT staff review complaints, resolve issues when possible, or provide explanation if customer expectations exceed program rules (e.g., client wants to choose provider).

Clients have the right to request a fair hearing, except in relation to provisions that are inapplicable under 42 CFR 440.170. Fair hearings are conducted before an impartial administrative law judge in accordance with the State's administrative hearings procedures (the same process as for other Medicaid healthcare services). Following an initial decision, clients have appeal rights to a Board of Appeals.

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24. a. Transportation (cont)

(b) Governmental entities

(1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a):

/X/ (1) state-wideness (indicate areas of State that are covered)
Broker region (approved in SPA 08-028, effective 10/01/2008):
3A: Island, San Juan, Skagit, and Whatcom counties

/ / (10)(B) comparability (indicate participating beneficiary groups)

/X/ (23) freedom of choice (indicate mandatory population groups)

(2) Transportation services provided will include:

/X/ Wheelchair van
/X/ Taxi
/X/ Stretcher car
/X/ Bus passes
/X/ Tickets
/X/ Secured transportation
/X/ Other transportation

Instructions:
Describe other transportation: When cost- effective, appropriate, and necessary to ensure access to eligible medical services, will consider using/authorizing gas/fuel vouchers, mileage reimbursement, grouped-ride vehicle, volunteer drivers, parking, tolls, ferries, and air transport, and will provide lodging and meal reimbursement as outlined at 42 CFR 440.170(a)(3)(ii).

[Note: Grouped or shared ride vehicles are a cost-effective method to transport groups of clients with similar trip origins and destinations, or more than one client in a locale similar to an airport shuttle. Brokers pay transportation subcontractors on a contracted mileage-based or time-based system; costs are allocated equitably to the clients' specific medical program account codes.]

See response at ATTACHMENT 3.1-A, 24.a.(a)(2) (Transportation services provided will include), Page 62___.

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24. a. Transportation (cont)

(3) The State assures that transportation services will be provided under a contract with a broker who:
(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, qualifications, and costs;
(ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transportation is timely and transport personnel are licensed, qualified, competent, and courteous;
(iii) is subject to regular auditing and oversight by the State in order to ensure the quality and timeliness of the transportation services provided and the adequacy of beneficiary access to medical care and services;
(iv) complies with such requirements related to prohibitions on referral and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under Section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate.)

(4) The broker contract will provide transportation to the following categorically needy mandatory populations:
/X/ Low-income families with children (section 1931)
/X/ Deemed AFDC-related eligibles
/X/ Poverty-level-related pregnant women
/X/ Poverty-level-related infants
/X/ Poverty-level children 1 through 5
/X/ Poverty-level children 6 through 18
/X/ Qualified pregnant women AFDC-related
/X/ Qualified children AFDC-related
/X/ IV-E foster care and adoption assistance children
/X/ TMA recipients (due to employment) (section 1925)
/X/ TMA recipients (due to child support)
/X/ SSI recipients

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24. a. Transportation (cont)

(5) The broker contract will provide transportation to the following categorically needy optional populations:

/X/ Optional poverty-level-related pregnant women
/X/ Optional poverty-level-related infants
/X/ Optional targeted low-income children
/X/ Non-IV-E children who are under State adoption assistance agreements
/X/ Non-IV-E independent foster care adolescents who were in foster care on their 18th birthday.
/X/ Individuals who meet income and resource requirements of AFDC or SSI
/X/ Individuals who would meet the income and resource requirements of AFDC if childcare costs were paid from earnings rather than by a State agency
/ / Individuals who would be eligible for AFDC if the State plan had been as broad as allowed under Federal law
/X/ Children aged 15 through 20 who meet AFDC income and resource requirements
/X/ Individuals who would be eligible for AFDC or SSI if they were not in a medical institution
/X/ Individuals infected with TB
/X/ Individuals screened for breast or cervical cancer by CDC program
/ / Individuals receiving COBRA continuation benefits
/X/ Individuals in a special income level group, in a medical institution for at least 30 consecutive days, with gross income not exceeding 300% of the SSI income standard
/X/ Individuals receiving home and community based waiver services who would only be eligible under the State plan if in a medical institution (NEMT is provided to 1905(a) services but not to 1915(c) waivered services (e.g., socialization, work training, etc.)
/X/ Individuals terminally ill if in a medical institution and will receive hospice care
/X/ Individuals aged or disabled with income not above 100% FPL
/X/ Individuals working disabled who buy into Medicaid (BBA working disabled group)
/X/ Employed medically improved individuals who buy into Medicaid under TWWIIA Medical Improvement Group
/ / Individuals disabled aged 18 or younger who would require an institutional level of care (TEFRA 134 kids)

(6) Payment Methodology

(A) The State will pay the contracted broker by the following method:
/ / (i) Risk capitation
/ / (ii) Non-risk capitation
/X/ (iii) Other (e.g., brokerage fee and direct payment to providers)

(B) Who will pay the transportation provider?
/X/ (i) Broker
/ / (ii) State
/ / (iii) Other

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24. a. Transportation (cont)

Instructions:
Describe who will pay the transportation provider.

See response at ATTACHMENT 3.1-A, 24.a.(a) (6) Payment Methodology, Page 62___.

(C) What is the source of the non-Federal share of transportation payments?

Instructions:
Describe the source of the non-Federal share of the transportation payments proposed under this State plan amendment. If more than one source exists to fund the non-Federal share of the transportation payments, please separately identify each source of non-Federal share funding.

The source of the non-Federal share of the transportation payments is State general funds.

(D) The State assures that no agreement (contractual or otherwise) exists between the State or any form of local government and the transportation broker to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly). This assurance is not intended to interfere with the ability of a transportation broker to contract for transportation services at a lesser rate and credit any savings to the program.

(E) The State assures that payment proposed under this State plan amendment will be made directly to transportation providers and that the transportation provider payments are fully retained by the transportation providers and no agreement (contractual or otherwise) exists between the State or local government and the transportation provider to return or redirect any of the Medicaid payment to the State or form of local government (indirectly or directly).

/ / (7) The broker is a non-governmental entity:

/ / The broker is not itself a provider of transportation nor does it refer to or subcontract with any entity with which it has a prohibited financial relationship as described at 45 CFR 440.170(4)(ii).

/ / The broker is itself a provider of transportation or subcontracts with or refers to an entity with which it has a prohibited financial relationship and:

(i) / / Transportation is provided in a rural area as defined at 412.62(f) and there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

(ii) / / Transportation is so specialized that there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

(iii) / / The availability of other non-governmental Medicaid participating providers or other providers determined by the State to be qualified is insufficient to meet the need for transportation.

24. a. Transportation (cont)

/X/ (8) The broker is a governmental entity and provides transportation itself or refers to or subcontracts with another governmental entity for transportation. The governmental broker will:

/X/ Maintain an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the Medicaid brokerage will be completely separate from any other program.

/X/ Document that with respect to each individual beneficiary's specific transportation needs, the governmental provider is the most appropriate and lowest cost alternative.

/X/ Document that the Medicaid program is paying no more for fixed route public transportation than the rate charged to the general public and no more for public paratransit services than the rate charged to other State human services agencies for the same service.

(9) /X/ Please describe how the NEMT brokerage program operates.

Instructions:
Describe how the Brokerage program will operate. Include the services that will be provided by the broker. If applicable, describe any services that will not be provided by the broker and name the entity that will provide these services.

Governmental broker serving region 3A.

The broker serving Region 3A is a governmental entity (a council of governments) and serves Island, San Juan, Skagit, and Whatcom counties. This broker does not directly provide trips, but does purchase trips on two public transit system (in Skagit and Whatcom counties). This broker also authorizes trips using other available modes of transportation as listed in Section (2).

(A) The State pays for direct transportation expenses (e.g., cost of the trips by subcontracted transportation providers, bus tickets, gas vouchers) per detailed report. The State pays separately for the governmental broker's cost of operating the brokerage (call center, etc.), on a set monthly amount basis.

The governmental broker maintains an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the Medicaid brokerage will be completely separate from any other program. The governmental broker maintains an accounting system as required by this authority. The broker is both required by law and committed to assuring that all agency costs are allocated to the appropriate activity and fund source. All costs clearly attributable to a specific activity and fund source are directly charged to that fund source. Activities which benefit all programs operated by the organization are allocated based upon a cost allocation plan (this applies to a portion of the broker's cost of operating the brokerage).

24. a. Transportation (cont)

(B) The governmental broker has a procedure related to evaluating each individual beneficiary's specific needs and making a determination related to the most appropriate, lowest cost trip, with a specific focus on the procedure related to governmental providers (i.e., public transit). These determinations are made on a case-by-case basis each month.

(C) For Medicaid beneficiaries, the governmental broker pays the same rate/fare as the general public pays for all fixed route transportation. The cost of the bus pass may not exceed the total cost of all trips a beneficiary would make to Medicaid providers to obtain Medicaid services, were the trips purchased individually. The governmental broker also pays the same rate as the general public for paratransit trips, which is no more than human service agencies pay for the service. The public rates are utilized in determining whether public transit will be the most appropriate low cost service for a specific beneficiary's needs in any given month. In general, public transit trips in the broker's regions are significantly lower in cost than other modes of transportation available.

For additional information see "Description" at ATTACHMENT 3.1-A, 24.a.(a) (9) (how the NEMT brokerage program operates), Page 62___.

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24. d. Nursing facility services for patients under 21 years of age

The admission requires prior approval.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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25. Home and community care for functionally disabled elderly Individuals, as defined, described and limited in Supplement 2 to attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A

Provided
__X__ Not provided

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

26. Personal care services

a. Eligibility for services.
Persons must living in their own home, Adult Family Home, family foster home, or assisted living facility.

b. Persons must be determined to be categorically needy and have three ADL needs requiring minimal assistance or one ADL need requiring more than minimal assistance. Personal care services means physical or verbal assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) due to functional limitations. ADL assistance means physical or verbal assistance with bathing, turning and repositioning, body care, dressing, eating, mobility, medication assistance, toileting, transfer, personal hygiene, nurse delegated tasks, and self-directed treatment. IADL assistance is incidental to the provision of ADL assistance and includes ordinary housework, laundry, essential shopping, wood supply (if wood is the primary source of heat) and transportation assistance.

c. Persons receiving personal care from an Individual Provider have employer authority including hiring, firing, scheduling, and supervision of providers.

d. Services are provided by these provider types:
- State-licensed agencies providing personal care services, consisting of licensed home-care agencies and licensed adult residential care providers who are contracted with the Medicaid Agency. Home health agencies providing personal care services do not require Medicare certification;
- State-licensed adult residential care providers; and
- Consumer Directed Employer of Individual providers who have a valid Washington business license, demonstrated financial stability, five years' experience in healthcare or social service, meet staffing requirements, have a commitment to consumer choice and self-direction, and are contracted with the Department. The CDE will ensure that individual providers who provide personal care:
    - Clear background checks as required by state law;
    - Complete training and certification as required under state law; and
    - Complete continuing education credits as stipulated in state law in order to continue to provide personal care services.

e. Individual providers of the CDE may not work more than the provider's assigned work week limit. This limitation does not affect the participant's total hours of service, and may necessitate the use of more than one provider.

f. For individuals under 21 years of age, services will be provided in accordance with EPSDT requirements at 1905(r) subject to determination of medical necessity and prior authorization by the Medicaid Agency.

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27. Emergency Medical Services for Aliens

An alien who is a non-qualified alien or a qualified alien subject to the five-year ban and is otherwise eligible for Medicaid is eligible only for care and services necessary to treat an emergency medical condition as defined in section 1903(v) of the Act.

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28. Program of all-inclusive care for the elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A

_X_ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

___ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

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28b. Licensed or Otherwise State-Approved Freestanding Birthing Center

a. Facilities must:
(i) Be licensed by the Department of Health (DOH) under chapter 246-349 WAC;
(ii) Be specifically approved by DOH to provide birthing center services; and
(iii) Maintain standards of care required by DOH for licensure.

b. Covered practitioners providing services in the freestanding birthing center

(i) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State Plan.

The following practitioners may provide birthing center services and must be licensed in the State of Washington as a:
(a) Physician under chapter 18.57 or 18.71 RCW;
(b) Nurse midwife under chapter 18.79 RCW; or

(ii) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birthing center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60.
(a) Midwife under chapter 18.50 RCW.

(iii) Other health care professionals recognized by the State to provide these birth attendant services.
NA

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30. Coverage of Routine Patient Cost in Qualifying Clinical Trials

*The state needs to check each assurance below.

Provided: __X__

I. General Assurances:

Routine Patient Cost – Section 1905(gg)(1)

_X_ Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

Qualifying Clinical Trial – Section 1905(gg)(2)

_X_ A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

Coverage Determination – Section 1905(gg)(3)

_X_ A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may notconduct or sponsor, and a person is not required to respond to, a collection of information unlessit displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 SecurityBoulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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HIV/AIDS CASE MANAGEMENT SERVICES

A. Target Group:

Clients who have a current medical diagnosis of HIV or AIDS and who are eligible for Title XIX (Medicaid) coverage under the Categorically Needy Program (CNP) or the Medically Needy Program (MNP). The clients require assistance obtaining and effectively using necessary medical, social, and educational services or the client's condition is such the client requires 90 days continued monitoring.

B. Areas of State in which services will be provided:

/X/ Entire State.

/ / Only in the following geographic areas (authority of section 1915 (g) (1)) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services:

/ / Services are provided in accordance with section 1902 (a) (10) (B) of the act.

/X/ Services are not comparable in amount, duration, and scope. Authority of section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of section 1902 (a) (10) (B) of the Act.

D. Definition of Services

MAA requires that HIV/AIDS case management providers perform the following functions:

1. Notify HIV positive persons, verbally or by signing a statement, of their choice of available HIV/AIDS case management providers statewide. This requirement does not obligate HIV/AIDS case management.

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HIV/AIDS CASE MANAGEMENT SERVICES (cont.)

D. Definition of Services (continued)

providers to accept all clients who request their services. The case management provider will refer the client to another provider.

2. Obtain and maintain a current Authorization to Release/Obtain Information form. The provider must have a valid authorization on file for the months that case management services are billed to MAA. The provider cannot charge the client for services or documents related to covered services.

3. Maintain sufficient contact to ensure effectiveness of ongoing services. MAA requires a minimum of one contact per month between the HIVIAIDS case manager and the client. However, contact frequency must be sufficient to ensure implementation and ongoing maintenance of the Individual Service Plan (ISP).

Case management includes services which will assist clients in: living as independently as possible, maintaining and improving their health, reducing behaviors that put themselves and others at risk, and gaining access to needed medical, social, and educational services.

Description of Services:

Case management functions (core and support) are provided under the direction of a qualified case manager and are detailed below.

Core Functions:

Comprehensive Assessment: A comprehensive assessment is an evaluation to determine client's needs for case management services in several areas. This evaluation includes demographic information, physical status, HIV diagnosis, psychological/social/cognitive functioning and mental health history, ability to perform daily activities, financial and employment status, medical benefits and insurance coverage, informal support systems, legal status, and reportable behaviors which could lead to HIV transmission or reinfection.

Service Plan Development: An individual service plan must be developed in conjunction with the comprehensive assessment to identify and document the client's unmet needs and the resources needed to assist in meeting those needs.

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HIV/AIDS CASE MANAGEMENT SERVICES (cont.)

D. Definition of Services, Core Functions (cont.)

Service Plan Implementation: The case manager is responsible for implementation of the service plan, but may delegate specific functions to others, such as the home health nurse, discharge planners, etc.

Service Plan Review: The case manager must review the service plan monthly through in-person contact or by telephone contact with the client.

Narrative Records: Case managers must keep ongoing records, which clearly document case management services. These records must include the reason for the case manager's interaction with the client and the plans in place or to be developed to meet unmet client needs.

Support Functions:

Client Advocacy: Intervene with agencies or persons to help individual clients receive appropriate benefits or services.

Assistance: Assist or arrange for the client to obtain a needed service or accomplish a necessary task.

Consultation: Consult with service providers and professionals to utilize their expertise on the client's behalf.

Networking: Help a client to access services through linkages between formal and informal support systems for the purpose of creating an effective continuum of care.

Family Support: Arrange for appropriate referrals to help the family or significant others to deal with stress and changes related to the client's impairments.

E. Qualifications of Providers:

Provider Qualifications - Individual case managers

An HIV/AIDS case manager shall:

1. Be either a professional or a paraprofessional (HIV/AIDS case manager assistant) under the direct supervision of a professional;

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HIV/AIDS CASE MANAGEMENT SERVICES (cont.)

E. Qualifications of Providers (continued)

2. Be employed and enrolled as an HIV/AIDS case manager by a public or private health, social service, or education agency.

3. Have demonstrated skills and knowledge necessary to perform his/her job responsibilities at the time of employment or have the potential of achieving the required skills and knowledge through training;

4. Have a general knowledge of HIV/AIDS-related conditions and diseases, the AIDSNET service delivery system, and other service delivery systems in his/her community;

5. Meet at least the following requirements for education and experience:

(a) Master's Degree in behavioral or health sciences (e.g. social work, clinical psychology, sociology, guidance counseling, nursing, and public health) and one year of paid social service experience;

(b) Bachelor's Degree in behavioral or health sciences and two years of paid social services experience;

(c) Bachelor's Degree and three years of paid social services experience.

HIV Client Services, Department of Health may make exceptions to the above requirements when the service population is geographically or culturally isolated, or has limited English speaking ability.

Provider qualification - Case management agencies

An HIV/AIDS case management agency must:

1. Be a public or private social service, health, or education agency employing staff with HIV/AIDS case manager qualifications;

2. Demonstrate linkage and referral ability with social and health service agencies and individual practitioners;

3. Have experience working with persons living with HIV/AIDS;

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HIV/AIDS CASE MANAGEMENT SERVICES (cont.)

E. Qualifications of Providers (continued)

4. Meet applicable state and federal laws and regulations governing the participation of providers in the Medicaid program;

5. Have caseload size standards that allow HIV/AIDS case management staff to perform the duties established in the Title XIX HIV/AIDS case management standards;

6. Have supervisors who meet the HIV/AIDS case manager qualifications and have:

(a) A Master's Degree and two years of paid social service experience; or

(b) A Bachelor's Degree and three years of paid social service experience, including one supervisory year.

F. Choice of Providers

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902 (a) (23) of the Act. Eligible recipients will have free choice of the providers of:

1. HIVIAIDS case management services; and

2. Other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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II. VULNERABLE ADULTS

1915(g)(1) TARGET POPULATION

Recipients age 18 and over who:

a) Require services from multiple health/social service providers; and,

b) Are unable to obtain the required health/social services for themselves; and,

c) Do not have family or friends who are able and willing to provide the necessary assistance; and,

d) Have at least minimal need for assistance with one or more activities of daily living.

1915 (g) (1) STATEWIDENESS

This service will be offered on a statewide basis.

1915(g)(1)
1902 (a) (1) COMPARABILITY

In accord with Section 1915(g)(1), case management services will be provided without regard to the requirements of Section 1902(a)(10)(B) of the act. Services will be provided to all recipients age 18 and over.

1915(g)(1)
1902 (a) (23 FREEDOM OF CHOICE

In accord with Section 1902(a)(23) of the Social Security Act, individuals eligible to receive medical services shall be free to obtain such services from any institution, agency or person qualified to provide services available under the Medical Assistance program.

1915 (g) (2) DEFINITION OF SERVICE

Case management means services which will assist individuals eligible under the plan in gaining access to needed health and related social services.

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Case Management, Vulnerable Adults, cont.

DESCRIPTION OF SERVICE:

Required services include screening and referral as well as comprehensive assessment of individual needs and development of detailed individual plans of service and related activities. The plan is designed to assist clients to obtain needed health-related services in the least restrictive service setting. Case management functions are provided under the direction of a qualified case manager and may be divided into core functions and support, functions.

Core Functions:

Intake Evaluation: A comprehensive assessment to determine a client's need for case management and/or other services.

Service Plan Development: An individual case management service plan is developed when the client has been determined to meet target population criteria.

Service Plan Implementation: The case manager is responsible or implementation of the service plan, but may delegate specific functions to others. Service plan implementation includes counseling to encourage client cooperation in implementing the service plan, service authorization when appropriate, referral for services, case coordination and maintaining regular contact with the client to carry out the service plan.

Service Plan Review: Service plan reviews will be conducted as needed and always in person.

Termination Planning: The case manager is responsible or planning to terminate case management services when the client's situation has stabilized.

Support Functions:

Client Advocacy: Intervene with agencies or persons to help individual clients receive appropriate benefits or services.

Assistance: Help the client obtain a needed service or accomplish a necessary task (complete a form, obtain appropriate authorization, find a living situation, help with moving, provide transportation or escort, etc.)

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Case Management, Vulnerable Adults, cont.

Description of Service (cont.)

Consultation: Consult with service providers and professionals to utilize their expertise on the client's behalf.

Networking: Develop a series of linkages between formal and informal support systems for the purpose of creating an effective continuum of care.

Crisis Intervention: Provide short-term intervention in an emergency situation.

PROVIDERS:

Services will be provided by qualified case managers who meet the case management standards promulgated by the Division of Medical Assistance. The Division of Medical Assistance will assure freedom of choice of providers to eligible clients.

QUALIFICATIONS:

Case Managers will meet at least the following requirements for education and experience:

1. Master's Degree in behavioral or health sciences and one year of paid on-the-job social service experience;

OR

2. Bachelor's Degree in behavioral or health sciences and two years of paid on-the-job social service experience;

OR

3. Bachelor's Degree and four years of paid on-the-job social service experience.

Exceptions to qualification requirements will be granted by the Division of Medical Assistance when the population to be served is:

1. Of limited-English speaking ability or is culturally isolated and access is assured by hiring bilingual bicultural staff;

OR

2. Geographically isolated.

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(Case Management, Vulnerable Adults, cont)

It is the intent of this policy that exceptions will be rare.

Case managers qualifying under these circumstances will be designated as case manager trainees. Case manager trainees will participate in on-the-job training. Their supervisor must review and provide follow-up on all cases managed by the trainee each month. At the end of three years, the trainee will be evaluated by the supervisor; if his or her work meets the standards required, he/she will move to regular case manager status.

RELATION TO STATE AGENCY:

In accordance with the Title XIX State Plan, responsibility for administration will be with the Single State Agency. Discrete functions may be delegated to other agencies, but only under formal, written agreements.

ASSURANCES

1915(b) (c) NON-DUPLICATION OF OTHER CASE MANAGEMENT SERVICES

Payments made for targeted case management services will not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

The Division of Medical Assistance will maintain an adequate audit trail to ensure that match is non-federal in origin and that billed services were actually delivered.

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INFANT CASE MANAGEMENT SERVICES

Target Group

The Department provides infant case management services to Medicaid infants and their parent(s) for the direct benefit of the eligible infant from the time the infant is three months of age through the month of the infant's first birthday. Services are based on individual client needs which are identified through a screening process.

For the purpose of this program, the State defines a parent(s) as a person who resides with an infant, provides the day-to-day care, is authorized to make health care decisions, and is:

A. The infant's natural or adoptive parent(s);
B. A person other than a foster parent who has been granted legal custody of the infant; or
C. A person who is legally obligated to support the infant.

B. Comparability of services

[ ] Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

[X] Services are not comparable in amount, duration, and scope. Authority of Section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a) (10) (B) of the Act.

C. Components of Infant Case Management Services

Infant case management provides information and assistance to eligible infants and their parent(s) in order for the parent(s) to access needed medical, social, educational, and other services for the direct benefit of the eligible infant. Parents do not receive TCM services separately from what is provided to the eligible infant.

Case management includes contacts with non-eligible individuals that are directly related to identifying the infant's needs and care, for the purposes of helping the infant access services, identifying needs and supports to assist the infant in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the infant's needs.

The core functions of the infant case manager are to:

Screen/Assess: The infant and parent(s) to identify needs. Screening identifies risks to the infant and parent(s) that jeopardize the welfare of the infant. An assessment determines the need for any medical, educational, social, and other services. Assessment involves taking infant and parent(s) history, identifying the risks to the infant, identifying the needs of the parent(s), and completing related documentation. It also includes gathering information from other sources such as family members, medical providers, and educators, if necessary, to form a complete assessment of the Medicaid infant and parent(s). Subsequent screening and/or reassessments will occur based on individual needs and as documented in the care plan.

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Infant Case Management Services (cont.)

C. Components of Infant Case Management Services (cont)

Develop a Care Plan: To build on the information collected through the screening/assessment. A care plan will be developed, periodically reviewed, and revised as needed. A care plan will include:

- An overview of identified risks that jeopardize the welfare of the infant;
- Activities such as ensuring the active participation of the infant and working with the infant or parent(s);
- Specific goals and actions to address the medical, social, educational, and other services needed by the infant, including frequency of reassessments, if needed;
- Identification of local services and/or resources that improve the welfare of the infant;
- Expected outcomes of receiving ICM services.

Refer & Link: Medicaid-eligible infants and their parent(s) with medical, social, and educational services. For example, identifying a medical resource with the parent, and then contacting the medical resource to make an appointment on behalf of the parent.

Provide On-going Follow-up: To ensure the care plan is implemented and continues to adequately address the needs of the infant and parent(s). It also provides an opportunity for the infant case manager to make sure the parent(s) has information and resources necessary to meet the basic health and safety needs of the infant and that those services are being provided according to the infant's care plan. The activities and contacts made by the infant case manager may be with the Medicaid-eligible infant, parent(s), other family members, providers, and other entities that can assist the parent(s) and infant case manager in addressing the risks identified and included in the care plan. Changes in the needs or status of the infant are reflected in the care plan. Follow-up contact may be as frequent as necessary during the eligibility period with monitoring activities based on individual client circumstances.

D. Qualifications of Providers

Infant case managers must:

1. Work for a case management agency; the agency must have a National Provider Identification (NPI) number assigned by DSHS; and

2. Meet licensure requirements as determined and established by the Washington State Department of Health (DOH); and

3. Meet one of the following:

   A. Participate as a current member of the interdisciplinary maternity support services team as a community health nurse, behavioral health specialist, or registered dietician, all of whom are registered with and meet licensure requirements established by the Washington State Department of Health (DOH).

   -OR-

   B. Have a Bachelor's or Master's degree in a social service-related field such as social work, behavioral sciences, psychology, child development, or mental health **plus** one year of experience working in community services, social services, public health services, crisis intervention, outreach programs or other related field.

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Infant Case Management Services (cont.)

D. Qualifications of Providers (cont)

-OR-

C. Have a two-year Associate of Arts (AA) degree in a social service-related field such as social work, behavioral sciences, psychology, child development, or mental health **plus** two years of full time experience in community services, social services, public health services, crisis intervention, outreach programs or other related field. This staff person must receive monthly clinical supervision by a person listed in sub-paragraph D.3.A above or a staff person who has a Bachelor's or Master's degree in a social service-related field such as social work, the behavioral sciences, psychology, child development, mental health, nursing, or a closely allied field and provides oversight to this program as part of their daily administrative responsibilities. Clinical supervision may include face-to-face meetings or chart review or both, with the frequency dependent on the level of experience demonstrated by the staff person with the AA.

E. Case Management Agencies:

1. Are public or private social, health or education agencies employing staff with infant case managers.
2. Demonstrate the ability to refer, link and collaborate with individual practitioners, social, health and education agencies.
3. Have experience working with low-income families including pregnant and parenting women and children.
4. Meet applicable state and federal laws and regulations governing the participation of providers in the Medicaid program.

F. Access to Services

The state assures:

1. Infant case management services will not be used to restrict a client's access to other services under the Plan;
2. Clients will not be compelled to receive case management services, conditional receipt of case management services on the receipt of other Medicaid services, or conditional receipt of other Medicaid services on receipt of case management services; and
3. Infant case management providers do not exercise the department's authority to authorize or deny the provision of other services under the Plan.

G. The state assures that there are no restrictions on a client's free choice of providers in violation of Section 1902 (a) (23) of the Act.

All eligible Medicaid infants and their parent(s) have freedom to choose:

1. Whether or not to receive infant case management services.
2. Which infant case management provider they want to work with.
3. Which providers of other medical care under the plan they want to work with.

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Infant Case Management Services (cont.)

H. Payment

Payment for case management or TCM services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

I. Case Records

Providers maintain case records for all infants receiving case management. Case records contain the following documentation:

1. Name of the infant;
2. Date(s) of case management services;
3. Name of provider agency and case manager;
4. Nature, content, units of case management services received by infant and whether goals specified in the care plan have been achieved;
5. Whether the infant or parent(s) has declined services in the care plan;
6. The need for, and occurrences of, coordination with other case managers;
7. A timeline for obtaining needed services; and
8. A timeline for reevaluation of the plan.

J. Federal Financial Participation (FFP) Assurances

1. Case management does not include, and FFP is not claimed for:
   a. Infant case management when those activities are an integral and inseparable component of other covered Medicaid services.
   b. Case management services that are direct delivery of underlying medical, educational, social, or other services for which an eligible infant has been referred, including foster programs. These services include, but are not limited to, the following:
      i. Research gathering and completion of documentation required by the foster care program;
      ii. Assessing adoption placement;
      iii. Recruiting or interviewing potential foster care parents;
      iv. Serving legal papers;
      v. Home investigations;
      vi. Providing transportation;
      vii. Administering foster care subsidies; and
      viii. Making placement arrangements.

2. FFP is only available for case management service or TCM services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program. The exception to this is case management that is included in an individualized family service plan consistent with §1903(c) of the Act (§§1902(a)(25) and 1905(c)).

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TARGETED CASE MANAGEMENT SERVICES
[Target Group]

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):
[Describe target group and any subgroups. If any of the following differs among the subgroups, submit a separate State plan amendment describing case management services furnished; qualifications of case management providers; or methodology under which case management providers will be paid.]

All children under age 21 who have been removed, or are at risk of such removal, from his/her home into publicly funded care or supervision due to family crisis or dysfunction; and their caretakers (parents of such children, or persons serving in a parental capacity, excluding paid foster parents). Assistance to caretakers is provided for the direct benefit of the child.

___ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to ____ [insert a number; not to exceed 180] consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
_X_ Entire State
___ Only in the following geographic areas: [Specify areas]

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
_X_ Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include

- taking client history;
- identifying the individual's needs and completing related documentation; and
- gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

[Specify and justify the frequency of assessments.]
Case management activities, including assessment, re-assessment, care plan development, and monitoring and revision of care plans, for the individuals identified in the target group will be based upon a Significant Encounters Model. Frequency of case management encounters must be no less than one contact per month. These encounters are identified as face-to-face visits with the child and parent/caretaker; phone calls, as needed during the month, of at least 15 minutes duration if related to linking child or parent/caretaker to needed medical, educational, social or other services. Significant encounters, as needed during the month, may include contact with service providers to ensure adequacy of services and client participation. Following assessment or re-assessment, the resulting plan of care will be recorded in the Individual Service and Safety Plan (ISSP), or other document that details the assessment or re-assessment of the individual's specific needs, a course of action to address those needs, and the progress of the individuals included in the target group relative to their specific plans of care.

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Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that specifies the goals and actions to address the medical, social, educational, and other services needed by the individual; includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and identifies a course of action to respond to the assessed needs of the eligible individual;

Development and periodic revision of a specific care plan will follow the same guidelines as those specified in the Significant Encounter model above. The progress of the individual with respect to goals identified in his or her care plan will be detailed and recorded in the Individual Service and Safety Plan (ISSP), or other detailed care plan document which specifies goals, actions, client participation and progress. The care plan will be reviewed and, if necessary, revised, no less frequently than every six months, or more frequently if needed.

Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:

- Activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

Monitoring and follow-up activities:

Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:

- services are being furnished in accordance with the individual's care plan;
- services in the care plan are adequate; and
- changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers. [Specify the type of monitoring and justify the frequency of monitoring.]

Monitoring using the Significant Encounter Model will include face-to-face visits with the child and parent/caretaker at least once per month; phone calls of at least 15 minutes duration, as needed during the month, if related to linking child or parent/caretaker to needed medical, educational, social or other services. This may include contact with service providers, as needed during the month, to ensure adequacy of services and client participation. This frequency (of no less than once per month) is the minimum necessary to monitor the adequacy of the individual's progress with the care plan, the adequacy of the care plan to address the individual's needs, and to determine if any adjustments should be made to the care plan to better serve the individual's needs. The progress of the care plan will be recorded in the Individual Service and Safety Plan (ISSP), or an equivalent detailed document.

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_X_ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
[Specify provider qualifications that are reasonably related to the population being served and the case management services furnished.]

- Any public or private entity licensed by the State as a child-placing agency.
- Providers will possess, at a minimum, a B.A. in Social Work or a closely allied field, and will have a minimum of one year's experience in working with children and families.
- TCM provider agencies: TCM case managers employed by the child-placing agency must meet the following requirements for education and/or experience: possess at least a B. A. in Social Work or a closely allied field from an accredited college or university, and one year of experience in performing case management duties working with children and families.

Freedom of choice (42 CFR 441.18(a)(1):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
__ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

[Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]

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Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

[Specify any additional limitations.]

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CASE MANAGEMENT SERVICES

A. Targeted Population:

Title XIX eligible individuals who:

(1) Are Limited English Speaking (LES); and

(2) Are 16 years of age and over; and

(3) Are refugees or immigrants who lack English proficiency, are unable to access information or obtain assistance, or a job in order to become economically independent; and

(4) Require services from multiple health/social service providers; and

(5) Are unable to obtain the required health/social services for themselves; and

(6) Do not have family or friends who are able and willing to provide the necessary assistance.

16 to 18 year old clients will only be served if these services are not available through the public school system and or the Superintendent of Public Instruction Office.

B. Areas of State in which services will be provided:

_X_ Entire State

This service will be offered on a statewide basis.

___ Only in the following geographic areas (authority of section 1915(g)(1)) of the Act is invoked to provide services less than Statewide:

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State WASHINGTON

(Case Management, LES, cont)

C. Comparability of Services:

__ Services are provided in accordance with section 1902 (a) (10) (B) of the Act.

_X_ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902 (a)(10)(B) of the Act.

D. Definition of Service:

Case Management services for limited English speaking clients is an ongoing process designed to assist eligible recipient (s) to obtain and effectively utilize necessary medical, social, educational and other services. Under this plan the Division of Refugee Assistance (DORA) will offer two levels of case management services (1) barriers removal (i.e., assessment, planning and follow-up) and (2) intensive self-sufficiency services and supportive services.

Core Functions:

1. *Comprehensive Assessment and follow up*- This service includes an intake interview and assessment of client's needs for medical, educational, social and other related services deemed appropriate by the case manager. The case manager will prepare a detailed plan of services needed to help the client overcome barriers to self-sufficiency. The focus of this service is client referral and access to needed services. Follow-up on this plan is essential to insure that appropriate services are received.

2. *Self-Sufficiency Service:* This service is provided to inform each client about, and gain access to, needed services, such as health, social and educational opportunities (English as a Second Language (ESL), Vocational Training, etc. ,). Access to services is accomplished by setting, on an individual basis, personal goals for self-sufficiency, and designing realistic plans for the individual client related to access to specific services.

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(Case Management, LES, cont)

Providers will also establish linkages with other organizations to assist the clients with accessing health, social, and education needs.

Support Function:

Client Advocacy: Intervene with agencies or persons to help individual clients receive appropriate benefits or services.

E. Qualification of Providers:

Case management services will be provided through contracts between the Medicaid agency and any provider meeting the below specified qualifications:

1. Case Management Agencies:

   a. Must be a social service agency, employing staff with case management qualifications.

   b. Must be able to provide referral services and demonstrate linkages and referral ability with essential social and health service agencies.

   c. Have a minimum of one year experience in assisting low income families obtain medical, employment training, and other related social service.

2. Case Managers must meet the following requirements for education and experience:

   a. A Bachelor's Degree in social services or an allied field and **one year** of social service experience with refugees and immigrants. **Two years** of social service experience or providing case management services to refugee families may be substituted for two years of the required education.

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(Case Management, LES, cont)

b. Preferably be bilingual (read, write and speak fluently in the client's native language) and/or bicultural (have in-depth knowledge of the client's culture).

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

3. Eligible clients will have the option to participate in the services offered under this plan.

G. Payment for case management services under the plan will not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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CASE MANAGEMENT SERVICES

A. Target Group:

Persons who are Medicaid recipients (clients) and alcohol- or other drug-dependent who need assistance in obtaining necessary medical, social, educational, vocational, and other services.

B. Areas of State in which services will be provided:

/X/ Entire State

C. Comparability of Services:

/X/ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Case management is an ongoing process to assist eligible clients gain access to and effectively use necessary health and related social services.

Description of Services:

Case management will be used to either involve eligible clients in chemical dependency treatment or to support them as they move through stages of chemical dependency treatment within or between separate treatment agencies.

Core Functions: The core functions of the case manager are to provide or assist in providing:

Identification of Needs
Complete a comprehensive and ongoing assessment of the client's needs for medical, social, educational, and other related services. Address the barriers to accessing or utilizing chemical dependency treatment services and other services.

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(Case Management, Alcohol/Drug Dependent, cont)

D. Description of services (con't)

Planning
Prepare and implement a written service plan that reflects the client's needs and the resources available to meet those needs in a coordinated, integrated fashion.

Linkage
Facilitate access to needed services through linkages between support systems to avoid duplication of services. These services will augment/reinforce the treatment for chemical dependency.

Advocacy
Intervene with agencies/persons to help clients receive appropriate benefits or services. Also, help the client obtain a needed service or accomplish a necessary task. Be available to help problem-solve when there is a crisis in the client's treatment plan. Advocate for the client's treatment needs with treatment providers.

Accountability
Retain documentation of case management plan and services provided. Submit data as required.

E. Qualifications of Providers:

Case management services will be provided through contracts between the Medicaid agency and chemical dependency treatment agencies certified under Chapter 388-805 WAC in order to ensure that the case managers for these clients are capable of providing the full range of services needed by these targeted clients.

Case management services will be provided by a Substance Abuse counselor who meets the requirements of a certified Chemical Dependency Professional or a Chemical Dependency Professional Trainee as defined in WAC 388-805.

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State WASHINGTON

(Case Management, Alcohol/Drug Dependent, cont)

F. The state assures that the provision of case management services will not restrict a client's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible clients will have free choice to receive or not receive case management services.

2. Eligible clients will have free choice of the providers of other medical care under the plan.

Payment for case management services under the plan will not duplicate payments made to public agencies or private entities under other program authorities this same purpose.

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AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES FOR THE CATEGORICALLY NEEDY

1. The State of _____ provides home and community care to functionally disabled elderly individuals to the extent described and defined in this Supplement (and Appendices) in accordance with section 1929 of the Social Security Act.

2. Home and community care services are available Statewide.

   _____ Yes _____ No

   If no, these services will be available to individuals only in the following geographic areas or political subdivisions of the State (specify):

   _____

   _____

3. The home and community care services specified in this Supplement will be limited to the following target groups of recipients (specify all restrictions that will apply):

   a. _____ Aged (age 65 and older, or greater than age 65 as limited in Appendix B)

   b. _____ In accordance with §1929(b)(2)(A) of the Act, individuals age 65 or older who were served under a waiver granted pursuant to section 1915(c) of the Act on the date on which that waiver was terminated. Financial eligibility standards for these individuals are specified in Appendix A. Minimum disability standards for these individuals are specified in Appendix B.

   c. _____ In accordance with §1929(b)(2)(A) of the Act, individuals who were served under a waiver granted pursuant to section 1915(d) of the Act on the date on which that waiver was terminated. Financial eligibility standards for these individuals are specified in Appendix A. Minimum disability standards for these individuals are specified in Appendix B.

   d. _____ In accordance with §1929(b)(2)(B) of the Act, individuals who meet the test of disability under the State's §1115 waiver which provides personal care services under the State plan for functionally disabled individuals, and which was in effect on December 31, 1990. Financial eligibility standards for these individuals are specified in Appendix A. Functional disability standards for these individuals are specified in Appendix B.

4. Additional targeting restrictions (specify):

   a. _____ Eligibility is limited to the following age groups (specify):

   _____

   _____

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AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES FOR THE CATEGORICALLY NEEDY

b. _____ Eligibility is limited by the severity of disease or condition, as specified in Appendix B.

c. _____ Eligibility is limited to individuals who have been shown to have a need for one or more of the services elected by the State under this benefit.

5. Standards for financial eligibility are set forth in Appendix A. Each individual served shall meet applicable standards for financial eligibility.

6. Each individual served will meet the test of functional disability set forth in Appendix B.

7. The State will provide for a comprehensive functional assessment for a financially eligible individual who meets the targeting requirements set forth in item 3 of this Supplement. This assessment will be provided at the request of the individual or another person acting on such individual's behalf. The individual will not be charged a fee for this assessment.

8. The comprehensive functional assessment will be used to determine whether the individual is functionally disabled, as defined in Appendix B. Procedures to ensure the performance of this assessment are specified in Appendix D.

9. The comprehensive functional assessment is based on the uniform minimum data set specified by the Secretary. Check one:

   a. _____ The State will use the assessment instrument designed by HCFA.

   b. _____ The State will use an assessment instrument of its own designation. The assessment instrument to be used is consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by HCFA. A copy of the assessment instrument can be found at Appendix D.

10. The comprehensive functional assessment will be reviewed and revised .not less often than every 12 months. Procedures to ensure this review and revision are specified in Appendix D.

11. The comprehensive functional assessment and review will be conducted by an interdisciplinary team designated by the State. Qualifications of the interdisciplinary team are specified in Appendix D.

12. Based on the comprehensive functional assessment or review, the interdisciplinary team will:

   a. identify in each such assessment or review each individual's functional disabilities and need for home and community care, including information about the individual's health status, home and community environment, and informal support system; and

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AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES FOR THE CATEGORICALLY NEEDY

b. based on such assessment or review, determine whether the individual is (or continues to be) functionally disabled.

13. The results of the comprehensive functional assessment or review will be used in establishing, reviewing and revising the person's individual community care plan (ICCP).

14. An ICCP will be developed by a qualified community care case manager for each individual who has been determined, on the basis of a comprehensive functional assessment, to be a functionally disabled elderly individual.

15. All services will be furnished in accordance with a written ICCP which:

a. is established, and periodically reviewed and revised, by a qualified community care case manager after a face-to-face interview with the individual or primary care giver;

b. is based upon the most recent comprehensive functional assessment .of the individual;

c. specifies, within the amount, duration and scope of service limitations specified in Appendix C, the home and community care to be provided under the plan. The ICCP will specify the community care services to be provided, their frequency, and the type of provider to furnish each service;

d. indicates the individual's preferences for the types and providers of services and documents the individual's free choice of providers and services to be furnished; and

e. may specify other services required by the individual.

A copy of the ICCP format to be used in implementing this benefit is included in Appendix E.

16. Each individual's ICCP will be established and periodically reviewed and revised by a qualified community care case manager, as provided in Appendix E.

17. A qualified community care case manager is a nonprofit or public agency Y organization which meets the conditions and performs the duties specified in Appendix E.

18. The State will provide the following home and community care services, as defined, described and limited in Appendix C to the groups specified in items 3, 4, 5 and 6 of this Supplement.

a. _____ Homemaker services

b. _____ Home health aide services

c. _____ Chore services

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AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES FOR THE CATEGORICALLY NEEDY

d. _____ Personal care services

e. _____ Nursing care services provided by, or under the supervision of, a registered nurse

f. _____ Respite care

g. _____ Training for family members in managing the individual

h. _____ Adult day care

i. _____ The following services will be provided to individuals with chronic mental illness:

1. _____ Day treatment/Partial hospitalization

2. _____ Psychosocial rehabilitation services

3. _____ Clinic services (whether or not furnished in a facility)

j. _____ Other home and community-based services (other than room and board) as the Secretary may approve. The following other services will be provided:

1. _____ Habilitation

A. _____ Residential Habilitation

B. _____ Day Habilitation

2. _____ Environmental modifications

3. _____ Transportation

4. _____ Specialized medical equipment and supplies

5. _____ Personal Emergency Response Systems

6. _____ Adult companion services

7. _____ Attendant Care Services

8. _____ Private Duty Nursing Services

9. _____ Extended State plan services (check all that apply):

A. _____ Physician Services

B. _____ Home health care services

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C. _____ Physical therapy services

D. _____ Occupational therapy services

E. _____ Speech, hearing and language services

F. _____ Prescribed drugs

G. _____ Other State plan services (specify): _____

10. _____ Other home and community-based services (specify): ____

19. The State assures that adequate standards for each provider of services exist and will be met. These provider standards are found at Appendix C-2.

20. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to individuals who are adversely affected by the determinations of the interdisciplinary team, or who are denied the service(s) of their choice, or the provider(s) of their choice, or who disagree with the ICCP which has been established.

21. FFP will not be claimed for the home and community care services specified in item 18 of this Supplement prior to the development of the ICCP. FFP will not be claimed for home and community care services which are not included in the ICCP.

22. The State provides the following assurances to HCFA:

a. Home and community care services will not be furnished to recipients while they are inpatients of a hospital, NF, or ICF/MR.

b. FFP will not be claimed in expenditures for the cost of room board, except when provided as part of respite care furnished in a facility which is (1) approved by the State, and (2) not a private residence. Meals furnished under any community care service (or combination of services) will not constitute a "full nutritional regimen" (3 meals a day).

c. FFP will not be claimed in expenditures for, the cost of room and board furnished to a provider of services.

d. The agency will provide HCFA annually with information on the amount of funds obligated by the State with respect to the provision of home and community care to the functionally disabled elderly in that fiscal year. These reports will begin with information relative to FFY 1990 and will be provided in the manner prescribed by HCFA. The State assures that it will provide data on its maintenance of effort, as required by section 1929(e) of the Social Security Act, in such format and at such times as are specified by HCFA.

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e. The home and community care provided in accordance with this Supplement and Appendices will meet all requirements for individual's rights and quality of care as are published or developed by HCFA.

1. All individuals providing care are competent to provide such care; and

2. Each provider of services under this benefit will meet the requirements applicable to the provision of home and community care as set forth in Appendix C.

3. Each individual receiving home and community care will be accorded the rights specified in Appendix F.

4. Case managers will comply with all standards and procedures set forth in Appendix E.

23. FFP will not be claimed for the home and community care services specified in item 18 of this Supplement in any quarter to the extent that cost of such care in the quarter exceeds 50 percent of the product of:

a. the average number of individuals in the quarter receiving home and community care;

b. the average per diem rate of Medicare payment for extended care services (without regard to coinsurance) furnished in the State during such quarter; and

c. the number of days in such quarter.

24. Community care settings in which home and community care is provided will meet the requirements set forth in section 1929(g) and (h) of the Act, as applicable to the specific setting. The State assures that the requirements of Appendix G will be met for each setting in which home and community care is provided under this section.

25. The State will refuse to provide home and community care in settings which. have been found not to meet the requirements of sections 1929(g) and (h) of the Act.

26. The State will comply with the requirements of section 1929(i), of the Act, regarding survey and certification of community care settings, as set forth in Appendix G.

27. The State will comply with the requirements of section 1929(i) of the Act, regarding the compliance of providers of home and community care and reviews of this compliance, as set forth in Appendix C.

28. The State will provide for an enforcement process for providers of community care, as required by section 1929(j) of the Act. This process is described in Appendix C.

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29. The State assures that payment for home and community care services will be made through rates which are reasonable and adequate to meet the costs of providing care efficiently and economically, in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

30. Payment will not be made for home and community care to reimburse (or otherwise compensate) a provider of such care for payment of a civil money penalty imposed under title XIX or title XI of the Social Security Act or for legal expenses in defense of an exclusion or civil money penalty under title XIX or title XI of the Social Security Act if there is no reasonable legal ground for the provider's case.

31. The State will begin provision of services under section 1905(a)(23) of the Social Security Act effective (specify date):

_____

These services will be provided to eligible individuals for a minimum of four calendar quarters, beginning on this date.

32. Services will be provided to eligible recipients for the duration of the period specified in item 31, above, without regard to the amount of Federal *financial participation* available to the State.

33. The State assures that it will monitor the appropriateness and accuracy of the assessments and reviews. Through its monitoring, the State assures the appropriateness and accuracy of the assessments and periodic reviews. The State assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the nature and severity of any deficiencies noted.

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MEDICAID ELIGIBILITY GROUPS SERVED

a. Home and community care services will be made available to individuals age 65 or older, when the individuals have been determined to be functionally disabled as specified in Appendix B.

b. Individuals served under this provision must meet the following Medicaid eligibility criteria (check all that apply):

1. _____ Age 65 or older who have been determined to be functionally disabled (as determined under the SSI program) as specified in Appendix B.

A. _____ The agency uses the same methodologies for treatment of income and resources as used in the SSI program (or the optional State supplement program which meets the requirements of 42 CFR 435.230, as appropriate). Individuals must be receiving SSI/SSP benefits to be eligible under this provision.

B. _____ The agency uses methodologies for treatment of income and resources that differ from those of the SSI program. These differences result from restrictions applied under section 1902(f) of the Act. The methodologies are described in Supplement 5 to Attachment 2.6-A. Individuals must be eligible for Medicaid under the State's plan to be eligible under this provision.

2. _____ Medically needy, age 65 or older who have been determined to be functionally disabled as specified in Appendix B. In determining the individual's eligibility, the State may, at its option, provide for the determination of the individual's anticipated medical expenses (to be deducted from income). (Check one):

A. _____ The State does not consider anticipated medical expenses.

B. _____ The State considers anticipated medical expenses over a period of _____ months (not to exceed 6 months).

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INDIVIDUALS PREVIOUSLY COVERED UNDER A WAIVER

a. _____ The State used a health insuring organization before January 1, 1986, and had in effect a waiver under §1115 of the Act, which provides personal care services under the State plan for functionally disabled individuals, and which was in effect on December 31, 1990. In accordance with S1929(b)(2)(B) of the Act, the following individuals will be eligible to receive home and community care services. (Check all that apply):

1. _____ Age 65 or older.

2. _____ Disabled, receiving SSI.

These individuals meet the resource requirement and income standards that apply in the State to individuals described in 51902(a)(10)(A)(ii)(V) of the Act.

b. _____ In accordance with S1929(b)(2)(A) the Act, individuals age 65 or older who were served under a waiver granted pursuant to section 1915(c) of the Act on the date on which that waiver was terminated. This waiver was terminated during the period in which the State furnished home and community care to functionally disabled elderly individuals under its state plan. Financial eligibility standards for these individuals (which are the same as those in effect on the date on which the waiver was terminated) are attached to this Appendix.

c. _____ In accordance with S1929(b)(2)(A) the Act, individuals age 65 or older, who were served under a waiver granted pursuant to section 1915(d)of the Act on the date on which that waiver was terminated. This waiver was terminated during the period in which the State furnished home and community care to functionally disabled elderly individuals under its State plan. Financial eligibility standards for these individuals (which are the same as those in effect on the date on which the waiver was terminated) are attached to this Appendix.

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State WASHINGTON

FUNCTIONAL DISABILITY

Home and community care services, as defined in this Supplement, are provided to the following classifications of individuals who have been found on the basis of an assessment to be functionally disabled. Services will be limited to individuals who meet the following targeting criteria.

Check all that apply:

a. _____ Services are provided to individuals, who have been determined, on the basis of an assessment, to require substantial human assistance with at least two of the following activities of daily living: toileting, transferring, eating.

b. _____ Services are provided to individuals, who have been determined, on the basis of an assessment, to require substantial human assistance with each of the following activities of daily living: toileting, transferring, eating.

c. _____ Services are provided to individuals who have been determined, on the basis of an assessment, to have a primary or secondary diagnosis of Alzheimer's Disease, and are unable to perform without substantial human assistance (including verbal reminding or physical cueing) or supervision, at least 2 of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.

d. _____ Services are provided to individuals, who have been determined, on the basis of an assessment, to have a primary or secondary diagnosis of Alzheimer's Disease, and are unable to perform without substantial human assistance (including verbal reminding or physical cueing) or supervision, (check one):

1. _____ at least 3 of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.

2. _____ at least 4 of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.

3. _____ all of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.

e. _____ Services are provided to individuals who have been determined, on the basis of an assessment, to have a primary or secondary diagnosis of Alzheimer's Disease, and are sufficiently cognitively impaired so as to require substantial supervision from another individual because they engage in inappropriate behaviors that pose serious health or safety hazards to themselves or others.

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AGE

Check all that apply:

a. _____ Services are provided to individuals age 65 and older.

b. _____ Services are provided to individuals who have reached at least the following age, greater than 65 (specify): _____

c. _____ Services are provided to individuals who meet the criteria set forth in item 3.b. of Supplement 2, as set forth in Appendix B-3, who were 65 years of age or older on the date of the waiver's discontinuance.

d. _____ Services are provided to individuals who meet the criteria set forth in item 3.c. of Supplement 2, as set forth in Appendix B-3, who were served under the waiver on the date of its discontinuance.

e. _____ Services are provided to individuals who meet the criteria in item 3.d. of Supplement 2, who fall within the following age categories (check all that apply):

1. _____ Age 65 and older

2. _____ Age greater than 65. Services are limited to those who have attained at least the age of (specify): _____

3. _____ Age less than 65. Services will be provided to those in the following age category (specify): _____

4. _____ The State will impose no age limit.

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INDIVIDUALS PREVIOUSLY SERVED UNDER WAIVER AUTHORITY

a. _____ In accordance with 1929(b)(2)(A) of the Act, the State will discontinue the following home and community-based services waiver(s), approved under the authority of §1915(c) or §1915(d) of the Act. (Specify the waiver numbers):

Waiver Number	Last date of waiver operation
_____	_____
_____	_____
_____	_____
_____	_____

b. For each waiver specified in Appendix B-3-a, above, the State will furnish at least 30 days notice of service discontinuance to those individuals under 65 years of age, and to those individuals age 65 or older who do not meet the test of functional disability specified in Appendix B-1 (except those individuals who will continue to receive home and community-based services under a different waiver program).

c. Individuals age 65 years of age or older, who were eligible for benefits under a waiver specified in Appendix B-3-a on the last date of waiver operation, who would, but for income or resources, be eligible for home and community care under the State plan, shall be deemed functionally disabled elderly individuals for so long as they would have remained eligible for services under the waiver.

d. The financial eligibility standards which were in effect on the last date of waiver operation are attached to this Appendix.

e. The following are the schedules, in effect on the last date of waiver operation, under which individuals served under a waiver identified in Appendix B-3-a were reevaluated for financial eligibility (specify):

Waiver Number	Reevaluation schedule
_____	_____
_____	_____
_____	_____
_____	_____

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Appendix C1/C2 removed via SPA 08-009

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

ASSESSMENT

a. The State will provide for a comprehensive functional assessment for a financially eligible individual who meet the targeting requirements set forth in items 3 and 4 of Supplement 2.

b. This assessment will be provided at the request of the individual, or another person acting on the individual's behalf.

c. The individual will not be charged a fee for this assessment.

d. Attached to this Appendix is an explanation of the procedures by which the state will ensure the performance of the assessment.

e. The assessment will be reviewed and revised not less often than (check one):

1. _____ Every 12 months

2. _____ Every 6 months

3. _____ Other period not to exceed 12 months (Specify): _____
_____

f. Check one:

1. _____ The State will use an assessment instrument specified by HCFA.

2. _____ The State will use an assessment instrument of its own specification. A copy of this instrument is attached to this Appendix. The State certifies that this instrument will measure functional disability as specified in section 1929(b) and (c) of the Act. The State requests that HCFA approve the use of this instrument, and certifies that at such time as HCFA may publish a minimum data set (consistent with section 1929(c)(2) of the Act), the assessment instrument will be revised, as determined necessary by HCFA, to conform to the core elements, common definitions, and uniform guidelines which are contained in the minimum data set.

g. In conducting the assessment (or the periodic review of the assessment), the interdisciplinary team must:

1. Identify in each such assessment or review each individual's functional disabilities; and

2. Identify in each such assessment or review each individual's need for home and community care. This identification shall include:

A. Information about the individual's health status;

B. Information about the individual's home and community environment; and

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C. Information about the individual's informal support system.

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ASSESSMENT (con't)

3. Determine whether the individual is, or continues to be, functionally disabled. This determination will be made on the basis of the assessment or review.

h. The interdisciplinary team conducting the assessment shall furnish the results to the Medicaid agency and to the qualified community care case manager designated by the Medicaid agency (as specified in Appendix F,) to establish, review and revise the individual's ICCP.

i. The Medicaid agency will monitor the appropriateness and accuracy of the assessments and periodic reviews on an ongoing basis, and whenever it is informed by a qualified community care case manager that inaccuracies appear to exist in the assessment of an individual. All problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the nature and severity of any deficiencies noted.

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INTERDISCIPLINARY TEAM

a. Initial assessments will be performed by interdisciplinary teams designated by the State. The agency will designate interdisciplinary teams that meet the following criteria (check all that apply):

1. _____ The interdisciplinary teams will be employed directly by the Medicaid agency.

2. _____ The interdisciplinary teams will be employed directly by other agencies of State government, under contract with the Medicaid agency.

3. _____ The interdisciplinary teams will be employed directly by agencies of local government under contract with the Medicaid agency.

4. _____ The interdisciplinary teams will be employed directly by nonpublic organizations which do not provide home and community care or nursing facility services and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation, or relationship with, an entity that provides community care or nursing facility services.

Interdisciplinary teams may utilize data gathered by other professionals, and may consult with service providers in conducting comprehensive functional assessments.

When assessments are provided under contract with an agency or organization which is not part of the Medicaid agency, the Medicaid agency will specify, as part of the contract, that the contracting agency or organization may not subcontract with another entity for the performance of the assessments without the prior written approval of the Medicaid agency.

b. Periodic reviews of assessments will be performed by interdisciplinary teams designated by the State. The agency will designate interdisciplinary teams that meet the following criteria (check all that apply):

1. _____ The interdisciplinary teams will be employed directly by the Medicaid agency.

2. _____ The interdisciplinary teams will be employed directly by other agencies of State government, under contract with the Medicaid agency.

3. _____ The interdisciplinary teams will be employed directly by agencies of local government under contract with the Medicaid agency.

4. _____ The interdisciplinary teams will be employed directly by nonpublic organizations which do not provide home and community care or nursing facility services and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation, or relationship with, an entity that provides community care or nursing facility services.

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INTERDISCIPLINARY TEAM (con't)

Interdisciplinary teams may utilize data gathered by other professionals, and may consult with service providers in conducting periodic reviews of the individuals' comprehensive functional assessments.

When periodic reviews of assessments are provided under contract with an agency or organization which is not part of the Medicaid agency, the Medicaid agency will specify, as part of the contract, that the contracting agency or organization may not subcontract with another entity for the performance of the periodic reviews without the prior written approval of the Medicaid agency.

c. The interdisciplinary teams conducting initial assessments shall consist, at a minimum, of (check all that apply, but at least 2):

1. _____ Registered nurse, licensed to practice in the State
2. _____ Licensed Practical or Vocational nurse, acting within the scope of practice under State law
3. _____ Physician (M.D. or D.O.), licensed to practice in the State
4. _____ Social Worker (qualifications attached to this Appendix)
5. _____ Case manager
6. _____ Other (specify): _____
_____

d. The interdisciplinary teams conducting periodic reviews of assessments shall consist, at a minimum, of (check all that apply, but at least 2):

1. _____ Registered nurse, licensed to practice in the State
2. _____ Licensed Practical or Vocational nurse, acting within the scope of practice under State law
3. _____ Physician (M.D. or D.O.), licensed to practice in the State
4. _____ Social Worker (qualifications attached to this Appendix)
5. _____ Case manager
6. _____ Other (specify): _____
_____

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State WASHINGTON

INDIVIDUAL COMMUNITY CARE PLAN (ICCP)

a. A written individual community care plan (ICCP) will be developed for each individual who has been determined, on the basis of a comprehensive functional assessment performed in accordance with Appendix D, to be a functionally disabled elderly individual, according to the criteria set forth in Appendices A and B.

b. The ICCP will be established, and periodically reviewed and revised, by a Qualified Community Care Case Manager after a face-to-face interview with the individual or primary caregiver.

c. The ICCP will be based on the most recent comprehensive functional assessment of the individual conduced according to Appendix D.

d. The ICCP will specify, within the amount, duration and scope of service limitations set forth in Appendix C, the home and community care to be provided to such individual under the plan.

e. The ICCP will indicate the individual's preferences for the types and providers of services.

f. The ICCP will specify home and community care and other services required by such individual. (Check one):

1. _____ Yes 2. _____ No

g. The ICCP will designate the specific providers (who meet the qualifications specified in Appendix C-2) which will provide the home and community care. (Check one):

1. _____ Yes 2. _____ No

h. Neither the ICCP, nor the State, shall restrict the specific persons or individuals (who meet the requirements of Appendix C-2) who will provide the home and community care specified in the ICCP.

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State WASHINGTON

QUALIFIED COMMUNITY CARE CASE MANAGERS

a. "Qualified Community Care Case Manager" will meet each of the following qualifications for the provision of community care case management.

1. Be a nonprofit or public agency or organization;

2. Have experience or have been trained in:

A. Establishing and periodically reviewing and revising ICCPs; and

B. The provision of case management services to the elderly.

The minimum standards of experience and training which will be employed by the State are attached to this Appendix;

3. Have procedures for assuring the quality of case management services. These procedures will include a peer review process.

4. The State will assure that community care case managers are competent to perform case management functions, by requiring the following educational or professional qualifications be met. (Check all that apply):

A. _____ Registered nurse, licensed to practice in the State

B. _____ Physician (M.D. or D.O.), licensed to practice in the State

C. _____ Social Worker (qualifications attached to this Appendix)

D. _____ Other (specify): _____
_____
_____

b. When community care case management is provided by a nonprofit, nonpublic agency, the agency providing the community case management will not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides home and community care or nursing facility services and will not furnish home and community care or nursing facility services itself. (Check one):

1. _____ Yes

2. _____ Not applicable. The State will not use nonprofit, nonpublic agencies to provide community care case management.

c. The State will employ procedures to assure that individuals whose home ad community care is managed by qualified community care case managers are not at risk of financial exploitation due to such managers. An explanation of these procedures is attached to this Appendix

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State WASHINGTON

QUALIFIED COMMUNITY CARE CASE MANAGERS (cont)

d. The State requests that the requirements of item E-2-b be waived in the case of a nonprofit agency located in a rural area. The State's definition of "rural area" is attached to this Appendix. (Check one):

1. _____ Yes 2. _____ No

3. _____ Not applicable. The State will not use nonprofit nonpublic agencies to provide community care case management.

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State WASHINGTON

COMMUNITY CARE CASE MANAGEMENT FUNCTIONS

a. A qualified community care case manager is responsible for:

1. Assuring that home and community care covered under the State plan and specified in the ICCP is being provided;

2. Visiting each individual's home or community care setting where care is being provided not less often than once every 90 days;

3. Informing the elderly individual or primary caregiver how to contact the case manager if service providers fail to properly provide services or other similar problems occur. This information will be provided verbally and in writing.

4. Completes the ICCP in a timely manner; and

5. Reviews and discusses new and revised ICCPs with elderly individuals or primary caregivers.

b. Whenever a qualified community care case manager has reason to believe that an individual's assessment or periodic review (conducted under Appendix D) appears to contain inaccuracies, the community care case manager will bring these apparent discrepancies to the attention of the agency which has performed the assessment or review. If the assessors and the community care case manager are unable to resolve the apparent conflict, the case manager shall report the situation to the component of the Medicaid agency which is responsible for monitoring the program.

1. _____ Yes 2. _____ No

c. Whenever a qualified community care case manager is informed by an elderly individual or primary caregiver that provider(s) have failed to provide services, or that other similar problems have occurred, the community care case manager shall take whatever steps are necessary to verify or disprove the complaint. If a problem is confirmed by this monitoring, the community care case manager shall address the problem in an appropriate and timely manner, consistent with the nature and severity of any deficiencies noted. This may include reporting the situation to the component of the Medicaid agency which is responsible for monitoring the program.

1. _____ Yes 2. _____ No

d. Whenever a qualified community care case manager is informed by a provider of service (whether paid or unpaid) that there has been a change in the individual's condition, or that a problem may have arisen which is not currently being addressed, the community care case manager shall take whatever steps are necessary to verify or disprove the information. If a problem is confirmed by this monitoring, the community care case manager shall address it in an appropriate and timely manner, consistent with the nature and severity of the situation.

1. _____ Yes 2. _____ No

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State WASHINGTON

COMMUNITY CARE CASE MANAGEMENT FUNCTIONS (con't)

e. Community care case managers shall verify the qualifications of each individual or agency providing home and community care services prior to the initiation of services, and at such intervals as are specified in Appendix C, thereafter. (Check one):

1. _____ Yes 2. _____ No

f. Where the provision of services in an individual's ICCP is not governed by State licensure or certification requirements, the community care case manager shall verify the qualifications of the individual or entity furnishing the services, and as necessary, provide or arrange for the training specified in Appendix C-2. (Check one):

1. _____ Yes 2. _____ No

3. _____ Not applicable. All services are governed by State licensure or certification requirements.

g. Community care case managers shall inform each elderly individual for whom an ICCP is established of the person's right to a fair hearing should the individual disagree with the contents of the ICCP.

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State WASHINGTON

RIGHTS SPECIFIED IN THE STATUTE

The State assures that home and community care provided under the State plan will meet the following requirements:

a. Individuals providing care are competent to provide such care. The State will maintain documentation to show that each provider of care meets or exceeds the applicable minimum qualifications specified in Appendix C-2.

b. Individuals receiving home and community care shall be assured the following rights:

1. The right to be fully informed in advance, orally and in writing, of the following:

a. the care to be provided,

b. any changes in the care to be provided; and

c. except with respect to an individual determined incompetent, the right to participate in planning care or changes in care.

2. The right to voice grievances with respect to services that are for fail to be) furnished without discrimination or reprisal for voicing grievances, and to be told how to complain to State and local authorities. A description of the procedures which the State will utilize to ensure this right is attached to this Appendix.

3. The right to confidentiality of personal and clinical records.

4. The right to privacy and to have one's property treated with respect.

5. The right to refuse all or part of any care and to be informed of the likely consequences of such refusal.

6. The right to education or training for oneself and for members of one’s family or household on the management of care.

7. The right to be free from physical or mental abuse, corporal punishment, and any physical or chemical restraints imposed for purposes of discipline or convenience and not included in the individual's ICCP.

8. The right to be fully informed orally and in writing of the individual's rights.

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State WASHINGTON

ADDITIONAL RIGHTS

The State assures that home and community care provided under the State plan will meet the following additional requirements:

a. The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community care services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities. Copies of these standards are maintained at the Medicaid agency.

b. In the case of an individual who has been adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the individual are exercised by the person appointed under State law to act on the individual's behalf.

c. In the case of an individual who resides in his or her own home, or in the home of a relative, when the individual has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the individual's rights to the extent provided by State law. In addition, all rights to be informed of the care to be provided, and to have input into the development of the ICCP specified in Appendix F-1-b shall be extended to the principal caregiver.

d. In the case of an individual who resides in a community care setting, and who has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the individual's rights to the extent provided by State law.

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State WASHINGTON

GUIDELINES FOR PROVIDER COMPENSATION

a. The following advisory guidelines are provided for such minimum compensation for individuals providing home and community care. These guidelines will be used to assure the availability and continuity of competent individuals to provide such care for functionally disabled individuals who have functional disabilities of varying levels of severity.

1. For services which are the same as, or similar (in content, complexity and provider qualifications) to those provided under the approved Medicaid State plan, the State will compensate the providers on the same basis as that which is approved as part of the plan.

A. _____ Yes B. _____ No

2. For services which are the same as, or similar (in content, complexity and provider qualifications) to those provided under another program funded and operated by the State, the State will compensate the providers on a basis which is equivalent to that used by the other publicly funded program.

A. _____ Yes B. _____ No

3. For services which are dissimilar to those provided under the plan or another program funded and operated by the State, the State will develop methods of compensation which are sufficient to enlist an adequate number of providers, taking into account the number of individuals receiving the service and their geographic location.

A. _____ Yes B. _____ No

b. The State assures that it will comply with these guidelines.

1. _____ Yes 2. _____ No

c. The methods by which the State will reimburse providers are described in attachment 4.19-B.

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State WASHINGTON

COMMUNITY CARE SETTINGS-GENERAL

a. Definitions.

1. Small residential community care setting. A small residential community care setting is defined as a facility in which between 3 and 8 unrelated adults reside, and in which personal services (other than merely board) are provided in conjunction with residing in the setting. To qualify as a small residential community care setting, at least one resident must receive home and community care under this benefit.

2. Small nonresidential community care setting. A small nonresidential community care setting is defined as a facility in which an organized program is operated (by the facility or on the premises of the facility) which serves between 3 and 8 individuals, at least one of which receives home and community care under this benefit at the setting.

3. Large residential community care setting. A large residential community care setting is a facility in which more than 8 unrelated adults reside, and in which personal services are provided in conjunction with residing in the setting. To qualify as a large residential community care setting, at least one resident must receive home and community care under this benefit.

4. Large nonresidential community care setting. A large nonresidential community care setting is defined as a facility in which an organized program is operated (by the facility or on the premises of the facility) which serves more than 8 individuals, at least one of which receives home and community care under this benefit at the setting.

5. Unrelated adults. Unless defined differently under State law, for purposes of this benefit, unrelated adults are individuals who are 13 years of age or older, and who do not have any of the following relationships to other adults resident in the facility: spouses, parent (including stepparent) or child (including stepchild), or siblings.

6. Personal services. Personal services are those services provided to the individual by the setting, which are intended to compensate for the absence, loss, or diminution of a physical or cognitive function. Personal services, as defined here, are not equated with personal care services available under either 42 CFR 440.170, or personal care services provided under the home and community care benefit.

b. The State will provide home and community care to individuals in the following settings:

1. _____ Nonresidential settings that serve 3 to 8 people.

2. _____ Residential settings that serve 3 to 8 people, and in which personal services (other than merely board) are provided in conjunction with residing in the setting.

3. _____ Nonresidential settings that serve more than 8 people.

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COMMUNITY CARE SETTINGS-GENERAL (con't)

4. _____ Residential settings that serve more than 8 people, and in which personal services (other than merely board) are provided in conjunction with residing in the setting.

5. _____ Not applicable. The State will not provide services in these types of community care settings.

c. The State assures that the requirements of sections 1929(g) and (h) of the Act (as applicable to the specific setting) will be met for each setting in which home and community care is provided under this section.

d. FFP will not be claimed for home and community care which is provided in settings which have been found not to meet the requirements of sections 1929(g) and (h) of the Act.

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SMALL NONRESIDENTIAL COMMUNITY CARE SETTINGS

The requirements of this Appendix shall apply to small nonresidential community care settings.

The State will require that small nonresidential community care settings meet requirements specified in this Appendix.

a. The setting shall protect and promote the rights of each client, including each of the following rights:

1. The setting shall extend to each client the right to choose a personal attending physician.

2. Each client shall be fully informed in advance about care and treatment, and of any changes in care or treatment that may affect his or her well-being.

3. Each client shall have the right to participate in planning care and treatment or changes in care or treatment. For clients who have been adjudged incompetent, this right shall be extended to the individual who has been appointed to make decisions on behalf of the client.

4. The setting shall ensure that each client has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms.

5. Restraints may only be imposed –

A. to ensure the physical safety of the individual or other clients served in the setting, and

B. only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances when such restraints are determined to be necessary to prevent immediate and significant threat to the life or safety of the individual, staff members, or other clients until such an order can reasonably be obtained).

6. The setting shall ensure the right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of client groups.

7. The setting shall preserve the individual's right to confidentiality of personal and clinical records. The setting shall grant the individual (or legal representative) access to any current clinical records maintained by the setting upon request of the individual or legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

8. The setting shall extend to the individual the right to receive services consistent with the individual's needs and preferences and the types of services provided by the setting, except where the health or safety of the individual or other clients would be endangered.

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SMALL NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

9. The individual shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the setting to resolve those grievances the client may have, including those with respect to the behavior of other clients.

10. The setting shall extend to the client the right to organize and participate in client groups in the setting and the right of the client's family to meet in the setting with the families of other clients in the setting.

11. The setting shall not restrict the right of the client to participate in social, religious and community activities that do not interfere with the rights of other clients in the setting.

12. The setting shall extend the right to examine, upon reasonable request, the results of the most recent survey of the setting conducted by HCFA or the State with respect to the setting and any plan of remedial action in effect with respect to the setting.

b. In the case of an individual adjudged incompetent under the laws of the State, the rights of the client shall devolve upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the individual's behalf.

c. Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the individual's ICCP) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each client receiving such drugs.

d. A small nonresidential community care setting must extend to each individual served the following access and visitation rights.

1. Permit immediate access to any client by any representative of HCFA, by any representative of the State, by an ombudsman or agency described in section 1919(c)(2)(B)(iii)(II), (III), or (IV) of the Social Security Act, or by the clients individual physician or case manager.

2. Permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by the immediate family or other relatives of the client.

3. Permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client.

4. Permit reasonable access to a client by any entity or individual that provides health, social, Legal, or other services to the client, subject to the client's right to deny or to withdraw consent at any time.

5. Permit representatives of the State ombudsman (described in section 1919(c)(2)(B)(iii)(II) of the Social Security Act), with the permission of the client (or the client's legal representative) and consistent with State law, to examine a client's clinical records.

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SMALL NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

e. If the setting receives or holds funds from its clients, or exercises control over client funds, on a permanent or temporary basis, the setting must meet the following requirements.

1. The setting may not require clients to deposit their personal funds with the setting, and

2. Upon the written authorization of the client, the setting must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this Appendix.

3. The setting must purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of clients deposited with the setting.

4. The setting may not impose a charge against the personal funds of a client for any item or service for which payment is made under the plan or under Medicare.

Nothing in this Appendix shall be construed as requiring a setting to receive or hold funds from a client.

f. If the setting receives or holds funds from a client, the setting must manage and account for the personal funds of the client deposited with the facility as follows:

1. The setting must deposit any amount of personal funds in excess of $50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the setting's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the setting must maintain such funds in a non-interest bearing account or petty cash fund.

2. The setting must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a client deposited with the setting, and afford the client or legal representative, reasonable access to such record.

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) of the Social Security Act and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

4. Upon the death of a client with such an account, the community care setting must convey promptly the client's personal finds (and a final accounting of such funds) to the individual administering the client's estate.

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SMALL NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

g. Each small nonresidential community care setting shall be required to inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.

h. Each small nonresidential community care setting must meet any applicable State and local certification or license, zoning, building and housing codes, and State and local fire and safety regulations.

i. Each small nonresidential community care setting shall be designed, constructed, equipped and maintained in a manner to protect the health and safety of clients.

j. Nothing in this section shall be construed to require a small nonresidential community care setting to provide or arrange for medical care or treatment to clients served under this benefit if the setting does not provide this care to other clients who receive similar services in the facility.

k. Except to the extent dictated otherwise by State law, a small nonresidential community care setting shall not be held responsible for actions or inactions of persons not employed by the setting, who furnish medical care or treatment on its premises, when the setting has not arranged for the provision of care by these persons.

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SMALL RESIDENTIAL COMMUNITY CARE SETTINGS

The requirements of this Appendix shall apply to small nonresidential community care settings.

The State will require that small nonresidential community care settings meet requirements specified in this Appendix.

a. The setting shall protect and promote the rights of each client, including each of the following rights:

1. The setting shall extend to each client the right to choose a personal attending physician.

2. Each client shall be fully informed in advance about care and treatment, and of any changes in care or treatment that may affect his or her well-being.

3. Each client shall have the right to participate in planning care and treatment or changes in care or treatment. For clients who have been adjudged incompetent, this right shall be extended to the individual who has been appointed to make decisions on behalf of the client.

4. The setting shall ensure that each client has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms.

5. Restraints may only be imposed –

A. to ensure the physical safety of the individual or other clients served in the setting, and

B. only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances when such restraints are determined to be necessary to prevent immediate and significant threat to the life or safety of the individual, staff members, other clients until such an order can reasonably be obtained).

6. The setting shall ensure the right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of client groups. This shall not be construed to require the setting to furnish a private bedroom for the individual.

7. The setting shall preserve the individual's right to confidentiality of personal and clinical records. The setting shall grant the individual (or legal representative) access to any current clinical records maintained by the setting upon request of the individual or legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

8. The setting shall extend to the individual the right to receive services consistent with the individual's needs and preferences and the types of services provided by the setting, except where the health or safety of the individual or other clients would be endangered.

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SMALL RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

9. The individual shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the setting to resolve those grievances the client may have, including those with respect to the behavior of other clients.

10. The setting shall extend to the client the right to receive notice before the room or the roommate of the resident in the setting is changed.

11. The setting shall extend to the client the right to organize and participate in client groups in the setting and the right of the client's family to meet in the setting with the families of other clients in the setting.

12. The setting shall not restrict the right of the client to participate in social, religious and community activities that do not interfere with the rights of other clients in the setting.

13. The setting shall extend the right to examine, upon reasonable request, the results of the most recent survey of the setting conducted by HCFA or the State with respect to the setting and any plan of remedial action in effect with respect to the setting.

b. In the case of an individual adjudged incompetent under the laws of the State, the rights of the client shall devolve upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the individual's behalf.

c. Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the individual's ICCP) designed to eliminate or 'modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each client receiving such drugs.

d. A small residential community care setting must extend to each individual served the following access and visitation rights.

1. Permit immediate access to any client by any representative of HCFA, by any representative of the State, by an ombudsman or agency described in section 1919(c)(2)(B)(iii)(II), (III), or (IV) of the Social Security Act, or by the clients individual physician or case manager.

2. Permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by the immediate family or other relatives of the client.

3. Permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client.

4. Permit reasonable access to a client by any entity or individual that provides health, social, legal, or other services to the client, subject to the client's right to deny or to withdraw consent at any time.

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SMALL RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

5. Permit representatives of the State ombudsman (described in section 1919(c)(2)(B)(iii)(II) of the Social Security Act), with the permission of the client (or the client's legal representative) and consistent with State law, to examine a client's clinical records.

e. If the setting receives or holds funds from its clients, or exercises control over client funds, on a permanent or temporary basis, the setting must meet the following requirements.

1. The setting may not require clients to deposit their personal funds with the setting, and

2. Upon the written authorization of the client, the setting must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this Appendix.

3. The setting must purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of clients deposited with the setting.

4. The setting may not impose a charge against the personal funds of a client for any item or service for which payment is made under the plan or under Medicare.

Nothing in this Appendix shall be construed as requiring a setting to receive or hold funds from a client.

f. If the setting receives or holds funds from a client, the setting must manage and account for the personal funds of the client deposited with the facility as follows:

1. The setting must deposit any amount of personal funds in excess of $50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the setting's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the setting must maintain such funds in a non-interest bearing account or petty cash fund.

2. The setting must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of a1: financial transactions involving the personal funds of a client deposited with the setting, and afford the client or legal representative, reasonable access to such record.

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) of the Social Security Act and the fact that if the amount in the account (in addition to the value of the clients other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

4. Upon the death of a client with such an account, the community care setting must convey promptly the client's personal finds (and a final accounting of such funds) to the individual administering the client's estate.

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SMALL RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

g. Each small residential community care setting shall be required to inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.

h. Each small residential community care setting must meet any applicable state and local, certification, licensure, zoning, building and housing codes, and State and local fire and safety regulations.

i. Each small residential community care setting shall be designed, constructed, equipped and maintained in a manner to protect the health and safety of residents.

j. Nothing in this section shall be construed to require a small residential community care setting to provide or arrange for medical care or treatment to clients served under this benefit if the setting does not provide this care to other clients who receive similar services in the setting.

k. Except to the extent dictated otherwise by State law, a small residential community care setting shall not be held responsible for the actions or inactions of persons not employed by the setting, who furnish medical care or treatment on its premises, when the setting has not arranged for the provision of care by these persons.

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LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS

The requirements of this Appendix shall apply to large nonresidential community care settings.

The State will require that large nonresidential community care settings meet requirements specified in this Appendix.

a. The setting shall protect and promote the rights of each client, including each of the following rights:

1. The setting shall extend to each client the right to choose a personal attending physician.

2. Each client shall be fully informed in advance about care and treatment, and of any changes in care or treatment that may affect his or her well-being.

3. Each client shall have the right to participate in planning care and treatment or changes in care or treatment. For clients who have teen adjudged incompetent, this right shall be extended to the individual who has been appointed to make decisions on behalf of the client.

4. The setting shall ensure that each client has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms.

5. Restraints may only be imposed –

A. to ensure the physical safety of the individual or other clients served in the setting, and

B. only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances when such restraints are determined to be necessary to prevent immediate and significant threat to the life or safety of the individual, staff members, or other clients until such an order can reasonably be obtained).

6. The setting shall ensure the right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of client groups.

7. The setting shall preserve the individual's right to confidentiality of personal and clinical records. The setting shall grant the individual (or legal representative) access to any current clinical records maintained by the setting upon request of the individual or legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

8. The setting shall extend to the individual the right to receive services consistent with the individual's needs and preferences and the types of services provided by the setting, except where the health or safety of the individual or other clients would be endangered.

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9. The individual shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the setting to resolve those grievances the client may have, including those with respect to the behavior of other clients.

10. The setting shall extend to the client the right to organize and participate in client groups in the setting and the right of the client's family to meet in the setting with the families of other clients in the setting.

11. The setting shall not restrict the right of the client to participate in social, religious and community activities that do not interfere with the rights of other clients in the setting.

12. The setting shall extend the right to examine, upon reasonable request, the results of the most recent survey of the setting conducted by HCFA or the State with respect to the setting and any plans of remedial action in effect with respect to the facility.

b. In the case of an individual adjudged incompetent under the laws of the state, the rights of the client shall devolve upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the individual's behalf.

c. Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the individual's ICCP) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each client receiving such drugs.

d. A large nonresidential community care setting must extend to each individual served the following access and visitation rights.

1. Permit immediate access to any client by any representative of HCFA, by any representative of the State, by an ombudsman or agency described in section 1919(c)(2)(B)(iii)(II), (III), or (IV) of the Social Security Act, or by the clients individual physician or case manager.

2. Permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by the immediate family or other relatives of the client.

3. Permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client.

4. Permit reasonable access to a client by any entity or individual that provides health, social, legal, or other services to the client, subject to the client's right to deny or to withdraw consent at any time.

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5. Permit representatives of the State ombudsman (described in section 1919(c)(2)(B)(iii)(II) of the Social Security Act), with the permission of the client (or the client's legal representative) and consistent with State law, to examine a client's clinical records.

c. If the setting receives or holds funds from its clients, or exercises control over client funds, on a permanent or temporary basis, the setting must meet the following requirements.

1. The setting may not require clients to deposit their personal funds with the setting, and

2. Upon the written authorization of the client, the setting must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this Appendix.

3. The setting must purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of clients deposited with the setting.

4. The setting may not impose a charge against the personal funds of a client for any item or service for which payment is made under the plan or under Medicare.

Nothing in this Appendix shall be construed as requiring a setting to receive or hold funds from a client.

d. If the setting receives or holds funds from a client, the setting must manage and account for the personal funds of the client deposited with the facility as follows:

1. The setting must deposit any amount of personal funds in excess of $50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the setting's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the setting must maintain such funds in a non-interest bearing account or petty cash fund.

2. The setting must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a client deposited with the setting, and afford the client or legal representative, reasonable access to such record.

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1511(a)(3)(B) of the Social Security Act and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

4. Upon the death of a client with such an account, the community care setting must convey promptly the client's personal finds (and a final accounting of such funds) to the individual administering the client's estate.

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LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

e. Each large nonresidential community care setting shall be required to inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.

f. Each large nonresidential community care setting must be designed, constructed, equipped and maintained in a manner to protect the health and safety of clients, personnel and the general public.

g. Nothing in this section shall be construed to require a large nonresidential community care setting to provide or arrange for medical care or treatment to clients served under this benefit if the setting does not provide this care to other clients who receive similar services in the facility.

h. Except to the extent dictated otherwise by State law, a large nonresidential community care setting shall not be held responsible for the actions or inactions of persons not employed by the setting, who furnish medical care or treatment on its premises, when the setting has not arranged for the provision of care by these persons.

i. A large nonresidential community care setting must be licensed or certified under applicable State and local law.

j. A large nonresidential community care setting must meet such provisions of the most recent edition of the Life Safety Code of the National Fire Protection Association as are applicable to the type of setting.

1. The State requests that HCFA waive certain provisions of this Code, which if rigidly applied would result in unreasonable hardship upon a setting. The State certifies that such a waiver would not adversely affect the health and safety of clients or personnel. The specific request for waiver and supporting documentation are attached.

_____ Yes _____ No

2. The State certifies to HCFA that there is in effect a fire and safety code, imposed by State law, which adequately protects clients and personnel in certain types of nonresidential community care settings. The specific types of settings are identified in attached documentation. The State requests that the provisions of the State code be substituted for those of the Life Safety Code of the National fire Protection Association for those particular settings.

_____ Yes _____ No

k. Each large nonresidential community care setting must disclose persons with an ownership or control interest (including such persons as defined 'n section 1124(a)(3) of the Social Security Act) in the setting.

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LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

1. A large nonresidential community care setting may not have, as a person with an ownership or control interest in the setting, any individual or person who has been excluded from participation in the program under Medicaid or who has had such an ownership or control interest in one or more community care settings which have been found repeatedly to be substandard, or to have failed to meet the requirements of this Appendix.

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LARGE RESIDENTIAL COMMUNITY CARE SETTINGS

The requirements of this Appendix shall apply to large residential community care settings.

The State will require that large residential community care settings meet requirements specified in this Appendix.

a. The setting shall protect and promote the rights of each client, including each of the following rights:

1. The setting shall extend to each client the right to choose a personal attending physician.

2. Each client shall be fully informed in advance about care and treatment, and of any changes in care or treatment that may affect his or her well-being.

3. Each client shall have the right to participate in planning care and treatment or changes in care or treatment. For clients who have been adjudged incompetent, this right shall be extended to the individual who has been appointed to make decisions on behalf of the client.

4. The setting shall ensure that each client has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms.

5. Restraints may only be imposed –

A. to ensure the physical safety of the individual or other clients served in the setting, and

B. only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances when such restraints are determined to be necessary to prevent immediate and significant threat to the life or safety of the individual, staff members, other clients until such an order can reasonably be obtained).

6. The setting shall ensure the right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of client groups. This shall not be construed to require the setting to furnish a private bedroom for the individual.

7. The setting shall preserve the individual's right to confidentiality of personal and clinical records. The setting shall grant the individual (or legal representative) access to any current clinical records maintained by the setting upon request of the individual or legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

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8. The setting shall extend to the individual the right to receive services consistent with the individual's needs and preferences and the types of services provided by the setting, except where the health or safety of the individual or other clients would be endangered.

9. The individual shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the setting to resolve those grievances the client may have, including those with respect to the behavior of other clients.

10. The setting shall extend to the client the right to receive notice before the room or the roommate of the resident in the setting is changed.

11. The setting shall extend to the client the right to organize and participate in client groups in the setting and the right of the client's family to meet in the setting with the families of other clients in the setting.

12. The setting shall not restrict the right of the client to participate in social, religious and community activities that do not interfere with the rights of other clients in the setting.

13. The setting shall extend the right to examine, upon reasonable request, the results of the most recent survey of the setting conducted by HCFA or the State with respect to the setting and any plan of remedial action in effect with respect to the setting.

b. In the case of an individual adjudged incompetent under the laws of the State, the rights of the client shall devolve upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the individual's behalf.

c. Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the individual's ICCP) designed to eliminate or 'modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each client receiving such drugs.

d. A large residential community care setting must extend to each individual served the following access and visitation rights.

1. Permit immediate access to any client by any representative of HCFA, by any representative of the State, by an ombudsman or agency described in section 1919(c)(2)(B)(iii)(II), (III), or (IV) of the Social Security Act, or by the clients individual physician or case manager.

2. Permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by the immediate family or other relatives of the client.

3. Permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client.

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LARGE RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

4. Permit reasonable access to a client by any entity or individual that provides health, social, Legal, or other services to the client, subject to the client's right to deny or to withdraw consent at any time.

5. Permit representatives of the State ombudsman (described in section 1919(c)(2)(B)(iii)(II) of the Social Security Act), with the permission of the client (or the client's legal representative) and consistent with State law, to examine a client's clinical records.

e. If the setting receives or holds funds from its clients, or exercises control over client funds, on a permanent or temporary basis, the setting must meet the following requirements.

1. The setting may not require clients to deposit their personal funds with the setting, and

2. Upon the written authorization of the client, the setting must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this Appendix.

3. The setting must purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of clients deposited with the setting.

4. The setting may not impose a charge against the personal funds of a client for any item or service for which payment is made under the plan or under Medicare.

Nothing in this Appendix shall be construed as requiring a setting to receive or hold funds from a client.

f. If the setting receives or holds funds from a client, the setting must manage and account for the personal funds of the client deposited with the facility as follows:

1. The setting must deposit any amount of personal funds in excess of $50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the setting's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the setting must maintain such funds in a non-interest bearing account or petty cash fund.

2. The setting must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a client deposited with the setting, and afford the client or legal representative, reasonable access to such record.

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

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LARGE RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

4. Upon the death of a client with such an account, the community care setting must convey promptly the client's personal finds (and a final accounting of such funds) to the individual administering the client's estate.

g. Each large residential community care setting shall be required to inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.

h. Each large residential community care setting shall be designed, constructed, equipped and maintained in a manner to protect the health and safety of clients, personnel and the general public.

i. Nothing in this section shall be construed to require a large residential community care setting to provide or arrange for medical care or treatment to clients served under this benefit if the setting does not provide this care to other clients who receive similar services in the setting.

j. Except to the extent dictated otherwise by State law, a large residential community care setting shall not be held responsible for actions or inactions of persons not employed by the setting, who furnish medical care or treatment on its premises, when the setting has not arranged for the provision of care by these persons.

k. A large residential community care setting must be licensed or certified under applicable State and local law.

l. A large residential community care setting must meet such provisions of the most recent edition of the Life Safety Code of the National Fire Protection Association as are applicable to the type of setting.

1. The State requests that HCFA waive certain provisions of this Code, which if rigidly applied would result in unreasonable hardship upon a setting. The State certifies that such a waiver would not adversely affect the health and safety of clients or personnel. The specific request for waiver and supporting documentation are attached.
_____ Yes _____ No

2. The State certifies to HCFA that there is in effect a fire and safety code, imposed by State law, which adequately protects clients and personnel in certain types of residential community care settings. The specific types of settings are identified in attached documentation. The State requests that the provisions of the State code be substituted for those of the Life Safety Code of the National fire Protection Association.
_____ Yes _____ No

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LARGE RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

m. Each large residential community care setting must disclose persons with an ownership or control interest (including such persons as defined in section 1124(a)(3) of the Social Security Act) in the setting.

n. A large residential community care setting may not have, as a person with an ownership or control interest in the setting, any individual or person who has been excluded from participation in the program under Medicaid or who has had such an ownership or control interest in one or more community care settings which have been found repeatedly to be substandard, or to have failed to meet the requirements of this Appendix.

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PACE State Plan Amendment Pre-Print

Name and address of State Administering Agency, if different from the State Medicaid Agency.

_____

_____

Regular Post Eligibility

The state applies post-eligibility treatment of income rules to PACE participants who are eligible under section 1902(a)(10)(A)(ii)(VI) of the Act (42 C.F.R. §435.217 of the regulations).
_X__Yes ___ No

Post-eligibility for states that have elected to apply the rules to PACE participants

Note: Section 2404 of the Affordable Care Act mandated that, for the five-year period beginning January 1, 2014, the definition of an "institutionalized spouse" in section 1924(h)(1) of the Social Security Act include all married individuals eligible for certain home and community-based services (HCBS), including HCBS delivered through 1915(c) waivers. As of this writing, the ACA provision has been extended through December 31, 2019. This means that married individuals eligible in the eligibility group described at 42 C.F.R. §435.217 must have their post-eligibility treatment-of-income rules determined under the rules described in section 1924(d). Because states that elect to apply post-eligibility treatment-of-income rules to PACE participants may only do so to the same extent the rules are applied to individuals eligibility under 42 C.F.R. §435.217, application of the post-eligibility treatment-of-income rules must be applied to married individuals receiving PACE services consistent with the provisions described herein under "Spousal post-eligibility" so long as the amendment to section 1924 of the Act made by the ACA remains in effect.

1. 1634 and SSI States

The State applies the post-eligibility rules to individuals who are receiving PACE services and are eligible under 42 C.F.R. §435.217 consistent with the rules of 42 C.F.R. §435.726, and, where applicable, section 1924 of the Act. Payment for PACE services is reduced by the amount remaining after deducting the following amounts om the PACE enrollee's income.

1. Allowances for the maintenance needs of the individual (check one):
    1. The amount deducted is equal to:
        (a) _____The SSI federal benefit rate
        (b) _____Medically Needy Income Level (MNIL)
        (c) _____The special income level standard for the institutionalized individuals eligible under section 1902(a)(10)(A)(ii)(V) of the Act
        (d) _____Percentage of the Federal Poverty Level: _____%
        (e) _____Other (specify):_____

    2._____The following dollar amount: $_____
        Note: If this amount changes, this item will be revised.

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3. _X_ The following formula is used to determine the needs allowance:
   1. For recipients who live in their own home, the personal needs allowance is 300% of the federal benefit rate (FBR).
   2. For recipients who live in state-contracted residential facility (e.g., adult family home, assisted living facility), the personal needs allowance is 100% of the federal benefit rate (FBR).

   In addition to the personal needs allowance in (1) or (2) , an allowance will be made for (when applicable):
   a) Any court ordered payee and/or guardianship fees;
   b) Any court-ordered guardianship-related costs; plus or related administrative costs; plus
   c) An amount for employed individuals equal to the first $65 of the recipient's earned income, plus one-half of any remaining earned income.

   In any case, the total deductions under (1) or (2), plus additional deductions of (a), (b), and (c), will not exceed 300% of the federal benefit rate.

Note: If the amount protected for a PACE enrollee in item 1 is equal to, or greater than, the PACE enrollee's income, enter N/A in items 2 and 3.

2. Allowance for the maintenance needs of the spouse:
   The amount deducted for the PACE enrollee's spouse is equal to:
   1.____ The SSI federal benefit rate
   2.____ Optional State Supplement Standard
   3.____ Medically Needy Income Level Standard
   4.____ The following dollar amount (provided it does not exceed the amount(s) described in 1-3): $_____
   5.____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
   6._X___ Not applicable (N/A)

3. Allowance of the maintenance needs of the family (check one):
   1.____ AFDC need standard
   2.__X__ Medically needy income standard

   The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

   3.____ The following dollar amount: $_____
   Note: If this amount changes, this item will be revised.
   4.____ The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.

5.____ The amount is determined using the following formula:

_____

_____

6.____ Other

7.____ Not applicable (N/A)

4. Allowance for medical and remedial care expenses, as described in 42 CFR 435.726(c)(4).

2. 209(b) States,

The State applies the post-eligibility rules to individuals who are receiving PACE services and are eligible under 42 C.F.R. §435.217 consistent with the rules of 42 C.F.R. §435.735, and, where applicable, section 1924 of the Act. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

1. Allowances for the maintenance needs of the individual (check one):

1.The amount deducted is equal to:

(a) _____The SSI federal benefit rate

(b) _____Medically Needy Income Level (MNIL)

(c) _____The special income level standard for the institutionalized individuals eligible under section 1902(a)(10)(A)(ii)(V) of the Act

(d) _____Percentage of the Federal Poverty Level: _____%

(e) _____Other (specify):_____

2._____The following dollar amount: $_____

Note: If this amount changes, this item will be revised.

3._____The following formula is used to determine the needs allowance:

_____

_____

Note: If the amount protected for a PACE enrollee in item 1 is equal to, or greater than, the PACE enrollee's income, enter N/A in items 2 and 3.

2. Allowance for the maintenance needs of the spouse:

The amount deducted for the PACE enrollee's spouse is equal to:

1.____ The more restrictive income standard established under 42 C.F.R. §435.121

2.____ Optional State Supplement Standard

3.____ Medically Needy Income Level Standard

4.____ The following dollar amount (provided it does not exceed the amount(s) described in 1-3): $_____

5 .____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.

6.____ Not applicable (N/A)

3. Allowance of the maintenance needs of the family (check one):

1.____ AFDC need standard
2.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4.____ The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.
5.____ The amount is determined using the following formula:
_____
_____
6.____ Other
7.____ Not applicable (N/A)

4. Allowance for medical and remedial care expenses, as described in 42 CFR 435.735 (c)(4).

Spousal Post Eligibility

State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance consistent with the minimum monthly maintenance needs allowance described in section 1924(d), a family allowance, for each family member, calculated as directed by section 1924(d)(1)(C), and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.
Yes _X_ No ____

Note: states must elect the use the post-eligibility treatment-of-income rules in section 1924 of the Act in the circumstances described in the preface to this section.

(a.) Allowances for the needs of the:

1. Individual (check one)

(A).____The following standard included under the State plan (check one):

1. _____SSI
2. _____Medically Needy
3. _____The special income level for the institutionalized
4. _____Percent of the Federal Poverty Level: _____%
5. _____Other (specify):_____

(B).____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

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(C)_____The following formula is used to determine the needs allowance:

_____

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

_____

II. Rates and Payments

A. The State assures CMS that the capitated rates will be less than the cost to the agency of providing State plan approved services to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the amount the state would have otherwise paid for a comparable population.

Amount that Would Otherwise have been Paid (AWOP) and Rate Methodology

The AWOP is based on fee-for-service (FFS) costs derived from: a population of nursing home and HCBS eligibles located in comparable county(s) with comparable age (55 or older), gender, clinical complexity, and care settings. In order to develop the AWOP, the data from sub-populations of nursing home and HCBS clients is blended into the final AWOP table. In lieu of FFS costs, the capitated managed care behavioral health rates of the Statewide model for a population comparative to PACE are used, unchanged, as the behavioral health component of the PACE AWOP. Incurred claims are the source data for the AWOP calculation. Detailed claims data is obtained from the State's payment system. The State assures CMS that the capitated rates are less than comparable FFS costs as defined by the PACE AWOP.

The following four groups, as approved by CMS, will be used to determine payment for PACE:

Medicaid Eligible Only, age 64 and under;
Medicaid Eligible Only, age 65 and above;
Medicaid & Medicare Eligible, age 64 and under;
Medicaid & Medicare Eligible, age 65 and above.

1.___ Rates are set at a percent of the amount that would otherwise been paid for a comparable population.
2.___ Experience-based (contractors/State's cost experience or encounter date)(please describe)
3.___ Adjusted Community Rate (please describe)
4._X__ Other (please describe)

Rates are based on FFS Medicaid data, but adjusted for the demographics and living situation of each PACE organization, as available. Rates include a provision of administrative costs and risk margin.

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B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner.

C. The State will submit all capitated rates to the CMS Regional Office for prior approval, and will include the name, organizational affiliate of any actuary used, and attestation/description of the capitation rates.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

PRA Disclosure Statement *The purpose of the PRA package is to provide a mechanism for states who voluntarily elect to provide medical assistance under Section 1934(a)(1) with respect to PACE program services to PACE program eligible individuals who are eligible for medical assistance under the State plan and who are enrolled in a PACE program under a PACE program agreement. 42 CFR 460.2 implements sections 1895, 1905(a), and 1934 of the Act, which authorizes the establishment of PACE as a State option under Medicaid to provide for Medicaid payment to, and coverage of benefits under, PACE. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1027 (Expires: 06/30/2023). The time required to complete this information collection is estimated to average 20 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1905(a)(29) Medication-Assisted Treatment (MAT)

i. General Assurance
MAT is covered under the Medicaid state plan for all Medicaid beneficiaries who meet the medical necessity criteria for receipt of the service for the period beginning October 1, 2020 and ending September 30, 2025.

ii. Assurances

a. The state assures coverage of naltrexone, buprenorphine, and methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

b. The state assures that methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.

c. The state assures coverage for all formulations of MAT drugs and biologicals for OUD that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262)

iii. Service Package
The state covers the following counseling services and behavioral health therapies as part of MAT

a) Please set forth each service and components of each service (if applicable), along with a description of each service and component service.
From October 1, 2020, through September 30, 2025, the state assures that MAT to treat OUD as defined at section 1905(ee)(1) of the Social Security Act (the Act) is covered exclusively under section 1905(a)(29) of the Act. See chart below.

b) Please include each practitioner and provider entity that furnishes each service and component service.
See chart below

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1905(a)(29) Medication-Assisted Treatment (MAT) (cont)

a. Service	a. Service Description	b. Providers Able to Render Service
Medication Management		
Screening	Obtain client history, review medications, demographics, determine services client is seeking	ARNP, MD/DO, PA (all may prescribe medication for MAT)
Medication Management	The prescribing of and monitoring of all drugs in all forms identified for use as MAT, under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).	ARNP, MD/DO, PA (all may prescribe medication for MAT)
Physical health management	Provision of an initial examination, review of past medical history and current medications to determine the appropriateness of medication assisted treatment. The identification, management, and referral to care as indicated for the treatment of medical conditions resulting from the use of MAT or those that might interfere with the success of MAT.	MD/DO, ARNP, PA

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1905(a)(29) Medication-Assisted Treatment (MAT) (cont)

a. Service	a. Service Description	b. Providers Able to Render Service
Opioid Use Treatment		
Assessment	Assessment documents an age-appropriate, strengths-based psychosocial assessment that considers current needs and the patient's relevant history according to best practices.	SUDP, SUDPT, Behavioral Health Co-occurring Disorder Specialist
Cognitive behavioral therapy (CBT)	Helps participant to look at the interactions between thoughts, feelings, behaviors, and physical symptoms, together with the situations within they occur, all affect and interact with each other. This helps the participant to identify what or where it is that they want to change.	Marriage & Family Therapist, Mental Health Counselor, SUDP with CBT training
Counseling	Individual, family, or group therapy designed to provide assistance and guidance in resolving personal, social, or psychological problems and difficulties. Facilitate the achievement and maintenance of maximum functional recovery. Family Therapy service that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.	ARNP, Behavioral Health Co-occurring Disorder Specialist, LPN, Marriage & Family Therapist, Mental Health Counselor, MD/DO, PA, RN, SUDP, SUDPT,

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1905(a)(29) Medication-Assisted Treatment (MAT) (cont)

a. Service	**a. Service Description**	**b. Providers Able to Render Service**
Opioid Use Treatment (cont)		
Motivational interviewing	Person-centered counseling for addressing the common problem of ambivalence about change. MI is done for or with someone, not on or to them. The four key aspects are partnership, acceptance, compassion, and evocation.	Marriage & Family Therapist, Mental Health Counselor, SUDP, SUDPT
Individual Service Plan	Be in terminology that is understandable to the participant. Must be a plan that is mutually agreed upon. Addresses issues identified by the individual or legal representative. Contains measurable goals and objectives and is initiated during the first individual sessions following the assessment with at least one goal identified by the individual. Must be updated to address applicable changes in identified needs and achievement of goals.	Marriage & Family Therapist, Mental Health Counselor, SUDP, SUDPT
Peer Services	Provides a wide range of activities to assist an individual in exercising control over their own life and recovery process through: developing self-advocacy and natural supports, maintenance of community living skills, promoting socialization and the practice of peer counselors sharing their own life experiences related to mental and substance use illness to build alliances that enhance the individual's ability to function.	Peer Counselors

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1905(a)(29) Medication-Assisted Treatment (MAT) (cont)

c) Please include a brief summary of the qualifications for each practitioner or provider entity that the state requires. Include any licensure, certification, registration, education, experience, training, and supervisory arrangements that the state requires.

- *Advanced Registered Nurse Practitioner (ARNP) is licensed and provides services within their scope of practice in accordance with state law. May prescribe medication for MAT.*
- *Behavioral Health Co-occurring Disorder Specialist is licensed and provides services within their scope of practice in accordance with state law*
- *Licensed Practical Nurse (LPN) is licensed and provides services within their scope of practice in accordance with state law*
- *Marriage and Family Therapist is licensed and provides services within their scope of practice in accordance with state law*
- *Mental Health Counselor is licensed and provides services within their scope of practice in accordance with state law*
- *Physician/osteopathic physician (MD/DO): is licensed and provides services within their scope of practice in accordance with state law. May prescribe medication for MAT.*
- *Physician Assistant is licensed and provides services within their scope of practice in accordance with state law. May prescribe medication for MAT.*
- *Registered Nurse (RN) is licensed and provides services within their scope of practice in accordance with state law*
- *Substance Use Disorder Professional (SUDP) is certified and provides services within their scope of practice in accordance with state law*
- *Substance Use Disorder Professional Trainee (SUDPT) is certified and provides services within their scope of practice in accordance with state law, working under the supervision of an SUDP.*
- *Peer Counselor is certified and provides services within their scope of practice in accordance with state law. See Attachment 3.1-A page 38 for requirements.*

Note: Providers prescribing medications for MAT must prescribe according to the authorities granted to them by the DEA and must follow all federal regulations/requirements when dispensing and administering methadone to treat people with opioid use disorder.

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State WASHINGTON

1905(a)(29) Medication-Assisted Treatment (MAT) (cont)

iv. Utilization Controls

__X__ The state has drug utilization controls in place. (Check each of the following that apply)

_X_ Generic first policy
_X_ Preferred drug lists
_X_ Clinical criteria
_X_ Quantity limits

_____ The state does not have drug utilization controls in place.

v. Limitations

Describe the state's limitations on amount, duration, and scope of MAT drugs, biologicals, and counseling and behavioral therapies related to MAT.

Medications to treat MAT may require prior authorization to determine medical necessity and may be subject to daily dose limits. All non-preferred products require a trial of preferred products with the same indication before a non-preferred drug will be authorized, unless contraindicated or not clinically appropriate. Requests for limitation extensions are considered and reviewed for medical necessity on a case-by-case basis.

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State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

The following ambulatory services are provided. *

Outpatient hospital services

Clinic services

Other laboratory services

Home health services

Physicians' services

Prescribed drugs, dentures, prosthetic devices and eyeglasses

Family planning services

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*Description provided on attachment.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

1. Inpatient hospital services other than those provided in an institution for mental diseases.

__X__ Provided: ____ No limitations __X__ With limitations*

2.a. Outpatient hospital services.

__X__ Provided: ____ No limitations __X__ With limitations*

d. Rural health clinic services and other ambulatory services furnished.

_X_ Provided: __X_ No limitations ___ With limitations*

a. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

__X_ Provided: _X_ No limitations ___ With limitations*

3. Other laboratory and x-ray services.

__X_ Provided: ___ No limitations _X_ With limitations*

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

__X__ Provided: ____ No limitations __X__ With limitations*

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.

__X__ Provided

c. Family planning services and supplies for individuals of childbearing age.

__X__ Provided: __X__ No limitations ____ With limitations*

d. Tobacco cessation counseling services for pregnant women

1) Face-to-face tobacco cessation counseling services

_X_ Provided ___ No limitations _X_ With limitations

2) Face-to-face tobacco cessation counseling services benefit package for pregnant women

_X_ Provided _X_ No limitations ___ With limitations

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5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

__X__ Provided: _____ No limitations __X__With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

__X__ Provided: _____No limitations __X__With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

__X__ Provided: _____ No limitations __X__With limitations*

Not Provided: _____

b. Optometrists' services.

__X__ Provided: _____No limitations __X__With limitations*

Not Provided: _____

c. Chiropractor's services.

_____ Provided: _____No limitations _____With limitations*

Not Provided: __X__

d. Other practitioners' services. Identified on attached sheet with description of limitations, if any.

__X__ Provided: _____No limitations __X__With limitations*

Not Provided: _____

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7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

__X__ Provided: ____No limitations __X__With limitations*

b. Home health aide services provided by a home health agency.

__X__ Provided: ____No limitations __X__With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

__X__ Provided: ____ No limitations __X__ With limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

__X__ Provided: ____ No limitations __X__ With limitations*

e. Other Medical services, supplies, equipment and appliances.

__X__ Provided: ____ No Limitations __X__ With limitations*

8. Private duty nursing services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

9. Clinic services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

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10. Dental services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

11. Physical therapy and related services.

a. Physical therapy.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

b. Occupational therapy.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

__X__ Provided: ____ No Limitations __X__ With limitations*

Not Provided: ____

12. Prescription drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

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12. Prescription drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist. (continued)

b. Dentures.

__X__ Provided: ____ No limitations __X__ With limitations*

c. Prosthetic devices.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

d. Eyeglasses.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

____ Provided: ____ No limitations ____ With limitations*

Not Provided: _X___

b. Screening services.

____ Provided: ____ No limitations ____ With limitations*

Not Provided: __X__

c. Preventive services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. (continued)

d. Rehabilitative services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

b. Nursing facility services.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

c. Intermediate care facility services.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

15.a. Intermediate care facility services for individuals with developmental disabilities who are determined in accordance with section 1902(a)(31) of the Act, to be in need of such care.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

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15.b. Including such services in a public institution (or district part thereof) for the mentally retarded or persons with related conditions.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

16. Inpatient psychiatric facility services for individuals under 21 years of age.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

17. Nurse -midwife services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

18 Hospice care in accordance with section 1905(o) of the Act.

__X__ Provided: ____ No limitations

__X__ Provided in accordance with section 2302 of the Affordable Care Act

__X__ With limitations* Not Provided: ____

19 Case management services and Tuberculosis related services.

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

__X__ Provided: ____ With limitations*

Not Provided: ____

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19. Case management services and Tuberculosis related services. (continued)

b. Special tuberculosis (TB) related services under section 1902(z)(2) of the Act.

____ Provided: ____ With limitations*

Not Provided: _X__

20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

__X__ Provided: _____ Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

__X__ Provided __X__ Additional coverage ++

21. Certified pediatric or family nurse practitioners' services.

__X__ Provided __X__ No limitations ____ With limitations*

Not Provided: ____

* Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

** Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

22. Special sickle-cell anemia-related services in accordance with section 1905(a) and section 1903(a)(3)(E) of the Act.

____ Provided: ____ With limitations*

Not Provided_X__

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22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act.

__X__ Provided: ____ No limitations __X__ With limitations

Not Provided: ____

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

b. Services provided in religious non-medical health care facilities.

____ Provided: ____ No limitations ____ With limitations*

Not Provided: __X__

c. Reserved.

____ Provided: ____ No limitations ____ With limitations*

Not Provided: __X__

d. Nursing facility services for residents under 21 years of age.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

e. Emergency hospital services.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

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24. Home and Community Care for Functionally Disabled elderly individuals, as defined, described and limited in Supplement 2 to attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

____ Provided: __X__ Not Provided

25. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are:

A. Authorized for the individual by a physician in accordance with a plan of treatment.
B Provided by an individual who is qualified to provide such services and who is not a member of the individual's family. And
C Furnished in a home.

____ Provided: ____ State Approved (Not Physician) Service Plan Allowed

____ Services Outside the Home Also Allowed

____ Limitations Described on Attachment

_X_ Not Provided.

26. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A

_____ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan Service.

__X__ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

27. Licensed or Otherwise State-Approved Freestanding Birthing Center

_X_ Provided ___ No limitations _X_ With Limitations*

* Limitations described on following pages

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DESCRIPTION OF LIMITATION OF SERVICES

1. Inpatient hospital services

a. Chronic pain management is limited to inpatient services provided by agency-approved pain centers in a hospital.

b. Long-term acute care services are provided in agency-approved hospitals and require prior authorization. This is not sub-acute care; rather this is intensive acute inpatient care provided to patients who would otherwise remain in intensive care or a similar level of care outside of a hospital's intensive care unit.

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2. a. Outpatient hospital services

(1) Hospital-owned institutional facilities that are hospital-based may provide outpatient hospital services to eligible clients when authorized by the agency to do so.

(2) Freestanding hospital-owned institutional facilities that are nonhospital-based may provide outpatient hospital services to eligible clients when authorized by the agency to do so.

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2.b. Rural Health Clinic (RHC) services and other ambulatory services that are covered under the plan and furnished by an RHC.

I. Rural Health Clinic (RHC)

A rural health clinic (RHC) is:

- A provider-based or freestanding facility certified by the secretary under Code of Federal Regulations (CFR), title 42, part 491.
- Located in a rural area designated as a shortage area as defined by the U.S. Census Bureau.
- An RHC may be a permanent or mobile unit.

II. Covered services

Covered services in accordance with 1905(a)(2)(B).

III. Other ambulatory services

In addition to all Medicaid-covered core services, RHCs will furnish other ambulatory services included in the state plan.

III. Core service providers

RHC services include services provided by physicians, nurse practitioners, physician assistants, nurse midwives, clinical psychologists, clinical social workers and other ambulatory services included in the state plan. RHC services also include services and supplies that are furnished incidental to professional services furnished by a physician, physician assistant, nurse practitioner, or nurse midwife, and, for visiting nurse care, related medical supplies other than drugs and biologicals.

IV. Additional providers

Providers who meet the qualifications in 3.1-A, 5a “Physicians’ Services,” 6d “Other Practitioners’ Services,” and 10. “Dental services and dentures (440.100) may provide services in an RHC.

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2.e. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC.

I. Federally qualified health centers (FQHC)

An FQHC is a facility that is any of the following:

- Receiving grants under Title 42, Chapter 6A, Subchapter II, Part D, subpart I, section 254b of the U.S. Code
- Receiving a Section 330 of the Public Health Service Act (PHS) grant based on the recommendation of the Health Resources and Services Administration within the Public Health Service, as determined by the secretary, to meet the requirements for receiving such a grant
- A tribe or tribal organization operating outpatient health programs or facilities under the Indian Self-Determination Act that elects to be designated as an FQHC

II. Covered services

Covered services in accordance with 1905(a)(2)(c)

III. Other ambulatory services

In addition to all Medicaid-covered core services, FQHCs will furnish other ambulatory services included in the state plan.

IV. Core service providers

FQHC services include services provided by physicians, nurse practitioners, physician assistants, nurse midwives, clinical psychologists, clinical social workers and other ambulatory services included in the state plan. FQHC services also include services and supplies that are furnished incidental to professional services furnished by a physician, physician assistant, nurse practitioner, or nurse midwife, and, for visiting nurse care, related medical supplies other than drugs and biologicals.

V. Additional providers
Providers who meet the qualifications in 3.1-A, 5.a “Physicians’ Services” and 6.d. “Other Practitioners’ Services” and 10. “Dental services and dentures” may provide services in an FQHC

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3. Other laboratory and x-ray services

a. Laboratory services

Pathology services are considered to be the same as laboratory services. The department covers all these services that are inpatient hospital. Limitations shown below are for outpatient.

Drug screens only when medically necessary and when:

- Ordered by a physician as part of a medical evaluation; or
- As drug and alcohol screens required to assess suitability for medical tests or treatment. For opiate substitution and pregnant women clients in the department's contracted treatment programs, drug screens for monitoring alcohol/drug use are reimbursed through a contract issued by the department.

One each of the following, per client per day:

- Blood draw fee; and
- Catheterization for collection of urine specimen.

b. Radiology services

The department covers all these services that are inpatient hospital. Limitations shown below are for outpatient.

The following services require prior approval through the Expedited Prior Authorization (EPA) process:

- Outpatient magnetic resonance imaging (MRI);
- Positron Emission Tomography (PET) scans;
- More than one annual screening mammogram for clients forty (40) years of age and older (based on the National Cancer Institute (NCI) recommendations regarding screening mammograms); and
- General anesthesia for radiological procedures. Allowed only when the medically necessary procedures cannot be performed unless the client is anesthetized.

Portable x-ray services furnished in the client's home or a nursing facility are limited to films that do not involve the use of contrast media.

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4. a. Nursing facility services

Prior approval of admission

Nursing facility (NF) services are available to eligible individuals in accordance with 42 CFR §440.42 and §440.155.

Specialized add-on services for certain NF residents.

Specialized add-on services require pre-authorization. Specialized add-on services are paid as add-on payments to the provider of the specialized add-on service, as described in Attachment 4.19-D, Part 1. Specialized add-on services are not provided by the NF. No services will be paid for as specialized add-on services if such services could be covered under other sections of the Plan (e.g., 3.1-A, 7(c) or 3.1-A, 11), within the limitations of those services. If a covered specialized add-on service is also covered under other sections of the Plan, but is in excess of the limitations described in those sections, it may be paid as a specialized add-on service.

Covered specialized add-on services include habilitative services. Habilitative services are medically necessary services intended to assist the resident in partially or fully attaining, learning, maintaining, or improving developmental-age appropriate skills that were not fully acquired as a result of a congenital, genetic, or early acquired health condition, and are required to maximize, to the extent practical, the client's ability to function in his or her environment. Habilitative services are provided only upon prior approval and recommendation of the individual's Interdisciplinary Team (IDT), as reflected in the individual's Individual Plan of Care (IPOC).Habilitative services, limitations, and the providers who may furnish the services are as follows.

Specialized add-on services may be provided remotely when appropriate. During a state or federal emergency, or when necessary to protect the health of nursing facility residents, specialized add-on services may be temporarily modified.

I. Assistive technology
   A. Assistive technology consists of items, equipment, or product systems used to develop the functional capabilities or to increase the community involvement of NF residents who require habilitation. Such services also directly assist the participant and caregivers to select, acquire, and use the technology. Assistive technology includes:
      1. The evaluation of the needs of the nursing facility (NF) resident, including a functional evaluation of the individual.
      2. Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices.
      3. Selecting, designing, fitting, customizing, adapting, applying, retaining, repairing, or replacing assistive technology devices.
      4. Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing care, service, and rehabilitation plans and programs.
      5. Training or technical assistance for the individual and/or if appropriate, the individual's staff and other support people.
      6. Training or technical assistance for professionals, including NF staff or other individuals who provide services to, employ, or are otherwise involved in the assistive technology-related life functions of individuals with disabilities.

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4. a. Nursing facility services (cont)

B. Limitations
1. Assistive technology must have generally accepted therapeutic value as determined by licensed professionals in the field of the treating professional and may not be experimental.

II. Habilitative behavior support and consultation
A. Habilitative behavior support and consultation includes the development and implementation of individualized strategies for helping an individual effectively relate to caregivers and other people in the individual's life; and direct interventions with the individual to decrease aggressive, destructive, and sexually inappropriate or other behaviors that compromise the individual's ability to remain in the community.

B. Limitations
1. Habilitative behavior support and consultation must include the following characteristics:
a. Treatment must be evidence-based and driven by individual outcome data, and consistent with DDA's positive behavior support guidelines.
b. Treatment goals must be objective and measurable. The goals must relate to an increase in skill development and/or a decrease in challenging behaviors that impede quality of life for an individual.
c. The following written components will be developed in partnership with the individual and his or her family (as appropriate) by the treating professional:
i. Functional behavioral assessment; and
ii. Positive behavior support plan based on functional behavioral assessment.

III. Community access services
A. Community access is an individualized habilitative service that provides individuals with opportunities to engage in community-based activities that support socialization, education, recreation, and personal development for the purpose of:
1. Building and strengthening relationships with others in the local community who are not paid to be with the person.
2. Learning, practicing and applying skills that promote greater independence and inclusion in the individual's community.

B. Limitations
1. Community access services can supplement, but cannot replace, activities that would otherwise be available as part of the NF activities program.

IV. Community guide
A. Community guide services provide short term instruction and support in order to increase access to the community when other supports are not available. Services are designed to develop creative, flexible, and supportive community resources for individuals with developmental disabilities.

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4. a. Nursing facility services (cont)

V. Habilitative therapy services
A. Habilitative therapy services are physical therapy, occupational therapy, and speech, hearing and language services that are intended to address habilitative goals. These therapies are in addition to any rehabilitative therapy services the individual may require.

B. Limitations
1. Habilitative therapy services must have generally accepted therapeutic value as determined by licensed professionals in the field of the treating professional and may not be experimental.

VI. Staff/family consultation and training
A. Staff/family consultation and training is professional assistance to families, NF staff, or direct service providers to help them better meet the habilitative goals of the NF resident. Topics on which consultation and training are provided include:
1. Health and medication monitoring
2. Positioning and transfer
3. Basic and advanced instructional techniques
4. Positive behavior support
5. Augmentative communication systems
6. Diet and nutritional guidance
7. Disability information and education
8. Strategies for effectively and therapeutically interacting with the participant
9. Environmental consultation
10. Individual and family counseling

B. Limitations
1. Staff/family consultation and training does not include any expenses related to conferences (e.g., room and board, attendance, tuition).

VII. Supported employment services
A. Supported employment services assist individuals with habilitative needs to obtain and maintain integrated gainful employment. These services provide intensive ongoing support and individualized assistance to gain and/or maintain employment. These services are tailored to individual needs, interests, and abilities, and are provided in individual or group settings.

Individual supported employment services include activities needed to sustain minimum wage pay or higher. These services are conducted in integrated business environments and include the following:

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4. a. Nursing facility services (cont)

1. Intake: An initial meeting to gather and share basic information and a general overview of employment supports, resources in the community and the type of available supports that the individual may receive
2. Discovery: A person-centered approach to learn the individual's likes and dislikes, job preferences, employment goals and skills
3. Job preparation: Includes activities of work readiness resume development, work experience, volunteer support transportation training
4. Marketing: A method to identify and negotiate jobs, building relationships with employers and customize employment development
5. Job coaching: The supports needed to keep the job
6. Job retention: The supports needed to keep the job, maintain relationship with employer, identify opportunities, negotiate a raise in pay, promotion and/or increased benefits

Group supported employment services include:

1. Supports and paid training in an integrated business setting
2. Supervision by a qualified employment provider during working hours
3. Groupings of no more than eight workers with disabilities
4. Individualized supports to obtain gainful employment

B. Limitations

1. Payment is made only for the employment support required as a result of the individual’s disabilities.
2. Payment for individual supported employment excludes the supervisory activities rendered as a normal part of the business setting.
3. The individual’s service hours are determined by the assistance needed to reach employment outcomes as determined by an assessment and might not equal the number of hours spent on the job or in job-related activities.

VIII. Transportation Services

A. Transportation services provide reimbursement for transportation required to facilitate the provision of authorized habilitative services when transportation is not already included in the service provider's contract and payment.

B. Limitations

1. Transportation is limited to travel to and from a habilitative service.
2. Reimbursement for provider mileage requires prior approval.
3. Purchase or lease of vehicles is not covered under this service.
4. Reimbursement for provider travel time is not included in this service.
5. Reimbursement to the provider is limited to transportation that occurs when the NF resident is with the provider.
6. The resident is not eligible for transportation services if the cost and responsibility for transportation is already included in the service provider's contract and payment

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4. a. Nursing facility services (cont)

IX. Other habilitative services and supplies

B. Other habilitative services and supplies are services and supplies that meet habilitative goals but that are not included in specialized add-on service categories above.

B. Limitations

1. The habilitative goal(s) of the service or supply must be clearly defined in writing, by the individual recommending the service or supply. In particular, the recommendation must describe how the service or supply will assist the resident in partially or fully attaining, learning, maintaining, or improving developmental-age appropriate skills that were not fully acquired as a result of a congenital, genetic, or early acquired health condition, and are required to maximize, to the extent practical, the client's ability to function in his or her environment

X. Providers

The following licensed, registered, or certified providers, or appropriately qualified providers who participate in one of the home and community-based services programs, or providers who are employed by a Regional Support Network may furnish the items, equipment, systems, or services described above in accordance with relevant state law and within their scope of practice:

- Audiologist
- American Sign Language instructor
- Community access service provider
- Community engagement service provider
- Community guide
- Counselor, mental health counselor, marriage and family therapist, or social worker.
- Music therapist
- Occupational therapist
- Person-centered plan facilitator
- Peer mentor
- Physical therapist
- Physician assistant working under the supervision of a psychiatrist
- Psychiatric advanced registered nurse practitioner (ARNP
- Psychiatrist
- Psychologist
- Recreation therapist
- Registered nurse or licensed practical nurse
- Sex offender treatment provider
- Speech and language pathologist
- Supported employment services provider
- Transportation services provider

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4. b. Early and periodic screening, diagnostic, and treatment

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a program providing EPSDT to persons under 21 years of age who are eligible for Medicaid. In conformance with 1905(r) of the Act, all medically necessary diagnosis and treatment services are provided regardless of whether the service is included in the plan. Limitations to EPSDT and all services provided to children do not apply other than based on medical necessity.

EPSDT health screening visits (well child checks) are provided based on the periodicity schedule described in the agency's provider guides.

Covered services available for children include, but are not limited to:

1. Dental services as described in 3.1-B. 10. II.

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4. b. EPSDT (cont)

2. Eye examinations, refractions, eyeglasses (frames and glasses) and fitting fees:
   (A) Medically necessary eye examinations, refractions, and fitting fees are covered every 12 months.
   (B) Frames, lenses, and contact lenses must be ordered from the Medicaid agency's contractor.

3. Hearing aids are covered on the basis of minimal decibel loss

4. Outpatient physical therapy, occupational therapy, and services for children with speech, hearing and language disorders are provided in accordance with 42 CFR 440.110.

   Duplicate services for occupational, physical, and speech therapy are not allowed for the same client when providers are performing the same or similar procedure(s).

5. Home health services;

   Outpatient occupational therapy, physical therapy, and services for individuals with speech, hearing and language disorders are limited to:
   (A) Clients who are not able to access their care in the community; and
   (B) Medically necessary care.

   When physical therapy and occupational therapy are both medically necessary during the same certification period in order to meet the client's physical or occupational therapy needs, the physician must document on the plan of care that the services are distinctly different and not duplicated.

   - Physical therapy services may be provided by a licensed physical therapist or a physical therapist assistant supervised by a licensed physical therapist. Physical therapist assistants must meet the requirements in chapter 18.74 RCW in effect as of July 1, 2009. Chapter 18.74 RCW specifies required education, experience, and the state's application and examination process for these providers.

   - Occupational therapy services may be provided by a licensed occupational therapist, a licensed occupational therapy assistant supervised by a licensed occupational therapist, or an occupational therapy aide, in schools, trained and supervised by a licensed occupational therapist. Licensed occupational therapy assistants and occupational therapy aides must meet the requirements in chapter 18.59 RCW in effect as of July 1, 2009. Chapter 18.59 RCW specified required education, experience, and the state's application and examination process for these providers.

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4. b. EPSDT (cont)

- Services for clients with speech, hearing, and language disorders must be provided by or under the supervision of a speech pathologist or audiologist. Speech pathologists, audiologists, and individuals providing services under their supervision must meet the requirements in chapter 18.35 RCW in effect as of July 1, 2009. Chapter 18.35 RCW specifies required education, experience, and the state's application and examination process for these providers.

6. Hospice care, including palliative care

7. School-based health care services

School-based healthcare services are provided to a child with a disability. The Medicaid agency reimburses school districts, charter schools and tribal schools for school-based health care services provided to children in Special Education, consistent with Section 1905(a) and 1903(c) of the Social Security Act. Covered services must:

- Address the physical and/or mental disabilities of the child;
- Be prescribed or recommended by a licensed physician or another licensed or credentialed practitioner within his or her scope of practice under state law; and
- Be in accordance with the Individuals with Disabilities Education Act (IDEA) by being included in the child's current Individual Education Plan (IEP) for Part B services, or Individualized Family Service Plan (IFSP) for Part C services.
- Be provided in the school setting, the natural environment, or an alternate placement in accordance with IDEA.

(a) Provider qualifications – School-based healthcare services provided to a child with a disability must be delivered by or under the direction of a qualified provider who meets both federal and state licensing or credentialing requirements. The professional must operate within the scope of his or her license and certification according to state law and professional practice standards.

(i) *Physical Therapist* – A 'licensed physical therapist' is an individual who meets the requirements set forth in 42 CFR 440.110(a). Physical therapy services may be provided by a 'licensed physical therapy assistant' or non-licensed personnel under the direction of a physical therapist per federal regulations and professional practice standards.

(ii) *Occupational Therapist* – A 'licensed occupational therapist' is an individual who meets the requirements set forth in 42 CFR 440.110(b). Occupational therapy services may be provided by a 'licensed occupational therapy assistant' or non-licensed personnel under the direction of an occupational therapist per federal regulations and professional practice standards. .

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4. b. EPSDT (cont)

(iii) *Speech-Language Pathologist* – A 'licensed speech-language pathologist' is an individual who meets the requirements set forth in 42 CFR 440.110(c)(2). Speech-language pathology services may be provided by a 'certified speech-language pathology assistant' or non-licensed personnel under the direction of a speech language pathologist per federal regulations and professional practice standards.

(iv) *Audiologist* – A 'licensed audiologist' is an individual who meets the requirements set forth in 42 CFR 440.110(c)(2). Audiology services may be provided by non-licensed personnel under the direction of a licensed audiologist per federal regulations and professional practice standards.

(v) *Advanced Registered Nurse Practitioner (ARNP)*, *Registered Nurse (RN), or Licensed Practical Nurse (LPN)* – An 'advanced registered nurse practitioner,' 'registered nurse,' or 'licensed practical nurse' is an individual who meets the requirements set forth in 42 CFR 440.60. Nursing and health services may be provided by non-licensed personnel under the direction of an ARNP or RN per professional practice standards.

(vi) *Psychologist* – A 'licensed psychologist' is an individual who meets the requirement set forth in 42 CFR 440.130(d). Mental health services may be provided by non-licensed personnel under the direction of a licensed psychologist per federal regulations and professional practice standards.

(vii) *Social Worker* – A 'licensed social worker' is an individual who meets the requirements set forth in 42 CFR 440.130(d). Mental health services may be provided by non-licensed personnel under the direction of a licensed social worker per federal regulations and professional practice standards.

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(viii) *Mental Health Counselor* – A 'licensed mental health counselor' is an individual who meets the requirements set forth in 42 CFR 440.130(d). Mental health services may be provided by a 'licensed mental health counselor associate' or non-licensed personnel under the direction of a licensed mental health provider per federal regulations and professional practice standards.

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4. b. EPSDT (cont)

(b) Covered services are provided in accordance with 1905(a) of the Social Security Act including: (4) (B), (6), (11), (13), (29), and subsection (r)(5).

Physical therapy evaluations and treatment services – Assessing, preventing, or alleviating movement dysfunction and related dysfunctional problems.

Occupational therapy evaluations and treatment services – Assessing, improving, developing, restoring functional impairment, loss through illness, injury or deprivation, and improving the ability to perform tasks toward independence when functions are lost.

Speech-language therapy evaluations and treatment services – Assessment of children with speech and language disorders, and diagnosis and appraisal of specific speech and language disorders. Referral to medical and other professional services necessary for the rehabilitation of speech and language disorders, provision of speech and language services, and for the prevention and improvement of communication disorders.

Audiology-hearing evaluations and treatment services –Assessments of children with hearing loss, determination of the range, nature and degree of hearing loss, including the referral to medical or other professional services for restoration and rehabilitation due to hearing disorders. Provision of rehabilitative activities, such as speech restoration or rehabilitation, auditory training, hearing evaluation and speech conversation, and determination of the child's need for individual amplification.

Nursing evaluations and treatment services – Assessment of a child's medical needs ordered by a prescribing physician or other licensed healthcare provider within his or her scope of practice. Treatment services include assessment, treatment, and supervision of delegated health care services provided to prevent disease, disability, or the progression of other health conditions.

Mental health services – Includes diagnostic and treatment services involving mental, emotional, or behavioral problems or dysfunctions. Mental health services include, but are not limited to, mental health evaluations, psychological testing, and individual and group counseling as specified in the child's IEP or IFSP.

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(c) Medicaid beneficiaries have the freedom to choose their providers. The state, school districts, charter schools and tribal schools may encourage, but may not require, Medicaid eligible children to receive necessary healthcare services in the school setting from school-based providers.

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4. d. Tobacco cessation counseling services for pregnant women

1) Face-to-face tobacco cessation counseling services provided:

_X_ (i) By or under supervision of a physician.

_X_ (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services. *

___ (iii) By any other health care professional legally authorized to provide tobacco cessation services under State law and who is specifically designated by the Secretary in regulations. (None are designated at this time; this item is reserved for future use).

* Describe if there are any limits on who can provide these counseling services

2) Face-to-face tobacco cessation counseling services benefit package for pregnant women

*Any benefit package that consists of less than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period (eight (8) per year) should be explained below.

Please describe any limitations:

The State's benefit package duplicates the benefits described above. Providers may request a limitation extension according to Washington Administrative Code (WAC).

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5. a. Physicians' Services

Exceptions for noncovered services and service limitations are allowed when medically necessary and prior authorized by the department.

(1) Critical care.

- A maximum of three hours of critical care per client per day.
- For inpatient critical care, only the attending physician(s) who assume(s) responsibility for care of the client during a life threatening episode is/are covered to deliver services.
- More than one physician may be covered to deliver services if the services are distinctly separate services (i.e., involve multiple organ systems (unrelated diagnosis)).
- In the emergency room, only one physician is covered to deliver services.

(2) Hospital visits. No payment for visits on those days that exceed the allowed length of stay unless an extension was requested and has been approved.

(3) Newborn care and neonatal intensive care unit (NICU) services.

- One routine NICU visit per client per day.
- Prolonged care and newborn resuscitation when the physician is present at the delivery (in addition to the one routine visit).

(4) Osteopathic manipulative therapy.

Up to ten osteopathic manipulations per client, per calendar year.

(5) Physical exams:

Routine physical exams are covered in specific instances, including but not limited to:

- EPSDT screening
- Nursing facility placement exams
- Disability determinations for Title XVI-related individuals
- Yearly exams for developmental disability determination (DDD) clients

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5. a. Physicians' services (cont.)

(6) Physician care plan oversight.

Provided once per client, per month. A plan of care must be established by the home health agency, hospice, or nursing facility, and the physician must provide 30 minutes or more of oversight each calendar month to the client.

(7) Physician standby services.
Must be:
- Requested by another physician;
- Involve prolonged physician attendance without direct (face-to-face) patient contact; and
- Exceed 30 minutes.

(8) Physician visits.
Limited to:
- Two physician visits per month for a client residing in a nursing facility or an intermediate care facility.
- One inpatient hospital visit per client, per day, for the same or related diagnosis.
- One office or other outpatient visit per non-institutionalized client, per day, for an individual physician, except for return visits to an emergency room.

Professional inpatient services during the follow-up period for a surgery are only covered if the services are performed on an emergency basis and are unrelated to the original surgery.

Prior authorization is required for additional services that are medically necessary.

(9) Psychiatric services:
Limited to:

Inpatient care
- One hospital call per day for direct psychiatric care

Outpatient care
- One psychiatric diagnostic interview examination per provider in a calendar year unless an additional evaluation is medically necessary.
- Medically necessary individual or family/group psychotherapy visits, with or without the client
- One psychiatric medication management service per day in an outpatient setting unless more is medically necessary

Prior authorization is required for additional services that are medically necessary.

See section 6.d.(8) for collaborative care (integrated medical and behavioral health services) provided in primary care settings

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5. a. Physicians' services (cont.)

(10) Physiatry services

- The Department does not cover duplicate services for occupational and physical therapy for the same client when both providers are performing the same or similar procedure(s).
- The Department does not pay separately for physical therapy services that are included as part of the payment for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.
- The Department does not limit covered physical therapy services for clients 20 years of age and younger.
- For adults:
  - 1 physical therapy evaluation (in addition to the 48 program unit limitation below) per calendar year
  - 48 physical therapy program units per calendar year
  - 2 DME needs assessments (in addition to the 48 program unit limitation) per calendar year
  - 1 wheelchair needs assessment (in addition to the DMS needs assessments) per calendar year
  - Prior authorization is required for additional program units that are medically necessary

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5. a. Physicians' services (continued)

(11) All physician services that an optometrist is legally authorized to perform are included in physicians' services under this plan and are reimbursed whether performed by a physician or an optometrist in accordance with 42 CFR 441.30.

Optometric physicians are subject to Washington scope of practice laws and are held to the same standards as are people licensed as physicians to practice medicine and surgery by the Washington Medical Board.

Optometric physicians are eligible providers for the Electronic Health Records (EHR) incentive program to the extent they provide services to children under age 21 and meet EHR participation criteria.

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5. b. Medical and surgical services furnished by a dentist

Services may be provided by a physician, doctor of dentistry, or Doctor of Dental Surgery.

Short stay procedures may also take place in ambulatory surgery settings.

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6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law

a. Podiatrists' services

(1) Foot care is covered only for specific medical conditions that must be treated by a podiatrist.

(2) Foot conditions for which treatment is not medically necessary are not covered.

b. Optometrists' services

(1) The Medicaid agency covers medically necessary eye examinations, refractions, and fitting fees every 24 months for asymptomatic adults 21 years of age and older.

(2) Exceptions will be considered for all individuals based on medical necessity.

(3) For clients under 21 years of age, services will be provided in accordance with EPSDT requirements at 1905(r), subject to determination of medical necessity and prior authorization by the Medicaid agency.

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6. d. Other practitioners' services

(1) All other practitioners covered by the department include, but are not limited to, the following licensed practitioners. These practitioners are limited to services within their scope of practice and specialty area.

- Advanced registered nurse practitioners including certified registered nurse anesthetists
- Certified behavior support specialists under the supervision of a licensed practitioner covered under this benefit whose scope of practice includes assessment, diagnosis, and treatment of identifiable mental and behavioral health conditions.
- Chiropractors (for EPSDT only)
- Dental health aide therapists* (under the supervision of a dentist within the scope of practice as defined under state law. The supervising licensed practitioner assumes professional responsibility for the services provided by the unlicensed practitioner and the licensed practitioner bills for services furnished by unlicensed practitioners.) **Technical correction: Dental health aide therapists added per SPA 17-0027 approved 6/21/2023 effective 7/23/2017*.
- Dental hygienists
- Denturists
- Licensed non-nurse midwives
- Naturopathic physicians (services are limited to physician-related primary care services)
- Opticians
- Pharmacists
  - Pharmacy interns and pharmacy technicians may furnish services in accordance with their professional scope of practice in accordance with state law.
  - Pharmacies are qualified providers of COVID-19 vaccinations per the HHS COVID-19 PREP Act Declaration and authorizations.
- Physician assistants
- Psychologist
- Certified substance use disorder professionals

(2) Other practitioners are covered as specified in other sections of the State Plan and as approved by the department.

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(3) Mental health outpatient services may be provided by the following providers licensed by the state under 42 CFR 440.060(a):

- Licensed Advanced Social Workers
- Licensed Advanced Social Worker Associates
- Licensed Independent Clinical Social Workers
- Licensed Independent Clinical Social Worker Associates
- Licensed Marriage and Family Therapists
- Licensed Marriage and Family Therapist Associates
- Licensed Mental Health Counselors
- Licensed Mental Health Counselor Associates
- Licensed Psychiatric Advance Nurse Practitioners
- Licensed Psychologists

To diagnose and treat clients eighteen years of age and younger, the practitioner must be listed above and must:

a. Meet state requirements for a Children's Mental Health Specialist; or
b. Be working under the supervision of a licensed practitioner listed above who meets the state requirement for a Children's Mental Health Specialist.

(4) Reserved

(5) Licensed non-nurse midwives
To participate in home births and in birthing centers, midwives must be an agency-approved provider.

(6) Psychologists.

- Psychological testing must be medically necessary, prior authorized, in an outpatient setting, and is limited to 2 units per client.
- Neurobehavioral status examinations require prior authorization.
- Neuropsychological testing requires prior authorization.
- Prior authorization is required for additional services that are medically necessary.

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6. d. Other practitioners' services (cont)

(7) Intensive behavior services (applied behavior analysis (ABA) provided by:

A. A lead behavior analysis therapist (LBAT) who under Washington State law is licensed under one of the following provisions:

- A licensed behavior analyst (LBA) practicing under the scope of state law as defined in Department of Health (DOH) RCW and WAC (may bill independently)
- A licensed psychiatrist, psychiatric advanced nurse practitioner, psychologist, mental health counselor, marriage or family therapist, or clinical social worker practicing under the scope of state law as defined in DOH RCW and WAC who is licensed as an LBA (may bill independently)
- A licensed assistant behavior analyst (LABA) practicing under the scope of state law as defined by DOH RCW and WAC and supervised by an LBA practicing under the scope of state law as defined in DOH RCW and WAC (may not bill independently)

Note: When licensed as an LBA, these professionals may supervise other providers including certified behavior technicians (CBTs), in accordance with their scope of practice in applicable DOH RCW and WAC. All licensed supervising practitioners will bill for services performed by unlicensed practitioners.

B. A licensed certified behavior technician (CBT) practicing under the scope of state law as defined in DOH RCW and WAC and supervised by an LBAT practicing under the scope of state law as defined in DOH RCW and WAC (may not bill independently)

C. A licensed psychiatrist, psychiatric advanced nurse practitioner, psychologist, mental health counselor, marriage or family therapist, or clinical social worker practicing under the scope of state law as defined by DOH RCW and attesting to having the training and experience to provide applied behavior analyst services in accordance with state law as defined in WAC (may bill independently)

The State provides assurance that these licensed providers:

- Provide services consistent with §440.60.
- Supervise according to the State's Scope of Practice Act for licensed practitioners.
- Assume professional responsibility for the services provided by the unlicensed practitioner.

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6. d. Other practitioners' services (cont)

(8) Collaborative care

The following health care professionals are eligible to participate on the collaborative care team to provide collaborative care and will furnish services in accordance with their scope of practice as defined by state law:

1. State-licensed advanced registered nurse practitioners
2. State certified behavioral health support specialists under the supervision of a licensed practitioner covered under this benefit whose scope of practice includes assessment, diagnosis, and treatment of identifiable mental and behavioral health conditions.
3. State-certified substance use disorder professionals
4. Substance use disorder professional trainees under the supervision of a state-certified chemical dependency professional
5. State-licensed marriage and family therapists
6. State-licensed marriage and family therapist associates under the supervision of a state-licensed marriage and family therapist or equally qualified mental health practitioner
7. State-licensed mental health counselors
8. Mental health counselor associates under the supervision of a state-licensed mental health counselor, psychiatrist, or physician
9. State-licensed physicians
10. State-licensed physician assistants under the supervision of a licensed physician
11. State-licensed psychiatrists
12. State-licensed psychiatric advanced registered nurses
13. State-licensed psychologists
14. State-licensed registered nurses
15. State-licensed social workers
16. State-licensed social worker associate independent clinical, under the supervision of state-licensed independent clinical social worker or equally qualified mental health practitioner.
17. State-licensed social worker associate advanced, under the supervision of a state-licensed independent clinical social worker, state-licensed advanced social worker, or equally qualified mental health practitioner.

For unlicensed practitioners that require supervision to furnish services, Washington assures that the supervising state-licensed or state-certified practitioner assumes professional responsibility for the services provided by the unlicensed practitioner.

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6.d. Other Licensed practitioners (cont)

(9) Emergency Medical Services (EMS) providers

EMS providers furnish services within their scope of practice as defined by state law. EMS practitioner certification is equivalent to licensure in the state.

(10) Social Work Services to Enhance the Effectiveness of Home Health Services

Licensed social workers are covered within their scope of practice in accordance with state law. Medical Social Services are provided as part of an authorizing practitioner-ordered Home Health service.

(11) Certified Community Health Aide Program (CHAP) providers, supervised by any licensed practitioner covered under this benefit within their scope of practice as defined under state law.

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7. Home health services

a. Intermittent or part-time nursing services

(1) Applies to home health agency and to services provided by a registered nurse when no home health agency exists in the area.
(2) Approval required when period of service exceeds limits established by the single state agency.
(3) Nursing care services are limited to:
  (a) Services that are medically necessary;
  (b) Services that can be safely provided in the home setting;
  (c) Two visits per day (except for the services listed below);
  (d) Three obstetrical visits per pregnancy for high-risk pregnancy clients; and
  (e) Infant home phototherapy that was not initiated in the hospital setting.
(4) Services must be ordered by a physician, physician assistant (PA), or advanced registered nurse practitioner (ARNP) as part of a written plan of care.
(5) Exceptions are made on a case-by-case basis.

b. Home health care services provided by a home health agency

Home health aide services must be:
(1) Intermittent or part time;
(2) Ordered by a physician on a plan of care established by the nurse or therapist;
(3) Provided by a Medicare-certified home health agency;
(4) Limited to one medically necessary visit per day; and
(5) Supervised by the nurse or therapist biweekly in the client's home.

Exceptions are made on a case-by-case basis.

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7. Home health services (cont.)

(5) Supervised by the nurse or therapist biweekly in the client's home.
(6) Exceptions are made on a case-by-case basis.

c. Medical supplies, equipment, and appliances in accordance with 42 CFR 440.70.

Medical supplies, equipment and appliances must be:
- Medically necessary;
- In the client's plan of care; and
- Ordered by the treating physician, physician assistant (PA), or advanced registered nurse practitioner (ARNP) and renewed annually.

All of the following apply to medical equipment supplies, appliances, and related services:
- Purchase of equipment and appliances and rental of medical equipment require prior approval.
- All appliances: prosthetics meeting the definition of home health appliances that replace a body part and orthotics supporting a body part are limited to one (1) per upper limb, lower limb, cranium, or spine per year. Prior authorization is required to exceed the limitation.

Home infusion-parenteral nutrition equipment and supplies are provided when medically necessary.

The Medical Nutrition Program provides medically necessary nutrition and related equipment and supplies, when the client is unable to meet daily nutritional requirements using traditional foods alone, due to injury or illness.

Limitations described below do not apply to the Medical Nutrition Program for clients under age 21 under EPSDT. All other exceptions to these limitations require prior authorization on a case-by-case basis and are based on medical necessity.
- Initial assessments limited to 2 hours (or 8 units) per year
- Reassessments limited to no more than 1 hour (or 4 units) per day
- Training and education provided to groups limited to 1 hour (or 4 units) per day

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility

Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders are provided in accordance with 42 CFR 440.110.

When physical therapy and occupational therapy are both medically necessary during the same certification period in order to meet the client's physical or occupational therapy needs, the physician must document on the plan of care that the services are distinctly different and not duplicated.

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7. d. Home health services (cont.)

Limitations for physical, occupational, and speech therapy

The following therapy units are limited as follows, per client per year:

- Physical and occupational therapy – 24 units (approximately 6 hours)
- Occupational therapy – 24 units (equals approximately 6 hours)
- Speech therapy – 6 units (equals a total of 6 untimed visits)

All of the following are limited to 1 per client per calendar year:

- Physical and occupational therapy
  - Evaluations
  - Re-evaluation at time of discharge
  - Wheelchair management. Assessment is limited to 4 15-minute units per assessment.

- Speech therapy
  - Evaluations of speech fluency, speech sound production, swallowing function, and oral speech device
  - With language comprehension and expression
  - Behavioral and qualitative analysis of voice and resonance
  - Speech language pathology re-evaluation at time of discharge

Limitations do not apply for clients under age 21 under EPSDT.

Additional services are covered with prior authorization on a case-by-case basis when medically necessary.

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8. Private duty nursing services

The purpose of the Private Duty Nursing (PDN) Program is to reduce the cost of healthcare services by providing equally effective, more conservative, and/or less costly treatment in a client's home. The department's Medical Assistance Administration has oversight for the program for clients 17 years of age or younger. Eligible clients must meet all of the following: be 17 years of age or younger; need continuous skilled nursing care that can be provided safely outside an institution; and have prior authorization from the department. PDN Program services for those age 18 and older are administered by the department's Aging and Disability Services Administration, and are comparable to services for those under age 18.

The department contracts with State licensed home health agencies to provide PDN services. Within the home health agency, private duty nursing services must be performed by a licensed and appropriately trained registered nurse and/or a licensed practical nurse. For persons 18 years and older with an approved exception to policy, a private (non-home health agency) RN or LPN under the direction of a physician can provide PDN services only when the geographic location precludes a contracted home health agency from providing services, or when no contracted home health agency is willing to provide PDN services.

PDN services meet complex medical needs for persons who require at least four continuous hours of skilled nursing services on a day-to-day basis. Services provide alternatives to institutionalization in a hospital or nursing facility and are not intended to supplant or replace other means of providing the services.

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9. Clinic services

a. Freestanding kidney centers

(1) Description of facility: A center devoted specially to treating End Stage Renal Disease (ESRD)

(2) Description of service: Peritoneal dialysis or hemodialysis for ESRD.

(3) Program coverage: Covered as an outpatient service when provided by a freestanding renal dialysis center or a freestanding community hemodialysis unit. Includes physician services, medical supplies, equipment, drugs, and laboratory tests.

(4) Prior authorization: Required for the facility but not the physician. Initial authorization may be granted for up to three months. Reauthorization may be granted for up to twelve months.

(5) Reimbursement: This service is reimbursed according to attachment 4.19-B, II, A.

b. Freestanding ambulatory surgery centers

Allowed procedures are covered when they:

- Are medically necessary; and
- Are not for cosmetic treatment surgery.

Some procedures are covered only when they:

- Meet certain limitation requirements; and
- Have been prior authorized by the department.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

10. Dental services and dentures

The Medicaid Agency covers the services listed below for eligible clients as indicated. Some of these services may require prior authorization. Limitations do not apply for children age 20 and under for EPSDT purposes and may be exceeded based on documented medical necessity with prior authorization. Beneficiaries who have a developmental disability, identified with an indicator provided by the Developmental Disabilities Administration (DDA) or clients who reside in a skilled nursing facility (SNF) or alternative living facility (ALF qualify for services that may exceed service limitations.

When medically necessary, dental services may be provided in ambulatory surgery centers, inpatient settings, and outpatient settings, including emergency departments.

I. For clients age 21 and over

A. Diagnostic
- Biopsy
- Examinations
- Pulp vitality test
- Radiographs (x-rays)

B. Preventive care
- Behavior management (only for adults identified by DDA)
- Fluoride
- Prophylaxis
- Sealants (only for adults identified by DDA)

C. Treatment
- Aveoloplasty
- Endodontic treatment for permanent anterior teeth
- Extractions/oral surgery
- Periodontic therapy
- Resin and amalgam restorations
- Non-emergency oral surgeries performed in an inpatient setting are not covered. The exception is for clients of DDA whose surgery cannot be performed in an office setting. Documentation must be maintained in the client's record.

D. Prosthodontics
- Complete and overdentures
- Denture repair, rebase, or reline
- Resin partial denture

E. Sedation
- Nitrous oxide
- General sedation for adults identified by DDA
- Conscious sedation for adults identified by DDA
- Office-based/mobile anesthesia for adults identified by DDA

F. Teledentistry

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

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10. Dental services and dentures (cont)

II. For clients age 20 and under

A. Diagnostic
- Biopsy
- Examinations
- Pulp vitality test
- Radiographs (x-rays)

B. Preventive care
- Behavior management
- Fluoride
- Oral hygiene instruction
- Prophylaxis
- Sealants
- Space maintenance

C. Treatment
- Amalgam and composite restorations
- Apexification/apicoectomy
- Crowns
- Endodontic treatment for permanent teeth
- Extractions/oral surgery
- Gingivectomy
- Periodontic therapy
- Pulpotomy

D. Orthodontics
- Limited to medically necessary treatment
- Occlusal orthotic devices for clients age 12 through 20 with prior authorization.

E Prosthedontics
- Complete and overdentures
- Denture repair, rebase, or reline
- Resin partial dentures

F. Teledentistry

G. Sedation
- Nitrous oxide
- General sedation
- Conscious sedation
- Office-based/mobile anesthesia; prior authorization required for clients age 9 through 20

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

10. Dental services and dentures (cont)

III. For clients age 5 and under and all clients age 20 and under based on the determination of medical necessity

A. In addition to the services described in section II, services include:
- Preventive care: family oral health education
- Treatment: interim therapeutic restorations (ITR)

B. Services must be furnished by a dentist or primary care provider who has completed an agency-approved training to provide these services.

C. Limitations do not apply for children age 20 and under for EPSDT purposes and may be exceeded based on documented medical necessity, with prior authorization.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

11. Physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders.

a. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders are provided in accordance with 42 CFR 440.110.

b. Duplicate services for occupational, physical, and speech therapy are not allowed for the same client when providers are performing the same or similar procedure(s).

c. Limitations do not apply for clients under the age of 21 under EPSDT.

d. Prior authorization is required to exceed set limits for clients twenty-one (21) years of age and older as follows:

(1) For physical therapy (PT) services beyond one PT evaluation and 24 units (approximately 6 hours) PT per calendar year, per client.

(2) For occupational therapy (OT) services beyond one OT evaluation and 24 OT units (approximately 6 hours) per calendar year, per client.

(3) For speech therapy (ST) services beyond one speech evaluation and 6 units/visits of speech therapy per calendar year, per client.

e. Under 42 CFR 440.110(a), physical therapy services may be provided by a licensed physical therapist or a physical therapist assistant supervised by a licensed physical therapist. Physical therapist assistants must meet the requirements in chapter 18.74 RCW in effect as of July 1, 2009. Chapter 18.74 RCW specifies required education, experience, and the state's application and examination process for these providers.

f. Under 42 CFR 440.110(b), occupational therapy services may be provided by a licensed occupational therapist, a licensed occupational therapy assistant supervised by a licensed occupational therapist, or an occupational therapy aide, in schools, trained and supervised by a licensed occupational therapist. Licensed occupational therapy assistants and occupational therapy aides must meet the requirements in chapter 18.59 RCW in effect as of July 1, 2009. Chapter 18.59 RCW specifies required education, experience, and the state's application and examination process for these providers.

g. Under 42 CFR 440.110(c), services for individuals with speech, hearing, and language disorders must be provided by or under the supervision of a speech pathologist or audiologist. Speech pathologists, audiologists, and individuals providing services under their supervision must meet the requirements in chapter 18.35 RCW in effect as of July 1, 2009. Chapter 18.35 RCW specifies required education, experience, and the state's application and examination process for these providers.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

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12. a. Prescribed drugs

Drug Coverage

(1) Covered outpatient drugs as defined in Section 1927 (k)(2) of the Act are those which are prescribed for a medically accepted indication and produced by any manufacturer, which has entered into and complies with an agreement under Section 1927 (a) of the Act.

(2) Prescriptions written as a result of an EPSDT visit will be approved as ordered by the prescriber.

(3) Drugs excluded from coverage as provided by Section 1927(d)(2) of the Act are designated in Attachment 3.1-A and 3.1-B, pages 32a and 32b of this plan. Experimental drugs are excluded from coverage.

(4) Drug shortages. Prescribed drugs that are not covered outpatient drugs (including drugs authorized for import by the Food and Drug Administration) are covered when medically necessary during drug shortages identified by the Food and Drug Administration (FDA).

Prior Authorization

(5) Prescription drugs may be subject to prior authorization by the agency to ensure that drugs are prescribed and dispensed appropriately.

(6) The agency determines which prescription drugs may require prior authorization by reviewing the drug(s) for the following:

- Safety
- Potential for abuse or misuse
- Narrow therapeutic index
- High cost when less expensive alternatives are available

(7) Prior authorization programs for covered outpatient drugs provide for a response within 24 hours of a request for prior authorization and provides for the dispensing of at least a 72-hours supply of medications in emergency situations.

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12. a. Prescribed drugs (cont.)

Supplemental Rebate Program

(7) The state is in compliance with Section 1927 of the Act. Based on the requirements for Section 1927 of the Act, the state has the following policies for the supplemental rebate program for Medicaid recipients:

a) All covered drugs of federal participating manufacturers remain available to the Medicaid program but may require prior authorization.
b) The current state supplemental rebate agreement between the state and a drug manufacturer for drugs provided to Medicaid recipients, submitted to CMS on July 15, 2008, and entitled “State of Washington Supplemental Rebate Contract” has been authorized by CMS remains in effect.
c) The state will continue the ability to have state-specific supplemental rebates and will also participate in a multi-state pooling program that will negotiate supplemental rebates in addition to federal rebates provided for in Title XIX. This multi-state pooling program is known as TOP$sm The Optimal PDL $olution (TOP$). TOP$ rebates will be separate from federal rebates.
d) A TOP$ rebate agreement, submitted to CMS on December 13, 2017, for drugs provided to the Medicaid program has been authorized by CMS.
e) TOP$ supplemental rebate agreements would apply to the drug benefit, both fee-for-service and those paid by contracted managed care organizations (MCOs), under prescribed conditions in Attachment A-2 to the TOP$ Supplemental Rebate Agreement.
f) Supplemental rebates received by the state in excess of those required under the federal drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the federal rebate agreement. The non-federal share of supplemental rebates received by the state will not be subject to the increased offset described in the Affordable Care Act.
g) The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification, in accordance with Section 1927(b)(3)(D).
h) Rebates paid under the CMS-authorized TOP$sm agreement for Washington State Medicaid population do not affect AMP or best price under the Medicaid program.
i) The CMS-authorized TOP$sm agreement for the Washington State Medicaid population only provides supplemental rebates for Medicaid programs eligible for federal rebates. It does not cover non-Medicaid programs.
j) Pharmaceutical manufacturers are allowed to audit utilization rates.
k) The state may enter into value-based contracts with manufacturers on a voluntary basis. The contracts will be executed on the model agreement entitled “Value-Based Supplemental Rebate Agreement” submitted to CMS on March 14, 2019, and authorized for use beginning January 1, 2019.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

12. a. Prescribed drugs (cont.)

Preferred Drug List

a. Pursuant to 42 U.S.C. section 1396r-8, the State is establishing a preferred drug list with prior authorization for drugs not included on the preferred drug list. Prior authorization programs for covered outpatient drugs provide for a response within 24 hours of a request for prior authorization, and provides for the dispensing of at least a 72-hour supply of medications in emergency situations, in accordance with provisions of section 1927(d)(5) of the Social Security Act. The prior authorization process is described in chapter 182-530 WAC.
b. The preferred drug list will be used by all contracted Medicaid managed care organizations and the Medicaid fee-for-service program.
c. Prior authorization will be established for certain drug classes or particular drugs in accordance with Federal law. All drugs covered by the program, irrespective of a prior authorization requirement, will comply with the provisions of the national drug rebate agreement.
d. A preferred drug list does not prevent Medicaid beneficiaries from obtaining access to medically necessary drugs of manufacturers that participate in the national drug rebate program.
e. The State will utilize the Drug Utilization Review Board to assure, that in addition to pricing consideration, preferred drugs are clinically appropriate.

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12. a. Prescribed Drugs (continued)

Citation	Provision
1935(d)(1)	Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full- benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.
1927(d)(2) and 1935(d)(2)	(a) The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D.

_X_ **The following excluded drugs are covered:**

select (i) Agents when used for anexoria, weight loss, weight gain: Progestin derivative appetite stimulant, androgenic agents

_No_ (ii) Agents when used to promote fertility

select (iii) Agents when used for the symptomatic relief cough and colds as listed on the Washington Apple Health Preferred Drug List located on the agency's website.

_X_ (iv) Prescription vitamins and mineral products, except prenatal vitamins and fluoride for documented deficiency.

select (v) Nonprescription (OTC) drugs when determined by the department to be the least costly therapeutic alternative for a medically accepted indication. OTC product coverage is listed within a product's therapeutic class on the Washington Apple Health Preferred Drug List located on the agency's website.

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12. a. Prescribed Drugs (continued)

none (vii) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee

___ No excluded drugs are covered.

(b) Agents when used for cosmetic purposes or hair growth are noncovered. Exceptions for noncovered services are allowed when medically necessary and prior authorized by the state.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

b. Dentures

These services have been moved under “Dental Services” based on CMS recommendation.

12. c. Prosthetic devices

(1) Prosthetics and orthotics must be:
- Medically necessary;
- In the client’s plan of care; and
- Ordered by the treating physician, physician assistant (PA), or advanced registered nurse practitioner (ARNP) and renewed annually.

All of the following apply to prosthetics and orthotics and related services:
- Purchase of equipment and appliances and rental of medical equipment require prior approval.
- Prosthetics replacing a body part and orthotics supporting a body part are limited to one (1) per upper limb, lower limb, cranium, or spine per year. Prior authorization is required to exceed the limitation.

(2) Hearing aids provided on the basis of minimal decibel loss

12. d. Eyeglasses (Included under “Optometrists’ Services”, section 6.b.)

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

13. c. Preventive services

Screening, Brief Intervention, and Referral to Treatment (SBIRT) services

In accordance with 42 CFR 440.130(c), the Medicaid agency covers alcohol and substance misuse counseling through screening, brief interventions, and referral to treatment (SBIRT) when recommended by a physician or other licensed practitioner within their scope of practice as defined in state law, and when provided by, or under the supervision of, a physician or other licensed practitioner within the scope of their practice as defined in state law.

A. PROVIDERS

To qualify as a qualified SBIRT provider, eligible state-licensed or state-certified health care professionals must complete an agency-approved SBIRT training.

The following health care professionals are eligible to become qualified SBIRT providers to deliver SBIRT services within their scope of practice as defined in state law:

- Licensed advanced registered nurse practitioners (ARNP)
- Licensed dentist
- Licensed dental hygienists
- Licensed marriage and family therapists
- Licensed marriage and family therapist associates
- Licensed mental health counselors
- Licensed mental health counselor associates
- Licensed practical nurse
- Licensed psychologist
- Licensed physician
- Licensed physician assistant
- Licensed registered nurse
- Licensed advance social workers
- Licensed advance social worker associates
- Licensed independent social workers
- Licensed independent social worker associates
- Certified substance use disorder professionals (SUDP)
- Certified behavioral health support specialists

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

13. c. Preventive services

Screening, Brief Intervention, and Referral to Treatment (SBIRT) services (cont)

B. SERVICES

SBIRT services are covered for determining risk factors that are related to alcohol and other drug use disorders. SBIRT services are:

- *Screening and assessment* (Occurs during an Evaluation and Management (E/M) exam which involves client history, a physical exam, and medical decision-making): The health care professional uses a standardized screening tool to assess a client's substance use behaviors.
- *Brief intervention* in the form of counseling (Limited to 4 sessions per client per provider per calendar year; additional sessions are allowed with prior authorization when medically necessary. In accordance with EPSDT requirements at 1905(r), clients under 21 years of age will receive all medically necessary services to which they are entitled): The health care professional engages the client in a short conversation, providing health information, feedback, motivation, and advice.
- *Referral for treatment*, if indicated: The health care professional provides a referral to a licensed and certified behavioral health agency for assessment and treatment as appropriate.

Washington covers and reimburses all United States Preventive Services Task Force (USPSTF) grade A and B preventive services and approved adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), and their administration, without cost-sharing. Changes to ACIP recommendations are incorporated into coverage and billing codes as necessary.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

13. c. Preventive Services

Doula Services

Pursuant to 42 CFR 440.130(c), doula services are provided as preventive services and must be recommended by a physician or other licensed practitioner acting within their scope of practice under state law.

A doula is a nonmedical support person trained to provide physical, emotional, and informational support to birthing persons. A doula advocates for and supports the birthing person and their family to self-advocate by helping them to know their rights and make informed decisions. Doula services are provided during pregnancy, childbirth or end of pregnancy, and the postpartum period (the 12-month period after the last day of pregnancy). These services are inclusive of all pregnancy outcomes.

Services include:

- Prenatal intake visit – one per pregnancy
- Labor and delivery support – as needed (no limit but may be billed only once per pregnancy)
- Comprehensive postpartum visit – one per pregnancy
- Additional prenatal and postpartum visits – limited to 20 hours

Limitations may be exceeded based on medical necessity.

Birth doulas must be at least 18 years old and possess current certification as a birth doula with Washington State Department of Health.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

13.c. Preventive Services

Community Health Worker Services

Per 42 CFR Section 440.130(c), Community Health Worker services are provided as preventive services and must be recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law.

I. Services

Community Health Worker (CHW) services are preventive health service to prevent disease, disability, and other health conditions or their progression, to prolong life and/or to promote physical and mental health and efficiency. CHW services leverage lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.

The following component services are covered when performed by CHWs:

1) Person-centered assessment, performed to better understand the individual context and needs, facilitate patient-driven goal setting, and establish a care plan.

2) Care coordination and health system navigation
   a. Communicate with practitioners, home- and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding:
      i. patient's psychosocial strengths and needs,
      ii. functional deficits,
      iii. goals,
      iv. preferences, and
      v. desired outcomes, including cultural and linguistic factors.
   b. Provide coordination of receipt of needed services and care transitions between and among health care practitioners and settings, including:
      i. access/health system navigation involving referral to other healthcare services, including identifying appropriate providers and helping secure appoints.
      ii. follow-up after discharges from emergency departments, hospitals, skilled nursing facilities or other health care facilities.
      iii. facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) to address the social determinates of health (SDOH) need(s).

3) Facilitating behavior change
   a. Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals.
   b. Facilitating and providing social and emotional support to help the patient cope with the problem(s) addressed in the initiating visit, the principal illness, facilitating access to community-based social services (E.g., housing, utilities, transportation, food assistance) to address social determinant of health (SDOH) need(s), and adjusting daily routines to better meet diagnosis and treatment goals

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13.c. Preventive Services (cont)

Community Health Worker Services (cont)

4) Health education and promotion
   a. Help patients to contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, and preferences, in the context of the principal illness and/or SDOH need(s) and educating the patient on how to best participate in medical decision-making.
   b. Build patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services addressing the principal illness and SDOH need(s), in ways that are more likely to promote personalized and effective diagnosis or treatment.

II. Providers

Community Health Workers (CHWs) are frontline public health workers who are trusted members of and/or have a close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

Community Health Representatives (CHRs) are well-trained, medically guided, tribal and Native community people, who provide a variety of health services within American Indian and Alaska Native communities. CHRs are recognized as CHWs for the purposes of CHW services.

1) CHWs must deliver services under the supervision of any licensed practitioner within the scope of their licensure as described in state law.

2) CHWs must have lived experience that aligns with and provides a connection between the CHW and the community being served.

3) CHWs must meet the following requirements:
   a. Have 2,000 supervised hours working as a CHW in paid or volunteer positions within the previous three years and demonstrated skills and practical training in the following areas:
      i. Communication
      ii. Interpersonal and relationship-building
      iii. Service coordination and navigation
      iv. Advocacy
      v. Capacity building
      vi. Professional conduct
      vii. Outreach
      viii. Individual and community assessment
      ix. Knowledge base in public health principles and social determinants of health
      x. Education and facilitation
      xi. Evaluation and research

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

13.c. Preventive Services (cont)

Community Health Worker Services (cont)

b. Demonstrate minimum qualifications through one of the following:
   i. CHW/CHR Certificate: A certificate of completion, including but not limited to any certificate issued by Washington State Department of Health or designee, or Indian Health Services of a curricula that attests to demonstrated skills and/or competencies in the list above.
   ii. Supervision Attestation**:** Medicaid-enrolled licensed supervisors may conduct a CHW assessment and attest to CHW skills and proficiencies to demonstrate the CHW's skills and competencies. The supervising provider must maintain documentation of the CHW assessment.

4) CHWs that do not meet any of the identified skills and/or practical training areas must obtain the necessary training within 18 months of employment.

5) All CHWs must complete a minimum of six hours of additional training annually. The supervising provider must maintain documentation of the CHW's completion of continuing education requirements.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

13. d. Rehabilitative services

1) Behavioral health (substance use disorders (SUD), mental health (MH), and MH/SUD co-occurring disorder (COD)) treatment services recommended by a physician or other licensed practitioner within their scope of practice, for a maximum reduction of physical or mental disability and restoration of a beneficiary to their best possible functional level.

Substance Use Disorder Case Management is covered under the Targeted Case Management benefit and described in Supplement 1F to Attachment 3.1.A

(a) Provider Types:
The following state-credentialled provider types, working within a state-licensed behavioral health agency may furnish services in accordance with their scope of practice, as defined by state law or exempt from such licensure pursuant to Title 25 U.S.C. Sec. 1621t of the Indian Health Care Improvement Act:

i. An individual who has one of the following credentials is considered a **Mental Health Professional:**
- Licensed Advanced Registered Nurse Practitioner working as a Psychiatric Advanced Registered Nurse Practitioner
- Certified Agency Affiliated Counselor
- Licensed Agency Affiliated Counselor
- Licensed Marriage and Family Therapist
- Licensed Marriage and Family Therapist Associate
- Licensed Mental Health Counselor
- Licensed Mental Health Counselor Associate
- Licensed Osteopathic Physician, working as a psychiatrist
- Licensed Physician, working as a Psychiatrist
- Licensed Physician Assistant working under the supervision of a Psychiatrist
- Licensed Physician, working as a Child Psychiatrist
- Licensed Psychologist
- Licensed Registered Nurse, working as a Psychiatric Nurse
- Licensed Social Worker (Advanced, Independent Clinical, or Associate)

Within the list of Mental Health Professionals above, the following definitions apply:
• "Psychiatrist" means a physician licensed by the state who has in addition completed four years of graduate training in psychiatry in a program approved by the American Board of Medical Specialties or the American Osteopathic Board and is certified or eligible to be certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.
• “Child psychiatrist" means a person having a license as a physician in this state, who has had graduate training in child psychiatry in a program approved by the American Board of Medical Specialties or the American Osteopathic Association, and who is board eligible or board certified in child psychiatry.
• "Psychiatric nurse" means a registered nurse who has a bachelor's degree from an accredited college or university, and who has had, in addition, at least two years’ experience in the direct treatment of mentally ill or emotionally disturbed persons, such experience gained under the supervision of a Mental Health Professional. "Psychiatric nurse" also means any other registered nurse who has three years of such experience.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

13. d. Rehabilitative services (cont)

- "Psychiatric advanced registered nurse practitioner" means a person who is licensed as an advanced registered nurse practitioner according to state law; who is board certified in advance practice psychiatric and mental health nursing.

ii. Licensed Practical Nurse
iii. Nursing Assistant Registered/Certified
iv. Medical Assistant – Certified
v. Licensed Pharmacist
vi. Licensed Osteopathic Physician Assistant
vii. Licensed Registered Nurse
viii. Certified Substance Use Disorder Professional
ix.. Certified Substance Use Disorder Professional Trainee
x. Certified Peer Counselor who has self-identified as in recovery from mental health conditions and or substance use disorders or is the parent or legal guardian of a person who has applied for, is eligible for, or has received mental health or substance use services; has received specialized training provided or contracted by the Health Care Authority; has passed a test, which includes both written and oral components of the training; has passed a Washington State background check; has been certified by the Health Care Authority and is working under an Agency Affiliated registration. Certified Peer Counselors work under the supervision of a Mental Health Professional or a Substance Use Disorder Professional.
xi. Mental Health Care Provider, means an individual working in a Behavioral Health Agency, under the supervision of a Mental Health Professional, who has primary responsibility for implementing an individualized plan for mental health rehabilitation services. To provide services as a Mental Health Care Provider, this person must be a Registered Agency Affiliated Counselor and have a minimum of one year of education or experience in mental health or a related field.
xii. Behavioral health Specialist is an individual that hold a state-credential from the list above and meets state requirements as:
- A "child mental health specialist"
- A "geriatric mental health specialist"
- An "ethnic minority mental health specialist"
- A "disability mental health specialist"
- A "Certified problem gambling counselor specialist "
- A "Co-Occurring Disorder Specialist-Enhancement"

xiii. Certified Behavioral Support Specialist (BHSS) means an individual certified by the state to deliver brief behavioral health services under the supervision of a Mental Health Professional or a licensed practitioner covered under this benefit whose scope of practice includes assessment, diagnosis, and treatment of identifiable mental and behavioral health conditions.. To provide services as a Certified Behavioral Health Specialist, this person must have a bachelor's degree and have completed the BHSS educational program approved by the state.
xiii. Certified Gambling Counselor is an individual who holds a state license as a Marriage and Family Therapist, a Marriage and Family Therapist Associate, A Mental Health Counselor, a mental Health Counselor Associate, a Social Worker (Advanced, Independent Clinical, or Associate), Psychologist or a state certification as a Substance Use Disorder Professional or Substance Use Disorder Professional Trainee and also holds a state certification as a Certified Gambling Counselor.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

13. d. Rehabilitative services (cont)

(b) Services

i. Crisis Intervention

Evaluation, assessment, and clinical intervention are provided to all Medicaid enrolled persons experiencing a behavioral health crisis. A behavioral health crisis is defined as a significant change in behavior in which instability increases, and/or risk of harm to self or others increases. The reasons for this change could be external or internal to the person. If the crisis is not addressed in a timely manner, it could lead to significant negative outcomes or harm to the person or others. Crisis services are available on a 24-hour basis. Crisis intervention services are intended to stabilize the person in crisis, prevent further deterioration, and provide immediate treatment and intervention, de-escalation, and coordination/referral efforts with health, social, and other services and supports as needed to effect symptom reduction, harm reduction, and/or to safely transition persons in acute crisis to the appropriate environment for continued stabilization. Crisis intervention should take place in a location best suited to meet the needs of the person and in the least restrictive environment available. Crisis intervention services may be provided prior to completion of an intake evaluation.

The following practitioners may furnish crisis intervention services within their scope of practice as defined by state law:

- Mental Health Professional (MHP)
- Mental Health Care Provider, under the supervision of an MHP
- Certified Behavioral Health Support Specialist under the supervision of an MHP

Additional Information:
In order to claim increased FMAP for services using the ‘community-based mobile crisis intervention services’ model, the requirements described in section 1947(b) of the Act must be met, including providing services to persons outside of a hospital or other facility setting through a multidisciplinary team, trained in trauma-informed care, de-escalation strategies, and harm reduction. The team must include, at a minimum, at least one individual who may conduct an assessment within their authorized scope of practice under state law and other professionals or paraprofessionals with appropriate expertise in behavioral health care.

ii. Crisis Stabilization

Services provided to Medicaid enrolled persons who are experiencing a behavioral health crisis. This service includes follow-up after a crisis intervention. These services are to be provided in the person's own home or another home-like setting, or a setting which provides safety for the person and the Mental Health Professional. Crisis stabilization services may include short-term assistance with life skills training and understanding medication effects. It may also include providing services to the person’s natural and community supports, as determined by a Mental Health Professional, for the benefit of supporting the person who experienced the crisis.
Stabilization services may be provided prior to an intake evaluation for behavioral health services. Stabilization services may be provided by a team of professionals, as deemed appropriate and under the supervision of a Mental Health Professional.

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13. d. Rehabilitative services (cont.)

The following practitioners may furnish crisis stabilization services within their scope of practice as defined by state law:

- Mental Health Professional (MHP)
- Mental Health Care Provider, under the supervision of an MHP
- Certified Peer Counselor, under the supervision of an MHP
- Substance Use Disorder Professional, under the supervision of an MHP
- Certified Behavioral Health Support Specialist under the supervision of an MHP

iii. Intake evaluation, assessment, and screenings (Mental Health)

This service is an evaluation of a person's behavioral health, along with their ability to function within a community, to establish the medical necessity for treatment, determine service needs, and formulate recommendations for treatment. Intake evaluations must be initiated prior to the provision of any other behavioral health services, except those specifically stated as being available prior to an intake. Services may begin before the completion of the intake once medical necessity is established.

Mental health intake evaluation, assessment, and screening services may be provided by a Mental Health Professional within their scope of practice as defined by state law. Psychological assessment and tests must by performed by or under the supervision of a licensed psychologist or psychiatrist.

iv. Intake evaluation, assessment, and screenings (Substance Use or Problem Gambling Disorder)

This service is a comprehensive evaluation of a person's behavioral health, along with their ability to function within a community, to determine current priority needs and formulate recommendations for treatment. The intake evaluation for substance use disorder includes a review of current intoxication and withdrawal potential, biomedical complications, emotional, behavioral, cognitive complications, readiness to change, relapse potential, and recovery environment. Intake evaluations for problem gambling disorders includes a biopsychosocial clinical assessment. Information from the intake is used to work with the person to develop an individualized service plan to address the identified issues.

Intake evaluations must be initiated prior to the provision of any other substance use or problem gambling disorder services. Services may begin before the completion of the intake once medical necessity is established.

Intake evaluations, assessments, and screenings may be provided by the following practitioners within their scope of practice as defined by state law:

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

13 d. 7. Rehabilitative services (cont.)

- Certified Substance Use Disorder Professional (SUDP)
- Certified Substance Use Disorder Professional Trainee (SUDPT), under the supervision of an SUDP
- Licensed Advanced Registered Nurse Practitioner Nurse
- Licensed Marriage and Family Therapist
- Licensed Marriage and Family Therapist Associate
- Licensed Mental Health Counselor
- Licensed Mental Health Counselor Associate
- Licensed Osteopathic Physician
- Licensed Osteopathic Physician Assistant
- Licensed Physician
- Licensed Physician Assistant
- Licensed Psychologists
- Licensed Social Worker (Advanced, Independent Clinical, or Associate)
- Persons with a Co-occurring Disorder Specialist-Enhancement, as described in 13.d.1(a) above

Additional Information
Assessments related to gambling disorders must be performed by or under the supervision of a licensed/certified practitioner, who holds a Certified Gambling Counselor Certification, as defined in state law.

v. Medication Management

Medication management is the prescribing and/or administering of psychiatric medications and reviewing of their side effects. This service may be provided in consultation with primary therapists, case managers, and/or natural supports, without the person present, but the service must be for the benefit of the person.

Medication management may be provided by the following practitioners within their scope of practice as defined by state law:

- Licensed Advanced Registered Nurse Practitioner
- Licensed Advanced Registered Nurse Practitioner/Psychiatric Advanced Registered Nurse Practitioner
- Medical Assistant – Certified
- Licensed Osteopathic Physician
- Licensed Osteopathic Physician/Psychiatrist
- Licensed Pharmacist
- Licensed Physician Assistant
- Licensed Physician
- Licensed Physician/Psychiatrist
- Licensed Practical Nurse
- Licensed Registered Nurse

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13. d. 7 Rehabilitative services (cont.)

vi. Medication Monitoring

Medication monitoring is one-on-one cueing, observing, and encouraging a Medicaid enrolled person to take their psychiatric medications as prescribed. Also includes reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid enrolled person. This service is designed to facilitate medication compliance and positive outcomes.

Medication monitoring may be provided by the following practitioners within their scope of practice as defined by state law:

- Mental Health Professional (MHP)
- Mental Health Care Provider, under the supervision of an MHP
- Certified Peer Counselor, under the supervision of an MHP
- Medical Assistant-Certified
- Licensed Nursing Assistant Registered/Certified
- Licensed Osteopathic Physician/Psychiatrist
- Licensed Osteopathic Physician Assistant
- Licensed Pharmacist
- Licensed Physician Assistant
- Licensed Physician/Psychiatrist
- Licensed Practical Nurse
- Licensed Registered Nurse
- Certified Behavioral Health Support Specialist under the supervision of an MHP

vii. Mental Health Treatment Interventions

Services delivered in a wide variety of settings that promote recovery, using therapeutic techniques. These services are provided, as medically necessary, along a continuum from outpatient up through residential and inpatient levels of care and include evaluation, stabilization, and treatment. Services provided in facility settings must have the appropriate state facility licensure.

Treatment services include the use of planned interventions to achieve and maintain maximum level of functioning for the person.

Treatment interventions include cognitive and behavioral interventions designed with the intent to stabilize the individual and return them to more independent and less restrictive treatment. Services are conducted with the person, their family, or others at their behest, for the direct benefit of the person. Services may include individual, family, and group therapy, as well as skill building/self-care necessary to maintain/restore functioning. Services may also include therapeutic psychoeducation, which focuses on assisting the individual and their identified supports in increasing knowledge of mental health and recovery, use and efficacy of medication, symptom reduction and management, effective problem solving, and emotional/behavioral regulation skills. Intensive or brief intervention treatment models may be utilized, as well as using a multi-disciplinary team-based approach.

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13 d. 7. Rehabilitative services (cont.)

Mental health treatment interventions may be provided by the following practitioners within their scope of practice as defined by state law:

- Mental Health Professional (MHP)
- Mental Health Care Provider, under the supervision of an MHP
- Certified Peer Counselor, under the supervision of an MHP

Additional Information
Individual and Family treatment may take place without the person present, with their consent, as required by law. However, the service must be for the benefit of attaining the goals identified by the person in their individualized service plan.

viii. Peer Support

This service provides scheduled activities that promote wellness, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Services provided by Certified Peer Counselors as noted in the individuals' Individualized Service Plan, or without an Individualized Service Plan when provided during/post crisis episode.

Certified Peer Counselors work with their peers (adults and youth) and the parents/caregiver of children receiving or who have received behavioral health services They draw upon their experiences to help peers find hope and make progress toward recovery and wellness goals. Certified Peer Counselors model skills in recovery and self-management to help individuals meet their self-identified goals.

Certified Peer Counselors must provide peer counseling services under the supervision of a MHP or SUDP who understands recovery. The peer's and clinical supervisor's expertise should be aligned with the needs of the populations served by the Certified Peer Counselor.

ix. Behavioral Health Care Coordination and Community Integration
A range of activities furnished to engage persons in treatment and assist them in transitioning from a variety of inpatient, residential, or non-permanent settings back into the broader community. To be eligible, the person must need transition support services in order to ensure timely and appropriate behavioral health treatment and care coordination.

Activities include assessment for discharge or admission to community behavioral health care, integrated behavioral health treatment planning, resource identification and linkage, and collaborative development of individualized service planning that promote continuity of care. These specialized behavioral health community integration activities are intended to promote discharge, maximize the benefits of the transition plan, minimize the risk of unplanned readmission, and increase the community tenure for the person. Services focus on reducing the disabling symptoms of mental illness or substance use disorder and managing behaviors resulting from other medical or developmental conditions that jeopardize the person's ability to live in the community. Services are individualized interventions for the individual or collateral contacts for the benefit of the person and may include skill-building to develop skills promoting community tenure.

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13 d. 7. Rehabilitative services (cont.)

This service may be provided prior to an intake evaluation or assessment.

Behavioral health care coordination and community integration services may be provided by the following practitioners:

- Mental Health Professional (MHP)
- Mental Health Care Provider, under the supervision of an MHP
- Certified Peer Counselor, under the supervision of an MHP or SUDP
- Certified Substance Use Disorder Professional (SUDP)
- Certified Substance Use Disorder Professional Trainee, under the supervision of an SUDP
- Licensed Pharmacist
- Licensed Physician Assistant
- Licensed Practical Nurse
- Licensed Registered Nurse
- Certified Behavioral Health Support Specialist under the supervision of an MHP

x. Substance Use Disorder Brief Intervention

A time limited, structured behavioral intervention designed to address risk factors that appear to be related to substance use disorders, using substance use disorder screening tools and brief intervention techniques, such as evidence-based motivational interviewing and referral to additional treatment services options when indicated.

This service may be provided prior to an intake evaluation or assessment.

Substance use disorder brief intervention services may be provided by the following practitioners:

- Certified Substance Use Disorder Professionals (SUDP)
- Certified Substance Use Disorder Professional Trainee under the supervision of an SUDP
- Licensed Advanced Registered Nurse Practitioner
- Licensed Marriage and Family Therapist
- Licensed Marriage and Family Therapist Associate
- Licensed Mental Health Counselor
- Licensed Mental Health Counselor Associate
- Licensed Osteopathic Physician
- Licensed Osteopathic Physician Assistant
- Licensed Physician
- Licensed Physician Assistant
- Licensed Psychologists
- Licensed Social Worker (Advanced, Independent Clinical, or Associate)
- Persons with a Co-occurring Disorder Specialist-Enhancement, as described in 13.d.1(a) above

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13 d. 7. Rehabilitative services (cont.)

xi. Substance Use or Problem Gambling Disorder Treatment Interventions
Services delivered in a wide variety of settings across the continuum that promote recovery, using therapeutic techniques. These services are provided, as medically necessary, along a continuum from outpatient up through residential and inpatient levels of care. Services provided in inpatient levels of care are provided in state certified facilities.

Treatment interventions include intentional intervention in the health, behavioral health, and personal and/or family life of a person with a substance use or problem gambling disorder. Interventions are designed to facilitate the affected individual to achieve and maintain maximum functional recovery. Treatment interventions include individual treatment, group treatment, family counseling, intensive and team-based approaches.

Provider Qualifications:

- Certified Substance Use Disorder Professionals (SUDP)
- Certified Substance Use Disorder Professional Trainee under the supervision of the SUDP
- Certified Peer Counselor, under the supervision of an SUDP
- Licensed Advanced Registered Nurse Practitioner
- Licensed Marriage and Family Therapist
- Licensed Marriage and Family Therapist Associate
- Licensed Mental Health Counselor
- Licensed Mental Health Counselor Associate
- Licensed Osteopathic Physician
- Licensed Osteopathic Physician Assistant
- Licensed Physician
- Licensed Physician Assistant
- Licensed Psychologist
- Licensed Social Worker (Advanced, Independent Clinical, or Associate)
- Persons with a Co-occurring Disorder Specialist-Enhancement, as described in 13.d.1(a) above

Additional Information:

- Counseling services related to gambling disorders must be performed by a licensed/certified practitioner, who holds a Certified Gambling Counselor Certification, as defined in state law, or be performed by a licensed/certified practitioner under the supervision of a Certified Gambling Counselor Supervisor.
- Individual and Family treatment may take place without the person present, with their consent, as required by law. However, the service must be for the benefit of attaining the goals identified by the person in their individualized service plan.

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13 d. 7. Rehabilitative services (cont.)

xii. Substance Use Disorder Withdrawal Management

Services required for the care and/or treatment of persons intoxicated or incapacitated by alcohol or other drugs that are provided during the initial period of care and treatment while the person recovers from the transitory effects of acute or chronic intoxication or withdrawal from alcohol or other drugs. Services are provided in state certified facilities. Services include:

- Screening of persons in need of withdrawal management; and
- The use of different counseling and treatment strategies, such as motivational interviewing and developing an initial service plan for persons admitted to a program. These services are used to refer, stimulate motivation to guide individuals to additional treatment, and sustain recovery.
- Different levels of withdrawal management are provided in a variety of settings, including residential, sub-acute and acute locations.

Substance Use Disorder withdrawal management services may be provided by the following practitioners within their scope of practice as defined by state law:

- Certified Substance Use Disorder Professionals (SUDP)
- Certified Substance Use Disorder Professionals Trainee under the supervision of an SUDP
- Certified Peer Counselor, under the supervision of an SUDP
- Licensed Advanced Registered Nurse Practitioner/Psychiatric Advanced Registered Nurse Practitioner
- Licensed Marriage and Family Therapist
- Licensed Marriage and Family Therapist Associate
- Licensed Mental Health Counselor
- Licensed Mental Health Counselor Associate
- Medical Assistant
- Nursing assistant registered/certified
- Licensed Osteopathic Physician/Psychiatrist
- Licensed Physician Assistant
- Licensed Physician/Psychiatrist
- Licensed Psychologists
- Licensed Registered Nurse
- Licensed Social Worker (Advanced, Independent Clinical, or Associate)
- Persons with a Co-occurring Disorder Specialist-Enhancement, as described in 13.d.1(a) above

d) Service Limitations

Services outlined within this section that are provided within residential or inpatient settings do not include room and board costs. Services provided within an Institution for Mental Disease (IMD) are not eligible for reimbursement.

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13. d. Rehabilitative services (cont.)

8. Therapeutic child-care to treat psychosocial disorders in children under 21 years of age based on medical necessity. Services Include: developmental assessment using recognized, standardized instruments play therapy; behavior modification; individual counseling; self esteem building; and family intervention to modify parenting behavior and/or the child's environment to eliminate/prevent the child's dysfunctional behavior. Prior approval is required. Payment rates are established per section X of Attachment 4.19-B

Line staff, responsible or planning and providing these services in a developmentally appropriate manner must have an AA degree in Early Childhood Education or Child-Development or related studies, plus five years' of related experience, including identification, reporting, and prevention of child abuse and/or neglect.

Supervisory staff must have a BA in Social Work or related studies, plus experience working with parents and children at risk of child abuse and/or neglect. Experience can be substituted for education using a 2:1 ratio. Their responsibilities are for development, implementation, and documentation of treatment plans for each child.

Agencies and individual providers must be approved as meeting Medicaid agency criteria and certification requirements under state law as appropriate.

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13. d. Rehabilitative services (cont.)

Behavior rehabilitative services are health and remedial services provided to children to remediate debilitating disorders, ordered by a physician or other licensed practitioner of the healing arts within the scope of his or her practice within state law, intended for the maximum reduction of mental disability and restoration of the individual to his or her best possible functional level. Prior approval is required.

Service Settings

BRS may be delivered in a group living setting (in the community), in a treatment foster home, or in a small number of cases, in the child's own home. In all setting, BRS is always provided by the credentialed staff of the BRS provider. Natural parents or foster parents do not provide BRS, nor does the State claim for such.

Service Description

Upon assessment and development of an individual service and treatment plan, specific services include milieu therapy, crisis counseling, regularly scheduled counseling and therapy, and health services. Care management and planning are ongoing and may include coordination with other agencies. When the child returns home, after care may be provided for up to six (6) months.

Milieu therapy: Refers to those activities performed with children to normalize their psycho-social development and promote the safety of the child and stabilize his or her behavior in any given environment. The child is monitored in structured activities conducive to interpersonal interaction (e.g., group work assignments), with the aim of promoting living skills development. As the child is monitored, intervention is provided to remediate the dysfunctional behaviors and encourage appropriate responses which the child may then apply in a broad range of settings. Aggression replacement training is provided to teach children to understand and replace aggression and anti-social behavior with positive alternatives. Providers include Social Service and Care Management staff. Child care staff provide assistance to these staff in the form of day-to-day supervision and behavioral feedback to the youth. (*see Provider Qualifications).*

Crisis counseling: Available on a 24 hour basis, providing immediate short term intervention to assist the child in responding to the crisis and/or stabilize the child's behavior until problems can be addressed in regularly scheduled counseling and therapy sessions. Children in the population served by BRS are subject to sudden, escalating disturbed behavior patterns. Crisis counseling is intended to quickly intervene and address escalating behavior, while scheduled counseling and therapy are intended to address the child's problems in the longer term. Example: A short term intervention would include the child having a face-to-face encounter with a counselor to discuss the nature of the child's current emotional/behavioral disturbance and his/her feelings that caused the disturbance. The child has the opportunity to work out a plan to cope with the immediate situation until longer term solutions can be developed. Providers include Social Service staff and Care Management staff (*see Provider Qualifications)*

Regularly scheduled counseling and therapy: May include psychological testing. Each child has an individual services and treatment plan which identifies the child's specific behavioral dysfunctions. Services and treatment are tailored to the child in his/her individual plan.

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13. d. 9. Rehabilitative services/Behavior rehabilitation (cont.)

Service Description (cont)

Therapy may be in an individual or group setting, which may include members of the child's peer group or family members, but therapy is directed at the child's behavioral problems. Irrespective of the therapeutic setting, counseling and therapy are provided to, or directed exclusively toward, the treatment of the Medicaid-eligible individual.

Providers include Social Services and Care Management staff. Child care staff may provide assistance to these staff in the form of day-to-day supervision and behavioral feedback to the youth (*see Provider Qualifications).*

Health Counseling: This component includes any service recommended by a licensed practitioner of the healing arts within the scope of his/her practice, aimed at reducing physical or mental disability of the individual and restoring the individual to his/her best possible functional level. Emergency and routine medical services are not claimed as BRS.

An EPSDT examination for the child must be arranged within the first 30 days of entry into BRS, and any recommendations resulting from the examination must be acted upon.

Youth may receive health counseling regarding health maintenance, disease prevention, nutrition, hygiene, pregnancy prevention, and prevention of sexually transmitted infections in a group setting or on a one-on-one basis with BRS social service staff or care management staff.

The population of youth served by BRS are at a higher risk of unsafe behaviors than the general population of youth in the community. They are also less concerned with maintaining personal habits that promote and sustain health such as nutrition, personal hygiene, and the prevention of disease. The counseling they receive reduces their dysfunctional behaviors.

BRS providers are required to provide or arrange for drug and/or alcohol treatment for all youth who require such treatment irrespective of the setting in which the youth resides, i.e., all settings. Drug and/or alcohol treatment may be sought in the community network of providers and paid for with the youth's Medicaid benefit and is not billed for in the BRS provider's rate. A small number of BRS providers have staff members who possess the required credentials to provide substance abuse treatment. In such cases, treatment could be provided within the facility without an increase in the provider's rate. Whether provided by a subcontracting community resource or within the BRS facility, substance abuse treatment is integrated into the youth's treatment plan and supported by the social service staff, the care management staff, and the child care staff.

Milieu therapy, crisis counseling, scheduled counseling and therapy, and health counseling are provided by care management staff and social service staff. The role of the child care staff is a supporting role to the care management and social service staff (see *Provider Qualifications and Responsibilities)*.

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13. d. 9. Behavior Rehabilitative Services (cont)

Demonstrations by staff of recreational or work activities are not claimed as BRS.

Population to be Served

Children who receive these services suffer from conditions that prevent them from functioning normally in their homes, schools, and communities. Dysfunctional behaviors may include drug and alcohol abuse; anti-social behaviors that require an inordinate amount of intervention and structure; sexual behavior problems; behaviors symptomatic of victims of severe family conflict; and behavioral disturbances resulting from psychiatric disorders of the parents.

Provider Qualifications and Responsibilities

Each provider must be licensed by the state's Division of Licensed Resources. Specific qualifications for all BRS providers' staff are listed below. In all settings, it is the providers' credentialed staff who perform BRS services.

Social Services Staff: The minimum qualification is a Masters Degree in social work or a social science such as psychology, counseling, or sociology. Social workers must meet the requirements in 18.225 RCW and chapter 246-809 WAC and have a Master's or Doctoral level degree from an educational program accredited by the Council on Social Work Education. Licensed/certified staff must successfully complete the Department of Health's examination and supervised/supervisory experience requirements. Social service staff without a Master's Degree must have a Bachelor's Degree in social work or a social science such as psychology, counseling, or sociology, and must consult at least eight hours per month with a person who has a Master's Degree.

Responsibilities include development of service plans; individual, group, and family counseling; and assistance to child care staff in providing appropriate treatment for clients.

The social service staff provides the child care staff with oversight and direction, when necessary, in the provision of appropriate treatment for children, in accordance with each child's specific treatment plan. Because the Social Service staff possess a higher educational credential and greater experience than the child care staff, they provide leadership to the child care staff.

Care Management Staff: The minimum qualification is a Master's Degree with major study in social work or a social science such as psychology, counseling, or sociology, or a Bachelor's Degree with major study in social work or a social science such as psychology, counseling, or sociology, and two (2) years' experience working with children and families. Mental health counselors must meet the requirements in 18.225 RCW and chapter 246-809WAC and have a Master's or Doctoral level degree in mental health counseling or a related field from an approved college or university. Licensed/certified staff must successfully complete the Department of Health's examination and supervised/supervisory experience requirements.

Responsibilities include case planning, individual and group counseling, assistance to child care staff in providing appropriate treatment for clients, coordination with other agencies, and documentation of client progress.

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13. d. 9. Behavior Rehabilitative Services (cont)

Care managers are in a leadership role to the child care staff. The care manager is responsible for maintaining oversight and providing direction to child care staff on a day-to-day basis for the child's behavior management, in accordance with each child's specific treatment plan. Care managers coordinate with other agencies to ensure that the child, when returned home, will have adequate supports to enable him/her to remain in the community. Examples of such supports could include ensuring that the child has a medical home, has a community treatment resource for drug and/or alcohol abuse, or has counseling for the treatment of sexually aggressive behavior. Coordination with other agencies depends on the specific problems of a specific child.

Therapeutic interventions are provided by social services staff, care management staff, and subcontracted individuals. All providers must meet the qualifications above, and as required, be licensed or certified by the Department of Health (DOH) according to chapter 18.25 RCW to furnish the service(s) provided by the BRS contractor.

Child Care Staff: Minimum qualifications require that no less than 50% of the childcare staff in a facility have a Bachelor's Degree. Combinations of formal education and experience working with children and families may be substituted for a Bachelor's degree.

Responsibilities include assisting social service staff in providing individual, group, and family counseling; and therapeutic intervention to address behavioral and emotional problems as they arise. Child care staff are responsible for understanding each child's treatment plan and providing day-to-day supervision and behavioral feedback to the child, in accordance with each child's individual treatment plan. These staff may provide input, based on their experience with the child, during case staffing and counseling sessions with the child and/or his/her family.

Master's Level Oversight: In addition to the staffing qualifications listed in this section, the Contractor's program must have Master's level oversight. This requirement may be met through a Master's level Program Director or Social Service staff or by subcontracting with a consultant.

17. Nurse midwife services

Limited to facilities approved by the Medicaid Agency to provide this service, or in the case of home births, to clients and residences approved for this service.

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18. Hospice care in accordance with section 1905(o) of the Act

A. Services
1. Itens not included in the daily rate require prior authorization.
2. Covered services
a. Covered services are intermittent except during brief periods of acute symptom control.
b. Core services are provided directly by hospice agency staff or contracted through a hospice agency as necessary, and include:

- Physician services related to administration of the plan of care.
- Nursing care provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of an RN.
- Medical social services provided by a social worker under the direction of a physician.
- Counseling services provided to a client and the client's family members or caregivers.

c. Additional services, which must be related to the hospice diagnosis, written in the plan of care, identified by the hospice interdisciplinary team, safe and meet the client's needs within the limits of the hospice program, and made available by the hospice agency on a 24-hour basis:

- A brief period of inpatient care for general or respite care provided in a Medicare-certified hospice care center, hospital, or nursing facility.
- Drugs, biologicals, and over-the-counter medications used for the relief of pain and symptom control of a client's terminal illness and related conditions.
- Home health aide, homemaker, and/or personal care services ordered by the client's physician and documented in the plan of care. (Home health aide services must be provided by a qualified home health aide and are an extension of skilled nursing or therapy services).
- Interpreter services as necessary for the plan of care.
- Medical equipment and supplies that are medically necessary for the palliation and management of a client's terminal illness and related conditions.
- Medical transportation services as required by the plan of care related to the terminal illness.
- Physical therapy, occupational therapy, and speech-language pathology therapy to manage symptoms or enable the client to safely perform activities of daily living and basic functional skills.
- Skilled nursing care.
- Other services or supplies documented as necessary for the palliation and management of the client's terminal illness and related conditions.
- Bereavement counseling

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18. Hospice care in accordance with section 1905(o) of the Act (cont)

B. Hospice Agency and Practitioner Qualifications

1. Hospice agency requirements:

- Documentation that it is Medicare, Title XVIII-certified by the State's Department of Health; and
- Has received written notification from the Medicaid Agency of enrollment as an approved hospice care center.

2. Practitioner requirements:
All practitioners who provide hospice services must be licensed, certified, accredited, or registered according to Washington State's laws and rules, including but not limited to physicians, registered nurses, licensed practical nurses, and social workers.

C. Hospice Election Periods

Hospice coverage is available for two (2) 90-day election periods followed by an unlimited number of 60-day election periods. A client or a client's authorized representative must sign an election statement to initiate or reinstate an election period for hospice care. An election period to receive hospice care continues through the initial election period and subsequent election periods without a break in care as long as the client:

- Remains in the care of a hospice agency; and
- Does not revoke the election

D. Face-to-face Encounters

Hospice agencies must have a face-to-face encounter with every hospice client prior to the one hundred eightieth-day recertification and prior to each subsequent recertification in order to determine continued eligibility of the client for hospice care. These encounters are not covered separately – they are included in the core services.

E. Concurrent care for children on hospice in accordance with section 2302 of the Affordable Care Act.

A. Hospice clients 20 years of age and under are eligible.

B. The hospice benefit may be elected without foregoing curative services to which the client is entitled for treatment of the terminal condition.

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20. Extended services for pregnant women, through the sixty days postpartum period.

The extended services include:

a. Maternity support services (MSS) by a provider approved by the Department of Health and the department consisting of the following. All staff meet Washington State licensure requirements according to Washington State's law cited in the Revised Code of Washington, RCW 43.24.030.

(1) Nursing assessment and/or counseling visits, provided by licensed registered nurses;
(2) Psychosocial assessment and/or counseling visits, provided by licensed or credentialed behavior health specialists;
(3) Nutrition assessment and/or counseling visit, provided by registered, state-certified dieticians;
(4) Community health worker visit, provided by community health educators; and
(5) Childbirth education, provided by licensed or credentialed child birth educators.

b. Outpatient alcohol and drug treatment for pregnant and postpartum women consisting of a chemical dependency assessment by an Alcohol and Drug Abuse Treatment and Services Act assessment center, parenting education, and chemical dependency treatment. These services are provided by Chemical Dependency Counselors approved by the Division of Behavioral and Health Rehabilitation according to Washington State's law cited in the Revised Code of Washington, RCW 43.24.030.

c. Rehabilitation alcohol and drug treatment services, excluding room and board, for pregnant and postpartum women recommended by a physician or licensed practitioner of the healing arts within the scope of their practice under State law. Services are provided in residential treatment facilities with 16 beds or less certified by the Division of Behavioral and Health Rehabilitation.

d. Genetic counseling performed by a genetic counselor approved by Parent-Child Health Services and Washington State's Department of Health according to Washington State's law cited in the Revised Code of Washington, RCW 43.24.030.

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22. Respiratory care services

As defined in rule, the department covers medically necessary oxygen and/or respiratory therapy equipment, supplies and services to eligible clients in nursing facilities, community residential settings, and in their homes. The above is prescribed by a health care practitioner authorized by law or rule in the State of Washington. Prior authorization is required for specified equipment, or when a request falls outside of the defined criteria.

Selected contracted nursing facilities are authorized to provide exceptional care needs to ventilator- and tracheostomy-dependent clients.

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23. a. Transportation

Ambulance transportation is provided as a medical service for emergencies, for scheduled non-emergencies when medically necessary, or as required by state law. Ambulance transportation is not provided through a brokerage system.

See Attachment 4.19-B, IX.C for reimbursement information.

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23. a.(a) Transportation (cont)

Transportation is provided in accordance with 42 CFR 440.170 as an optional medical service, excluding "school-based" transportation.

/ / Not Provided:
/ / Provided without a broker as an optional medical service:

(If state attests "Provided without a broker as an optional medical service" then insert supplemental information.)

Instructions:
Describe how the transportation program operates including types of transportation and transportation-related services provided and any limitations. Describe emergency and non-emergency transportation services separately. Include any interagency or cooperative agreements with other Agencies or programs.

/X/ Non-emergency transportation is provided through a brokerage program as an optional medical service in accordance with 1902(a)(70) of the Social Security Act and 42 CFR 440.170(a)(4).

(If the state attests that non-emergency transportation is being provided through a brokerage program then insert information about the brokerage program.)

Instructions:
/X/ The State assures it has established a non-emergency medical transportation program in accordance with 1902(a)(70) of the Social Security Act in order to more cost-effectively provide transportation, and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36(b)-(i).

See response at ATTACHMENT 3.1-A 24.a.(a) (information about the brokerage program), Page 62___.

(a) Non-governmental entity

(1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a):

/ / (1) state-wideness (indicate areas of State that are covered)

Broker regions covered by SPA 08-028, approved 08/17/2010, effective 10/01/2008:

1A: Chelan, Douglas, and Okanogan counties
3B: Snohomish County
4: King County
5: Pierce County
6B: Grays Harbor, Lewis, Mason-south, Pacific, and Thurston counties
6C: Clark, Cowlitz, Klickitat, Skamania, and Wahkiakum counties

Broker regions covered by SPA 11-11, effective 01/01/2011:

1B: Ferry, Pend Oreille, and Stevens counties
1C: Adams, Grant, and Lincoln counties
1D: Spokane County
1E: Asotin, Garfield, and Whitman counties
2: Benton, Columbia, Franklin, Kittitas, Walla Walla, and Yakima counties

Broker region covered by SPA 11-11, effective 04/01/2011:

6A: Clallam, Jefferson, Kitsap, and Mason-north counties

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

23. a.(a) Transportation (cont)

/ / (10)(B) comparability (indicate participating beneficiary groups)

/X/ (23) freedom of choice (indicate mandatory population groups)

(2) Transportation services provided will include:

/X/ Wheelchair van
/X/ Taxi
/X/ Stretcher car
/X/ Bus passes
/X/ Tickets
/X/ Secured transportation
/X/ Other transportation

Instructions:
Describe other transportation: When cost- effective, appropriate, and necessary to ensure access to eligible medical services, will consider using/authorizing gas/fuel vouchers, mileage reimbursement, grouped-ride vehicle, volunteer drivers, parking, tolls, ferries, and air transport, and will provide lodging and meal reimbursement as outlined at 42 CFR 440.170(a)(3)(ii).

[Note: Grouped or shared ride vehicles are a cost-effective method to transport groups of clients with similar trip origins and destinations, or more than one client in a locale similar to an airport shuttle. Brokers pay transportation subcontractors on a contracted mileage-based or time-based system; costs are allocated equitably to the clients' specific medical program account codes.]

See response at ATTACHMENT 3.1-A, 24.a.(a)(2) (Transportation services provided will include), Page 62___.

(3) The State assures that transportation services will be provided under a contract with a broker who:
(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, qualifications, and costs;

(ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transportation is timely and transport personnel are licensed, qualified, competent, and courteous;

(iii) is subject to regular auditing and oversight by the State in order to ensure the quality and timeliness of the transportation services provide and the adequacy of beneficiary access to medical care and services;

(iv) complies with such requirements related to prohibitions on referral and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under Section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate.)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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23. a. Transportation (cont)

(4) The broker contract will provide transportation to the following medically needy populations:

/X/ Children under age 21, or under age 20, 19, or 18 and reasonable classifications as the State may choose.
/ / Parents or other caretaker relatives with whom a child is living if child is a dependent child.
/X/ Aged (65 years of age or older)
/X/ Blind
/X/ Disabled
/X/ Permanently or totally disabled individuals 18 or older, under title XVI
/X/ Persons essential to recipients under title I, X, XIV, or XVI
/X/ Blind or disabled as defined in section 1614 with respect to States not eligible to participate in the State plan program under title XVI
/X/ Pregnant women
/X/ Newborns

(5) Payment Methodology

(A) The State will pay the contracted broker by the following method:
/ / (i) Risk capitation
/ / (ii) Non-risk capitation
/X/ (iii) Other (e.g., brokerage fee and direct payment to providers)

(B) Who will pay the transportation provider?
/X/ (i) Broker
/ / (ii) State
/ / (iii) Other

Instructions:
Describe who will pay the transportation provider.

See response at ATTACHMENT 3.1-A, 24.a.(a) (6) Payment Methodology, Page 62___.

(C) What is the source of the non-Federal share of transportation payments?

Instructions:
Describe the source of the non-Federal share of the transportation payments proposed under this State plan amendment. If more than one source exists to fund the non-Federal share of the transportation payments, please separately identify each source of non-Federal share funding.

The source of the non-Federal share of the transportation payments is State general funds.

(D) The State assures that no agreement (contractual or otherwise) exists between the State or any form of local government and the transportation broker to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly). This assurance is not intended to interfere with the ability of a transportation broker to contract for transportation services at a lesser rate and credit any savings to the program.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

23. a.(a) Transportation (cont)

(E) The State assures that payment proposed under this State plan amendment will be made directly to transportation providers and that the transportation provider payments are fully retained by the transportation providers and no agreement (contractual or otherwise) exists between the State or local government and the transportation provider to return or redirect any of the Medicaid payment to the State or form of local government (indirectly or directly).

/X/ (6) The broker is a non-governmental entity:

/X / The broker is not itself a provider of transportation nor does it refer to or subcontract with any entity with which it has a prohibited financial relationship as described at 45 CFR 440.170(4)(ii).

/ / The broker is itself a provider of transportation or subcontracts with or refers to an entity with which it has a prohibited financial relationship and:

(i) / / Transportation is provided in a rural area as defined at 412.62(f) and there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

(ii) / / Transportation is so specialized that there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

(iii) / / The availability of other non-governmental Medicaid participating providers or other providers determined by the State to be qualified is insufficient to meet the need for transportation.

/ / (7) The broker is a governmental entity and provides transportation itself or refers to or subcontracts with another governmental entity for transportation. The governmental broker will:

/ / Maintain an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the Medicaid brokerage will be completely separate from any other program.

/ / Document that with respect to each individual beneficiary's specific transportation needs, the governmental provider is the most appropriate and lowest cost alternative.

/ / Document that the Medicaid program is paying no more for fixed route public transportation than the rate charged to the general public and no more for public paratransit services than the rate charged to other State human services agencies for the same service.

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23. a.(a) Transportation (cont)

(8) /X/ Please describe how the NEMT brokerage program operates.

Instructions:
Describe how the Brokerage program will operate. Include the services that will be provided by the broker. If applicable, describe any services that will not be provided by the broker and name the entity that will provide these services.

Non-governmental brokers serving the following contract regions are all private non-profit 501(c)3 organizations: Regions:
1A, 3B, 4, 5, 6B and 6C (approved in SPA 08-028, effective 10/01/2008)
1B, 1C, 1D, 1E, and 2 (effective 01/01/2011)
6A (effective 04/01/2011)
For additional information see "Description" at ATTACHMENT 3.1-A, 24.a.(a) (9) (how the NEMT brokerage program operates), Page 62 ___.

(b) Governmental entities

(1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a):

/X/ (1) state-wideness (indicate areas of State that are covered)
Broker region (approved in SPA 08-028, effective 10/01/2008): 3A:Island, San Juan, Skagit, and Whatcom counties

/ / (10)(B) comparability (indicate participating beneficiary groups)

/X/ (23) freedom of choice (indicate mandatory population groups)

(2) Transportation services provided will include:

/X/ Wheelchair van
/X/ Taxi
/X/ Stretcher car
/X/ Bus passes
/X/ Tickets
/X/ Secured transportation
/X/ Other transportation

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23. a. Transportation (cont)

Instructions:
Describe other transportation: When cost- effective, appropriate, and necessary to ensure access to eligible medical services, will consider using/authorizing gas/fuel vouchers, mileage reimbursement, grouped-ride vehicle, volunteer drivers, parking, tolls, ferries, and air transport, and will provide lodging and meal reimbursement as outlined at 42 CFR 440.170(a)(3)(ii).

[Note: Grouped or shared ride vehicles are a cost-effective method to transport groups of clients with similar trip origins and destinations, or more than one client in a locale similar to an airport shuttle. Brokers pay transportation subcontractors on a contracted mileage-based or time-based system; costs are allocated equitably to the clients' specific medical program account codes.]

See response at ATTACHMENT 3.1-A, 24.a.(a) (2) (Transportation services provided will include), Page 62___.

(3) The State assures that transportation services will be provided under a contract with a broker who:
(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, qualifications, and costs;
(ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transportation is timely and transport personnel are licensed, qualified, competent, and courteous;
(iii) is subject to regular auditing and oversight by the State in order to ensure the quality and timeliness of the transportation services provided and the adequacy of beneficiary access to medical care and services;
(iv) complies with such requirements related to prohibitions on referral and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under Section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate.

(4) The broker contract will provide transportation to the following medically needy populations:

/X/ Children under age 21, or under age 20, 19, or 18 and reasonable classifications as the State may choose.
/ / Parents or other caretaker relatives with whom a child is living if child is a dependent child.
/X/ Aged (65 years of age or older)
/X/ Blind
/X/ Disabled
/X/ Permanently or totally disabled individuals 18 or older, under title XVI
/X/ Persons essential to recipients under title I, X, XIV, or XVI
/X/ Blind or disabled as defined in section 1614 with respect to States not eligible to participate in the State plan program under title XVI
/X/ Pregnant women
/X/ Newborns

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23. a. (b) Transportation (cont)

(5) Payment Methodology

(A) The State will pay the contracted broker by the following method:
/ / (i) Risk capitation
/ / (ii) Non-risk capitation
/X/ (iii) Other (e.g., brokerage fee and direct payment to providers)

(B) Who will pay the transportation provider?
/X/ (i) Broker
/ / (ii) State
/ / (iii) Other

Instructions:
Describe who will pay the transportation provider.

See response at ATTACHMENT 3.1-A, 24.a.(a) (6) Payment Methodology, Page ___.

(C) What is the source of the non-Federal share of transportation payments?

Instructions:
Describe the source of the non-Federal share of the transportation payments proposed under this State plan amendment. If more than one source exists to fund the non-Federal share of the transportation payments, please separately identify each source of non-Federal share funding.

The source of the non-Federal share of the transportation payments is State general funds.

(D) The State assures that no agreement (contractual or otherwise) exists between the State or any form of local government and the transportation broker to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly). This assurance is not intended to interfere with the ability of a transportation broker to contract for transportation services at a lesser rate and credit any savings to the program.

(E) The State assures that payment proposed under this State plan amendment will be made directly to transportation providers and that the transportation provider payments are fully retained by the transportation providers and no agreement (contractual or otherwise) exists between the State or local government and the transportation provider to return or redirect any of the Medicaid payment to the State or form of local government (indirectly or directly).

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23. a. (b) Transportation (cont)

/ / (7) The broker is a non-governmental entity:

/ / The broker is not itself a provider of transportation nor does it refer to or subcontract with any entity with which it has a prohibited financial relationship as described at 45 CFR 440.170(4)(ii).

/ / The broker is itself a provider of transportation or subcontracts with or refers to an entity with which it has a prohibited financial relationship and:

(i) / / Transportation is provided in a rural area as defined at 412.62(f) and there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

(ii) / / Transportation is so specialized that there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

(iii) / / The availability of other non-governmental Medicaid participating providers or other providers determined by the State to be qualified is insufficient to meet the need for transportation.

/X/ (8) The broker is a governmental entity and provides transportation itself or refers to or subcontracts with another governmental entity for transportation. The governmental broker will:

/X/ Maintain an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the Medicaid brokerage will be completely separate from any other program.

/X/ Document that with respect to each individual beneficiary's specific transportation needs, the governmental provider is the most appropriate and lowest cost alternative.

/X/ Document that the Medicaid program is paying no more for fixed route public transportation than the rate charged to the general public and no more for public paratransit services than the rate charged to other State human services agencies for the same service.

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24. a.(b) Transportation (cont)

(9) /X/ Please describe how the NEMT brokerage program operates.

Instructions:
Describe how the Brokerage program will operate. Include the services that will be provided by the broker. If applicable, describe any services that will not be provided by the broker and name the entity that will provide these services.

Governmental broker serving region 3A.

The broker serving Region 3A is a governmental entity (a council of governments) and serves Island, San Juan, Skagit, and Whatcom counties. This broker does not directly provide trips, but does purchase trips on two public transit systems (in Skagit and Whatcom counties). This broker also authorizes trips using other available modes of transportation as listed in Section (2).

(A) The State pays for direct transportation expenses (e.g., cost of the trips by subcontracted transportation providers, bus tickets, gas vouchers) per detailed report. The State pays separately for the governmental broker's cost of operating the brokerage (call center, etc.), on a set monthly amount basis.

The governmental broker maintains an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the Medicaid brokerage will be completely separate from any other program. The governmental broker maintains an accounting system as required by this authority. The broker is both required by law and committed to assuring that all agency costs are allocated to the appropriate activity and fund source. All costs clearly attributable to a specific activity and fund source are directly charged to that fund source. Activities which benefit all programs operated by the organization are allocated based upon a cost allocation plan (this applies to a portion of the broker's cost of operating the brokerage).

(B) The governmental broker has a procedure related to evaluating each individual beneficiary's specific needs and making a determination related to the most appropriate, lowest cost trip, with a specific focus on the procedure related to governmental providers (i.e., public transit). These determinations are made on a case-by-case basis each month.

(C) For Medicaid beneficiaries, the governmental broker pays the same rate/fare as the general public pays for all fixed route transportation. The cost of the bus pass may not exceed the total cost of all trips a beneficiary would make to Medicaid providers to obtain Medicaid services, were the trips purchased individually. The governmental broker also pays the same rate as the general public for paratransit trips, which is no more than human service agencies pay for the service. The public rates are utilized in determining whether public transit will be the most appropriate low cost service for a specific beneficiary's needs in any given month. In general, public transit trips in the broker's regions are significantly lower in cost than other modes of transportation available.

For additional information see "Description" at ATTACHMENT 3.1-A, 24.a.(b) (9) (how the NEMT brokerage program operates), Page 62___.

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State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

23. d. Nursing facility services provided for patients under 21 years of age

Admission requires prior approval.

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State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

28 b. Licensed or Otherwise State-Approved Freestanding Birthing Center

a. Facilities must:
(i) Be licensed by the Department of Health (DOH) under chapter 246-349 WAC;
(ii) Be specifically approved by DOH to provide birthing center services; and
(iii) Maintain standards of care required by DOH for licensure.

b. Covered practitioners providing services in the freestanding birthing center

(i) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State Plan.

The following practitioners may provide birthing center services and must be licensed in the State of Washington as a:
(a) Physician under chapter 18.57 or 18.71 RCW;
(b) Nurse midwife under chapter 18.79 RCW; or

(ii) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birthing center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60.
(a) Midwife under chapter 18.50 RCW.

(iii) Other health care professionals recognized by the State to provide these birth attendant services.
NA

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State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

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30. Coverage of Routine Patient Cost in Qualifying Clinical Trials

*The state needs to check each assurance below.

Provided: X

II. General Assurances:

Routine Patient Cost – Section 1905(gg)(1)

X Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

Qualifying Clinical Trial – Section 1905(gg)(2)

X A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

Coverage Determination – Section 1905(gg)(3)

X A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

HIV/AIDS CASE MANAGEMENT SERVICES

- Target Group

  Clients who have a current medical diagnosis of HIV or AIDS and who are eligible for Title XIX (Medicaid) coverage under the Categorically Needy Program (CNP) or the Medically Needy Program (MNP).

  The clients require assistance obtaining and effectively using necessary medical, social, and educational services or the client's condition is such the client requires 90 days continued monitoring.

- Areas of State in which services will be provided:

  [X] Entire State.

  [ ] Only in the following geographic areas (authority of section 1915 (g) (1)) of the Act is invoked to provide services less than Statewide:

  - Comparability of Services:

  [ ] Services are provided in accordance with section 1902 (a) (10) (B) of the act.

  [X] Services are not comparable in amount, duration, and scope. Authority of section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of section 1902 (a) (10) (B) of the Act.

  - Definition of Services

MAA requires that HIV/AIDS case management providers perform the following functions:

1. Notify HIV positive persons, verbally or by signing a statement, of their choice of available HIV/AIDS case management providers statewide. This requirement does not obligate HIV/AIDS case management providers to accept all clients who request their services. The case management provider will refer the client to another provider.

2. Obtain and maintain a current Authorization to Release/Obtain Information form. The provider must have a valid authorization on file for the months that case management services are billed to MAA. The provider cannot charge the client for services or documents related to covered services.

3. Maintain sufficient contact to ensure effectiveness of ongoing services. MAA requires a minimum of one contact per month between the HIV/AIDS case manager and the client. However, contact frequency must be sufficient to ensure implementation and ongoing maintenance of the Individual Service Plan (ISP).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

HIV/AIDS CASE MANAGEMENT SERVICES (cont.)

D. Definition of Services (continued)

Case management includes services which will assist clients in: living as independently as possible, maintaining and improving their health, reducing behaviors that put themselves and others at risk, and gaining access to needed medical, social, and educational services.

Description of Services:

Case management functions (core and support) are provided under the direction of a qualified case manager and are detailed below.

Core Functions:

Comprehensive Assessment: A comprehensive assessment is an evaluation to determine client's needs for case management services in several areas. This evaluation includes demographic information, physical status, HIV diagnosis, psychological/social/cognitive functioning and mental health history, ability to perform daily activities, financial and employment status, medical benefits and insurance coverage, informal support systems, legal status, and reportable behaviors which could lead to HIV transmission or reinfection.

Service Plan Development: An individual service plan must be developed in conjunction with the comprehensive assessment to identify and document the client's unmet needs and the resources needed to assist in meeting those needs.

Service Plan Implementation: The case manager is responsible for implementation of the service plan, but may delegate specific functions to others, such as the home health nurse, discharge planners, etc.

Service Plan Review: The case manager must review the service plan monthly through in-person contact or by telephone contact with the client.

Narrative Records: Case managers must keep ongoing records, which clearly document case management services. These records must include the reason for the case manager's interaction with the client and the plans in place or to be developed to meet unmet client needs.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

HIV/AIDS CASE MANAGEMENT SERVICES (cont.)

D. Definition of Services (continued)

Support Functions:

Client Advocacy: Intervene with agencies or persons to help individual clients receive appropriate benefits or services.

Assistance: Assist or arrange for the client to obtain a needed service or accomplish a necessary task.

Consultation: Consult with service providers and professionals to utilize their expertise on the client's behalf.

Networking: Help a client to access services through linkages between formal and informal support systems for the purpose of creating an effective continuum of care.

Family Support: Arrange for appropriate referrals to help the family or significant others to deal with stress and changes related to the client's impairments.

E. Qualifications of Providers:

Provider Qualifications – Individual case managers

An HIV/AIDS case manager shall:

1. Be either a professional or a paraprofessional (HIV/AIDS case manager assistant) under the direct supervision of a professional;

   i. Be employed and enrolled as an HIV/AIDS case manager by a public or private health, social service, or education agency.

   ii. Have demonstrated skills and knowledge necessary to perform his/her job responsibilities at the time of employment or have the potential of achieving the required skills and knowledge through training;

   iii. Have a general knowledge of HIV/AIDS-related conditions and diseases, the AIDSNET service delivery system, and other service delivery systems in his/her community;

   iv. Meet at least the following requirements for education and experience:

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State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

HIV/AIDS CASE MANAGEMENT SERVICES (cont.)

E. Qualifications of Providers (continued)

(a) Master's degree in behavioral or health sciences (e.g., social work, clinical psychology, sociology, guidance counseling, nursing, and public health) and one year of paid social service experience;

(b) Bachelor's degree in behavioral or health sciences and two years of paid social services experience;

(c) Bachelor's degree and three years of paid social services experience.

HIV Client Services, Department of Health may make exceptions to the above requirements when the service population is geographically or culturally isolated, or has limited English speaking ability.

Provider qualification – Case management agencies

An HIV/AIDS case management agency must:

1. Be a public or private social service, health, or education agency employing staff with HIV/AIDS case manager qualifications;

2. Demonstrate linkage and referral ability with social and health service agencies and individual practitioners;

3. Have experience working with persons living with HIV/AIDS;

4. Meet applicable state and federal laws and regulations governing the participation of providers in the Medicaid program;

5. Have caseload size standards that allow HIV/AIDS case management staff to perform the duties established in the Title XIX HIV/AIDS case management standards;

6. Have supervisors who meet the HIV/AIDS case manager qualifications and have:

(a) A master's degree and two years of paid social service experience; or

(b) A bachelor's degree and three years of paid social service experience, including one supervisory year.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

HIV/AIDS CASE MANAGEMENT SERVICES (cont.)

F. Choice of Providers

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902 (a) (23) of the Act. Eligible recipients will have free choice of the providers of:

1. HIV/AIDS case management services; and

2. Other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

CASE MANAGEMENT SERVICES

A. Target Group:

Persons who are Medicaid recipients (clients) and alcohol- or other drug-dependent who need assistance in obtaining necessary medical, social, educational, vocational, and other services.

B. Areas of State in which services will be provided:

[XX] Entire State

C. Comparability of Services:

[XX] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902 (a)(10)(B) of the Act.

D. Definition of Services:

Case management is an ongoing process to assist eligible clients gain access to and effectively use necessary health and related social services.

Description of Services:

Case management will be used to either involve eligible clients in chemical dependency treatment or to support them as they move through stages of chemical dependency treatment within or between separate treatment agencies.

Core Functions:

The core functions of the case manager are to provide or assist in providing:

Identification of Needs

Complete a comprehensive and on-going assessment of the client's needs for medical, social, educational, and other related services. Address the barriers to accessing or utilizing chemical dependency treatment services and other services.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

CASE MANAGEMENT SERVICES (cont.)

D. Definition of services (continued)

Planning
Prepare and implement a written service plan that reflects the client's needs and the resources available to meet those needs in a coordinated, integrated fashion.

Linkage
Facilitate access to needed services through linkages between support systems to avoid duplication of services. These services will augment/reinforce the treatment for chemical dependency.

Advocacy
Intervene with agencies/persons to help clients receive appropriate benefits or services. Also, help the client obtain a needed service or accomplish a necessary task. Be available to help problem-solve when there is a crisis in the client's treatment plan. Advocate for the client's treatment needs with treatment providers.

Accountability
Retain documentation of case management plan and services provided. Submit data as required.

E. Qualifications of Providers:
Case management services will be provided through contracts between the Medicaid agency and chemical dependency treatment agencies certified under Chapter 388-805 WAC in order to ensure that the case managers for these clients are capable of providing the full range of services needed by these targeted clients.

Case management services will be provided by a Substance Abuse counselor who meets the requirements of a certified Chemical Dependency Professional or a Chemical Dependency Professional Trainee as defined in WAC 388-805.

F. The state assures that the provision of case management services will not restrict a client's free choice of providers in violation of Section 1902 (a)(23) of the Act.

1. Eligible clients will have free choice to receive or not receive case management services.

2. Eligible clients will have free choice of the providers of other medical care under the plan.

Payment for case management services under the plan will not duplicate payments made to public agencies or private entities under other program authorities this same purpose.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

1905(a)(29) Medication-Assisted Treatment (MAT)

i. General Assurance

MAT is covered under the Medicaid state plan for all Medicaid beneficiaries who meet the medical necessity criteria for receipt of the service for the period beginning October 1, 2020 and ending September 30, 2025.

ii. Assurances

a. The state assures coverage of naltrexone, buprenorphine, and methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

b. The state assures that methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.

c. The state assures coverage for all formulations of MAT drugs and biologicals for OUD that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262)

iii. Service Package

The state covers the following counseling services and behavioral health therapies as part of MAT

a) Please set forth each service and components of each service (if applicable), along with a description of each service and component service.
From October 1, 2020, through September 30, 2025, the state assures that MAT to treat OUD as defined at section 1905(ee)(1) of the Social Security Act (the Act) is covered exclusively under section 1905(a)(29) of the Act. See chart below.

b) Please include each practitioner and provider entity that furnishes each service and component service.
See chart below

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

1905(a)(29) Medication-Assisted Treatment (MAT) (cont)

b. Service	c. Service Description	d. Providers Able to Render Service
Medication Management		
Screening	Obtain client history, review medications, demographics, determine services client is seeking	ARNP, MD/DO, PA (all may prescribe medication for MAT)
Medication Management	Medical treatment of Substance Use Disorders involving abstinence, medication to address withdrawal symptoms, monitoring client until they are free of toxins.	ARNP, MD/DO, PA (all may prescribe medication for MAT)
Physical health management	Provision of an initial examination, review of past medical history and current medications to determine the appropriateness of medication assisted treatment. The identification, management, and referral to care as indicated for the treatment of medical conditions resulting from the use of MAT or those that might interfere with the success of MAT.	MD/DO, ARNP, PA

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State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

1905(a)(29) Medication-Assisted Treatment (MAT) (cont)

a. Service	a. Service Description	b. Providers Able to Render Service
Opioid Use Treatment		
Assessment	Assessment documents an age-appropriate, strengths-based psychosocial assessment that considers current needs and the patient's relevant history according to best practices.	Behavioral Health Co-occurring Disorder Specialist, SUDP, SUDPT
Cognitive behavioral therapy (CBT)	Helps participant to look at the interactions between thoughts, feelings, behaviors, and physical symptoms, together with the situations within they occur, all affect and interact with each other. This helps the participant to identify what or where it is that they want to change.	Marriage & Family Therapist, Mental Health Counselor, SUDP with CBT training
Counseling	Individual, family, or group therapy designed to provide assistance and guidance in resolving personal, social, or psychological problems and difficulties. Facilitate the achievement and maintenance of maximum functional recovery Family Therapy service that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service."	ARNP, Behavioral Health Co-occurring Disorder Specialist, LPN, Marriage & Family Therapist, Mental Health Counselor, MD/DO, PA, RN, SUDP, SUDPT,

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

1905(a)(29) Medication-Assisted Treatment (MAT) (cont)

a. Service	a. Service Description	b. Providers Able to Render Service
Opioid Use Treatment (cont)		
Motivational interviewing	Person-centered counseling for addressing the common problem of ambivalence about change. MI is done for or with someone, not on or to them. The four key aspects are partnership, acceptance, compassion, and evocation.	Marriage & Family Therapist, Mental Health Counselor, SUDP, SUDPT
Individual Service Plan	Be in terminology that is understandable to the participant. Must be a plan that is mutually agreed upon. Addresses issues identified by the individual or legal representative. Contains measurable goals and objectives and is initiated during the first individual sessions following the assessment with at least one goal identified by the individual. Must be updated to address applicable changes in identified needs and achievement of goals	Marriage & Family Therapist, Mental Health Counselor, SUDP, SUDPT
Peer Services	Provides a wide range of activities to assist an individual in exercising control over their own life and recovery process through: developing self-advocacy and natural supports, maintenance of community living skills, promoting socialization and the practice of peer counselors sharing their own life experiences related to mental and substance use illness to build alliances that enhance the individual's ability to function.	Peer Counselors

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

1905(a)(29) Medication-Assisted Treatment (MAT) (cont)

c) Please include a brief summary of the qualifications for each practitioner or provider entity that the state requires. Include any licensure, certification, registration, education, experience, training, and supervisory arrangements that the state requires.

- *Advanced Registered Nurse Practitioner (ARNP) is licensed and provides services within their scope of practice in accordance with state law. May prescribe medication for MAT.*
- *Behavioral Health Co-occurring Disorder Specialist is licensed and provides services within their scope of practice in accordance with state law*
- *Licensed Practical Nurse (LPN). is licensed and provides services within their scope of practice in accordance with state law*
- *Marriage and Family Therapist is licensed and provides services within their scope of practice in accordance with state law*
- *Mental Health Counselor is licensed and provides services within their scope of practice in accordance with state law*
- *Physician/osteopathic physician (MD/DO): is licensed and provides services within their scope of practice in accordance with state law. May prescribe medication for MAT.*
- *Physician Assistant is licensed and provides services within their scope of practice in accordance with state law. May prescribe medication for MAT.*
- *Registered Nurse (RN) is licensed and provides services within their scope of practice in accordance with state law*
- *Substance Use Disorder Professional (SUDP) is certified and provides services within their scope of practice in accordance with state law*
- *Substance Use Disorder Professional Trainee (SUDPT) is certified and provides services within their scope of practice in accordance with state law, working under the supervision of an SUDP.*
- *Peer Counselor is certified and provides services within their scope of practice in accordance with state law. See Attachment 3.1-B page 38 for requirements.*

Note: Providers prescribing medications for MAT must prescribe according to the authorities granted to them by the DEA and must follow all federal regulations/requirements when dispensing and administering methadone to treat people with opioid use disorder.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

1905(a)(29) Medication-Assisted Treatment (MAT) (cont)

i. Utilization Controls

__X__ The state has drug utilization controls in place. (Check each of the following that apply)

_X_ Generic first policy
_X_ Preferred drug lists
_X_ Clinical criteria
_X_ Quantity limits

_____ The state does not have drug utilization controls in place.

ii. Describe the state's limitations on amount, duration, and scope of MAT drugs, biologicals, and counseling and behavioral therapies related to MAT.

Medications to treat MAT may require prior authorization to determine medical necessity and may be subject to daily dose limits. All non-preferred products require a trial of preferred products with the same indication before a non-preferred drug will be authorized, unless contraindicated or not clinically appropriate. Requests for limitation extensions are considered and reviewed for medical necessity on a case-by-case basis.

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section 1006(b) of the SUPPORT for Patients and Communities Act (P.L. 115-271) enacted on October 24, 2018. Section 1006(b) requires state Medicaid plans to provide coverage of Medication-Assisted Treatment (MAT) for all Medicaid enrollees as a mandatory Medicaid state plan benefit for the period beginning October 1, 2020 and ending September 30, 2025. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 60). Public burden for all of the collection of information requirements under this control number is estimated to take about 80 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

The Standards Established and the Methods Used to Assure High Quality Care

I. The State plan for medical assistance provides that the range of medical services included in the plan is available as determined necessary by qualified physicians and other practitioners. All of the medical services included in the plan are provided without delay attributable to administrative processes required under the plan. Medical services of a high level of quality are made available and this level of quality is affected by administrative procedures or requirements. The decision to provide medical care is always made by a qualified physician or other practitioner. To the greatest extent possible, the physicians and other practitioners take into account the social situation of the individual. Such supervision of professional services rendered as may be required is provided by professional persons in the field.

II. The State program for medical assistance includes reasonable and definite standards for determining that the medical services furnished were necessary and were supplied in an amount and variety consistent with accepted norms of professional practice. The administration of these standards is handled on a continuing basis by the local medical consultants and the local nursing care consultants; these standards are also subject to continuing review at the State office level.

III. To the greatest extent possible the administrative mechanisms required in this plan to insure prompt receipt of medical assistance are kept simple and clearly defined and in the best interests of the recipient. To this end, realistic schedules of compensation for all medical services included in the State plan are maintained and updated within the limits of federal regulations and available appropriations. Routine prior authorizations of medical care and services are kept at a minimum. In order that applicants, recipients, the general public, and the various providers of medical services involved be kept informed as fully as possible regarding the content of the medical care available and the circumstances under which it is provided, an ongoing program of public information, including the use of pamphlets and brochures, is carried out.

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Pages 2 – 15 removed via SPA 13-07 effective April 1, 2013

Superseded TN# 11-04

Pages 16 – 28 removed via SPA 13-20 effective Oct. 1, 2013

Superseded SPA 10-008

Pages 29 – 43 removed via SPA 13-07 effective April 1, 2013

Superseded TN# 09-011

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

METHODS OF ASSURING TRANSPORTATION

Non-emergency medical transportation is provided as an optional medical service in accordance with 42 CFR 440.170(a)(4) in all areas of the State of Washington with the exception of Region 6A (Clallam, Jefferson, Kitsap, and Mason-north counties) which was provided as an administrative activity until 3/31/2011. After 4/1/11 see Attachment 3.1-A, 24(a) Non-governmental entities.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

METHODS OF ASSURING TRANSPORTATION

Non-Emergency Medical Transportation (NEMT) (cont)

The Medicaid agency attests that all the minimum requirements outlined in 1902(a)(87) of the Act are met.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

I. General Coverage Standards:

Transplant services, including inpatient and outpatient pre- and post-operative medical, surgical hospital, and related transportation services are covered for eligible beneficiaries when medically necessary.

A. The following standards apply to all transplant services:

1. The recipient must be enrolled with the state Medicaid program at the time the service is provided.

2. Similarly situated individuals are treated alike.

3. Services must be provided in a Medicare-approved transplant facility that is an enrolled provider with the Medicaid agency. For services provided in-state, the facility must also be approved by Washington's Department of Health Certificate of Need (CoN) program.

4. Transplants must be medically necessary and meet the requirements for physician and hospital services. Payment is rendered only for the transplants listed below, except for the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) population of Medicaid eligible children under the age of 21, for whom services are furnished based on medical necessity.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

B. The following types of transplants and transplant-related procedures are covered, subject to the standards and criteria determined by the Organ Procurement and Transplantation Network (OPTN).

1. Bone Marrow

2. Cornea

3. Heart or combination heart-lung

4. Intestine

5. Kidney

6. Liver or combination liver-kidney

7. Lung single or bilateral

8. Pancreas or combination pancreas- kidney

9. Stem Cell, Autologous and Allogeneic

10. Other transplants determined to be medically necessary and that meet the requirements for physician and hospital services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

II. Out-of-State Coverage Standards

When services are available in-state, reimbursement will not be made to out-of-state transplant centers unless any of the conditions at 42 CFR 431.52(b) are met and all other criteria for a transplant are met. Out-of-state centers will be considered if one of the following criteria exists:

1. The out-of-state hospital is compliant with 42 CFR 482.72 through 482.104..

2. The type of transplant required is not available in-state or the type of transplant (e.g., liver transplant) is available in-state, but the in-state transplant center does not provide that type of transplant for all clients or for all covered diagnoses, (e.g., pediatric transplants)

3. An in-state transplant center requests the out-of-state transplant referral.

4. A contiguous out-of-state transplant center has a contract or special agreement with Washington.

5. It would be cost effective as determined by the agency. For example, if the transplant service is covered by the client's benefit package and the client's primary insurer (e.g., Medicare) requires the use of an out-of-state transplant center.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

III. Donor Services

The agency covers donor expenses incurred directly in connection with a covered transplant. Expenses incurred for complications that arise with respect to the donor are covered only if they are directly and immediately attributed to the surgery.

IV. Limitations on Transplant Services

The agency limits identical organ transplant procedures to only once for the duration of the specific organ's established viability or as determined to be medically necessary. Requests for services in excess of limitations are evaluated for medical necessity on a case-by-case basis.

V. Non-Covered Transplant Services

The following types of transplants are not covered:

1. Transplants not listed in this state plan

2. Transplants that are considered experimental or investigational or which are performed on an experimental or investigational basis.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

State WASHINGTON

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) and/or primary care case managers (PCCMs)) 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 described in 42 CFR 438.50(d).

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place check mark to affirm such compliance.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)-(2) B. Managed Care Delivery System.

The State will contract with the entity(ies) below and reimburse them as noted under each entity type.

1. ☐ MCO
a. ☐ Capitation

2. ☐ PCCM (individual practitioners)
a. ☐ Case management fee
b. ☐ Bonus/incentive payments
c. ☐ Other (please explain below)

3. ☒PCCM (entity based)
   a. ☒ Case management fee
   b. ☐ Bonus/incentive payments
   c. ☐ Other (please explain below)

For states that elect to pay a PCCM a bonus/incentive payment as indicated in B.2.b. or B.3.b, place a check mark to affirm the state has met ***all*** of the following conditions (which are representative of the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

☐a. 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.

State WASHINGTON

Citation	Condition or Requirement

☐b. Incentives will be based upon a fixed period of time.

☐c. Incentives will not be renewed automatically.

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

☐e. Incentives will not be conditioned on intergovernmental transfer agreements.

☐f. Incentives will be based upon specific activities and targets.

CFR 438.50(b)(4) C. Public Process

Describe the public process including tribal consultation, if applicable, 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's PCCM program is provided only through tribal clinics and urban Indian health organizations (FQHCs). The program was implemented in the early 1990s, and, as the program has evolved, the state has collaborated with external stakeholders and tribal governance boards and clinic staff regarding any changes in the program.

The State maintains a website which provides information about Apple Health managed care and PCCM updates and program changes. Users of the website are free to comment or ask questions whenever they wish to.

The State consults with American Indian/Alaska Native tribal (AI/AN) organizations and clinics on all PCCM program changes, including the Department of Social and Health Services' Indian Policy Advisory Committee (IPAC) and the American Indian Health Commission (AIHC).

D. 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. ☐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)

2. ☒The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.

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State WASHINGTON

Citation		Condition or Requirement
42 CFR 438.50(c)(2) 1902(a)(23)(A)		
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3.	☐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 Beneficiaries to receive their benefits through managed care entities will be met.
1932(a)(1)(A) 42 CFR 431.51 1905(a)(4)(C)	4.	☒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)	5.	☒The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i).
1932(a)(1)(A) 42 CFR 438 1903(m)	6.	☒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) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	7.	☐The state assures that all applicable requirements of 42 CFR 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)	8.	☒The state assures that all applicable requirements of 42 CFR 447.362 for 42 payments under any non-risk contracts will be met.
45 CFR 92.36	9.	☐The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

State WASHINGTON

Citation | Condition or Requirement

1932(a)(1)(A) E. Populations and Geographic Area
1932(a)(2)

1. Included Populations Please check which eligibility populations are included, if they are enrolled on a mandatory (M) or voluntary (V) basis, and the geographic scope of enrollment. Under the geography column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions.

Population	M	Geographic Area	V	Geographic Area	Excluded
Section 1931 Children & Related Populations – 1905(a)(i)			X	Benton, Clallam, Douglas, Ferry, Grant, Grays Harbor, Jefferson, King, Kitsap, Klickitat, Lincoln, Okanogan, Pacific, Pierce, Skamania, Snohomish, Spokane, Stevens, Whatcom and Yakima Counties	
Section 1931 Adults & Related Populations1905(a)(ii)			X	Please see above	
Low-Income Adult Group			X	Please see above	
Former Foster Care Children under age 21			X	Please see above	
Former Foster Care Children age 21-25			X	Please see above	
Section 1925 Transitional Medicaid age 21 and older			X	Please see above	
SSI and SSI related Blind Adults, age 18 or older* - 1905(a)(iv)			X	Please see above	
Poverty Level Pregnant Women – 1905(a)(viii)			X	Please see above	
SSI and SSI related Blind Children, generally under age 18 – 1905(a)(iv)			X	Please see above	
SSI and SSI related Disabled children under age 18			X	Please see above	
SSI and SSI related Disabled adults age 18 and older – 1905(a)(v)			X	Please see above	
SSI and SSI Related Aged Populations age 65 or older- 1905(a)(iii)			X	Please see above	
SSI Related Groups Exempt from Mandatory Managed Care under 1932(a)(2)(B)			X	Please see above	

State WASHINGTON

Citation Condition or Requirement

Population	M	Geographic Area	V	Geographic Area	Excluded
Recipients Eligible for Medicare			X	Please see above	
American Indian/Alaskan Natives			X	Please see above	
Children under 19 who are eligible for SSI			X	Please see above	
Children under 19 who are eligible under Section 1902(e)(3)			X	Please see above	
Children under 19 in foster care or other in-home placement			X	Please see above	
Children under 19 receiving services funded under section 501(a)(1)(D) of title V and in accordance with 42 CFR 438.50(d)(v)			X	Please see above	
Other Families or individuals eligible for an Alternative Benefit Plan (ABP) as the result of the federal Affordable Care Act Children enrolled under the Children's Health Insurance Program (CHIP)			X	Please see above.	

2. **Excluded Groups** Within the populations identified above as Mandatory or Voluntary, there may be certain groups of individuals who are excluded from the managed care program. Please indicate if any of the following groups are excluded from participating in the program:

   ☒Other Insurance--Medicaid beneficiaries who have other health insurance.

   ☒Reside in Nursing Facility or ICF/MR--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

   ☒Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program

   ☒Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

   ☐Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

State WASHINGTON

PRIMARY CARE CASE MANAGEMENT (PCCM)

Citation	Condition or Requirement

X Retroactive Eligibility–Medicaid beneficiaries for the period of retroactive eligibility.

☐ Other (Please define):

1932(a)(4) F. Enrollment Process

1. Definitions.

a. Auto Assignment- assignment of a beneficiary to a health plan when the beneficiary has not had an opportunity to select their health plan.

b. Default Assignment- assignment of a beneficiary to a health plan when the beneficiary has had an opportunity to select their health plan.

2. Please describe how the state effectuates the enrollment process. Select an enrollment methodology from the following options and describe the elements listed beneath it:

a. ☒ The applicant is permitted to select a health plan at the time of application.

i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

The PCCM program is voluntary. PCCM clinics available in the beneficiaries' service area are shown on the screen of the state's online eligibility and enrollment system through the Health Benefit Exchange. Most beneficiaries who are eligible for PCCM are already seeing a PCCM provider so select the clinic where they receive services.

ii. What action the state takes if the applicant does not indicate a plan selection on the application.

PCCM is a voluntary program. The state sends eligible beneficiaries a copy of the "Welcome to Apple Health" booklet, which provides information about the Apple Health/Medicaid program and presents the PCCM options available to the beneficiary. If the beneficiary is not otherwise mandatorily enrolled into managed care via a different authority, he or she may choose to enroll in PCCM, an MCO or remain in the fee-for-service system.

iii. If action includes making a default assignment, describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

iv. The state's process for notifying the beneficiary of the default assignment. (Example: *state generated correspondence*.)

State WASHINGTON

PRIMARY CARE CASE MANAGEMENT (PCCM)

Citation		Condition or Requirement

b. ☐ The beneficiary has an active choice period following the eligibility determination.

i. How the beneficiary is notified of their initial choice period, including its duration.

ii. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

iii. Describe the algorithm used for default assignment and describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

iv. The state's process for notifying the beneficiary of the default assignment.

c. ☐ The beneficiary is auto-assigned to a health plan immediately upon being determined eligible.

i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

ii. The state's process for notifying the beneficiary of the auto-assignment. (Example: state generated correspondence.)

iii. Describe the algorithm used for auto-assignment and describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

The state does not auto-enroll to the PCCM program.

1932(a)(4) 3. State assurances on the enrollment process.42 CFR 438.50
Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

a. ☒The state assures it has an enrollment system that allows Beneficiaries 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.

b. ☒The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid Beneficiaries 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).

c. ☒ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs in accordance with 42 CFR 438.52(b). Please list the impacted rural counties

State WASHINGTON

Citation	Condition or Requirement

Impacted Rural Counties are: Clallam, Douglas, Ferry, Grant, Grays Harbor, Jefferson, Kitsap, Klickitat, Lincoln, Okanogan, Pacific, Skamania, Stevens, and Whatcom Counties

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

d. ☒ 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 438.56

G. Disenrollment.

1. The state will☐/will not☒ limit disenrollment for managed care.

2. The disenrollment limitation will apply for twelve months (up to 12 months).

3. ☒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 the state's process for notifying the Medicaid Beneficiaries of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

The state sends eligible beneficiaries a copy of the "Welcome to Apple Health" booklet, which provides information about the Apple Health/Medicaid program and presents the PCCM options available to the beneficiary, including the beneficiary's ability to disenroll without cause. Because PCCM is a voluntary program, enrollees may end their enrollment, or may change from a PCCM provider to an MCO at any time, without cause.

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

H. Information Requirements for Beneficiaries

1932(a)(5)(c)
42 CFR 438.50
42 CFR 438.10

☒The state assures that its state plan program is in compliance with 42 CFR 438.10(e) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments.

1932(a)(5)(D)(b)
1903(m)
1905(t)(3)

I. List all benefits for which the MCO is responsible.

PCCM clinics provide or coordinate all covered services for enrollees and these services are covered through the State's fee-for-service system.

1932(a)(5)(D)(b)(4)
42 CFR 438.228

J. ☐The state assures that each managed care organization has established an internal grievance procedure for enrollees

State WASHINGTON

Citation	Condition or Requirement

1932(a)(5)(D)(b)(5)
42 CFR 438.206
42 CFR 438.207

K. Describe how the state has assured adequate capacity and services.

The state assures adequate capacity and services through the complaints system; we have received no complaints about access to care through any tribal clinic or urban Indian health organizations.

1932(a)(5)(D)(c)(1)(A)
42 CFR 438.240

L. ☐The state assures that a quality assessment and improvement strategy has been developed and implemented.

1932(a)(5)(D)(c)(2)(A)
42 CFR 438.350

M. ☐The state assures that an external independent review conducted by a qualified independent entity will be performed yearly.

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

N. 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☐ 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.)*

All tribal clinics and urban Indian health organizations are eligible to participate in the PCCM program, and may submit a contract request at any time. The tribal entity or urban Indian health organization is required to submit information about their organization and State staff makes a site visit prior to contracting for services. The State's Administrator of Tribal Affairs and Analysis plays an integral role in this process.

AI/ANs have a federal right to exempt themselves from Medicaid managed care, in part because tribal clinics and urban Indian health organizations already have the responsibility to manage the care of their AI/AN clients. In respect of this federal trust responsibility and of the relationship between tribal clinics/urban Indian health organizations and their clients, the State has offered the PCCM program through tribal clinics and urban Indian health organizations since it offered Medicaid managed care to non-AI/ANs. With a nominal monthly payment, the PCCM program supports care coordination by tribal clinics and urban Indian health organizations for clients who are not participating in Medicaid managed care and therefore not receiving care coordination from Medicaid managed care organizations.

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

State WASHINGTON

Citation	Condition or Requirement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0933. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

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APPLE HEALTH MANAGED CARE

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], primary care case managers [PCCMs], and/or PCCM entities) 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 described in 42 CFR 438.50(d).

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date. All applicable assurances should be checked, even when the compliance date is in the future. **Please see Appendix A of this document for compliance dates for various sections of 42 CFR 438.**

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.2
42 CFR 438.6
42 CFR 438.50(b)(1)-(2)

B. Managed Care Delivery System

The state will contract with the entity(ies) below and reimburse them as noted under each entity type.

1. X MCO
   a. X Capitation
   b. __ The state assures that all applicable requirements of 42 CFR 438.6, regarding special contract provisions related to payment, will be met.

2. __ PCCM (individual practitioners)
   a. __ Case management fee
   b. __ Other (please explain below)

3. __ PCCM entity
   a. __ Case management fee
   b. __ Shared savings, incentive payments, and/or financial rewards (see 42 CFR 438.310(c)(2))
   c. __ Other (please explain below)

   If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as in 42 CFR 438.2), in addition to PCCM services:

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APPLE HEALTH MANAGED CARE

Citation	Condition or Requirement

__ Provision of intensive telephonic case management
__ Provision of face-to-face case management
__ Operation of a nurse triage advice line
__ Development of enrollee care plans.
__ Execution of contracts with fee-for-service (FFS) providers in the FFS program
__ Oversight responsibilities for the activities of FFS providers in the FFS program
__ Provision of payments to FFS providers on behalf of the state.
__ Provision of enrollee outreach and education activities.
__ Operation of a customer service call center.
__ Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement.
__ Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.
__ Coordination with behavioral health systems/providers.
__ Coordination with long-term services and supports systems/providers.
__ Other (please describe:

CFR 438.50(b)(4) **C.** Public Process

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

The state uses the following processes, meeting,s and correspondence to invite stakeholder input for 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*
- *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*

APPLE HEALTH MANAGED CARE

Citation	Condition or Requirement
	If the program will include long term services and supports (LTSS), please indicate how the views of stakeholders have been, and will continue to be, solicited and addressed during the design, implementation, and oversight of the program, including plans for a member advisory committee (42 CFR 438.70 and 438.110) *This program does not cover LTSS, but coordinates with the Washington Department of Social and Health Services (DSHS)/Aging and Long Term Support Administration (ALTSA) to ensure provision and coordination of medically necessary health care services and LTSS.*
	D. 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 (including for PCCM entities) 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 beneficiaries to receive their benefits through managed care entities will be met.
1932(a)(1)(A) 42 CFR 431.51 as 1905(a)(4)(C) 42 CFR 438.10(g)(2)(vii)	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 defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A)	5. X The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i).
1932(a)(1)(A) 42 CFR 438 1903(m)	6. X The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs, PCCMs, and PCCM entities will be met.
1932(a)(1)(A) 438.5,	7. X The state assures that all applicable requirements of 42 CFR 438.4, 438.7, 438.8, and 438.74 for payments under any risk contracts will be met.

APPLE HEALTH MANAGED CARE

Citation	Condition or Requirement
42 CFR 438.4 42 CFR 438.5 42 CFR 438.7 42 CFR 438.8 42 CFR 438.74 42 CFR 438.50(c)(6)	
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	8. __ The state assures that all applicable requirements of 42 CFR 447.362 for payments under any non-risk contracts will be met.
45 CFR 75.326	9. X The state assures that all applicable requirements of 45 CFR 75.326 for procurement of contracts will be met.
42 CFR 438.66	10. Assurances regarding state monitoring requirements: X The state assures that all applicable requirements of 42 CFR 438.66(a), (b), and (c), regarding a monitoring system and using data to improve the performance of its managed care program, will be met. X The state assures that all applicable requirements of 42 CFR 438.66(d), regarding readiness assessment, will be met. X The state assures that all applicable requirements of 42 CFR 438.66(e), regarding reporting to CMS about the managed care program, will be met.
1932(a)(1)(A) 1932(a)(2)	**E.** Populations and Geographic Area 1. *Included Populations*. Please check which eligibility groups are included, if they are enrolled on a **Mandatory (M)** or **Voluntary (V)** basis (as defined in 42 CFR 438.54(b)) or **Excluded (E),** and the geographic scope of enrollment. Under the **Geographic Area** column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions. Also, if type of enrollment varies by geographic area (for example, mandatory in some areas and voluntary in other areas), please note specifics in the **Geographic Area** column. Under the **Notes** column, please note any additional relevant details about the population or enrollment. *NOTE: Effective January 1, 2020, the state's Integrated Managed Care program expanded statewide.*

APPLE HEALTH MANAGED CARE

A.2 Mandatory Eligibility Groups (Eligibility Groups to which a state must provide Medicaid coverage).

Effective January 1, 2020: *In Washington's Integrated Managed Care program, the following Eligibility Groups apply statewide:*

1. Family/Adult

Eligibility Group	Citation – (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if MVE varies by area)	Notes
1. Parents and Other Caretaker Relatives	§435.110	X			Statewide	
2. Pregnant Women	§435.116	X			Statewide	
3. Children Under Age 19 (inclusive of deemed newborns under §435.117)	§435.118	X			Statewide	
4. Former Foster Care Youth (up to age 26)	§435.150			X		
5. Adult Group (Non-pregnant individuals age 19 – 64 not eligible for Medicare with income no more than 133% FPL)	§435.119	X			Statewide	
6. Transitional Medical Assistance (Includes adults & children, if not eligible under §435.116, §435.118 or §435.119)	1902(a)(52), 1902(e)(1), 1925, and 1931(c)(2) of SSA	X			Statewide	
7. Extended Medicaid due to Spousal Support Collections	§435.115	X			Statewide	

2. Aged/Blind/Disabled Individuals

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
8. Individuals Receiving SSI age 19 and over only (See E.2. below regarding age <19)	§435.120	X			Statewide	
9. Aged and Disabled Individuals in 209(b) States	§435.121				N/A	
10. Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA Increase since April, 1977	§435.135	X			Statewide	
11. Disabled Widows and Widowers Ineligible for SSI due to an increase of OASDI	§435.137	X			Statewide	
12. Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	§435.138	X			Statewide	
13. Working Disabled under 1619(b)	1619(b), 1902(a)(10)(A)(i)(II), and 1905(q) of SSA	X			Statewide	
14. Disabled Adult Children	1634(c) of SSA	X			Statewide	

APPLE HEALTH MANAGED CARE

B. Optional Eligibility Groups

Effective January 1, 2020: *In Washington's Integrated Managed Care program, the following Eligibility Groups apply statewide:*

1. Family/Adult

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Optional Parents and Other Caretaker Relatives	§435.220				N/A	
2. Optional Targeted Low-Income Children	§435.229	X			Statewide	
3. Independent Foster Care Adolescents Under Age 21	§435.226				NA	
4. Individuals Under Age 65 with Income Over 133%	§435.218				N/A	
5. Optional Reasonable Classifications of Children Under Age 21	§435.222	X			Statewide	
6. Individuals Electing COBRA Continuation Coverage	1902(a)(10)(F) of SSA				N/A	

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APPLE HEALTH MANAGED CARE

2. Aged/Blind/Disabled Individuals

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
7. Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash	§435.210 and §435.230				N/A	
8. Individuals eligible for Cash except for Institutionalized Status	§435.211	X			Statewide	
9. Individuals Receiving Home and Community-Based Waiver Services Under Institutional Rules	§435.217	X			Statewide	
10. Optional State Supplement Recipients 1634 and SSI Criteria States – with 1616 Agreements	§435.232	X			Statewide	
11. Optional State Supplemental Recipients209(b) states and SSI criteria states without 1616 Agreements	§435.234				N/A	
12. Institutionalized Individuals Eligible under a Special Income Level	§435.236	X			Statewide	
13. Individuals Participating in a PACE Program under Institutional Rules	1934 of the SSA			X		Clients in PACE, a voluntary program, are excluded from IMC
14. Individuals Receiving Hospice Care	1902(a)(10)(A)(ii)(VII) and 1905(o) of the SSA	X			Statewide	
15. Poverty Level Aged or Disabled	1902(a)(10)(A)(ii)(X) and 1902(m) of the SSA				N/A	
16. Work Incentive Group	1902(a)(10)(A)(ii)(XIII) of the SSA				N/A	
17. Ticket to Work Basic Group	1902(a)(10)(A)(ii)(XV) of the SSA	X			Statewide	
18. Ticket to Work Medically Improved Group	1902(a)(10)(A)(ii)(XVI) of the SSA	X			Statewide	
19. Family Opportunity Act Children with Disabilities	1902(a)(10)(A)(ii)(XIX) of the SSA				N/A	
20. Individuals Eligible for State Plan Home and Community-Based Services	§435.219	X			Statewide	

APPLE HEALTH MANAGED CARE

3. Partial Benefits

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
21. Family Planning Services	§435.214			X		
22. Individuals with Tuberculosis	§435.215				N/A	
23. Individuals Needing Treatment for Breast or Cervical Cancer (under age 65)	§435.213			X		

C. Medically Needy

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Medically Needy Pregnant Women	§435.301(b)(1)(i) and (iv)			X		
2. Medically Needy Children under Age 18	§435.301(b)(1)(ii)			X		
3. Medically Needy Children Age 18 through 20	§435.308			X		
4. Medically Needy Parents and Other Caretaker Relatives	§435.310				N/A	
5. Medically Needy Aged	§435.320			X		
6. Medically Needy Blind	§435.322			X		
7. Medically Needy Disabled	§435.324			X		
8. Medically Needy Aged, Blind and Disabled in 209(b) States	§435.330				N/A	

2. **Voluntary Only or Excluded Populations**. Under this managed care authority, some populations cannot be subject to mandatory enrollment in an MCO, PCCM, or PCCM entity (per 42 CFR 438.50(d)). Some such populations are Eligibility Groups separate from those listed above in E.1., while others (such as American Indians/Alaskan Natives) can be part of multiple Eligibility Groups identified in E.1. above.

   Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
Medicare Savings Program – Qualified Medicare Beneficiaries, Qualified Disabled Working Individuals, Specified Low Income Medicare Beneficiaries, and/or Qualifying Individuals	1902(a)(10)(E), 1905(p), 1905(s) of the SSA		X		
"Dual Eligibles" not described under Medicare Savings Program - Medicaid beneficiaries enrolled in an eligibility group other than one of the Medicare Savings Program groups who are also eligible for Medicare			X		
American Indian/Alaskan Native— Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes	§438.14	X		Statewide	
Children Receiving SSI who are Under Age 19 - Children under 19 years of age who are eligible for SSI under title XVI	§435.120	X		Statewide	
Qualified Disabled Children Under Age 19 - Certain children under 19 living at home, who are disabled and would be eligible if they were living in a medical institution.	§435.225 1902(e)(3) of the SSA			N/A	

APPLE HEALTH MANAGED CARE

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
Title IV-E Children - Children receiving foster care, adoption assistance, or kinship guardianship assistance under title IV-E *	§435.145		X		
Non-Title IV-E Adoption Assistance Under Age 21*	§435.227		X		
Children with Special Health Care Needs - 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.		X		Statewide	

* = Note – Individuals in these two Eligibility Groups who are age 19 and 20 can have mandatory enrollment in managed care, while those under age 19 cannot have mandatory enrollment. Use the Notes column to indicate if you plan to mandatorily enroll 19 and 20 year olds in these Eligibility Groups.

APPLE HEALTH MANAGED CARE

3. **(Optional) Other Exceptions.** The following populations (which can be part of various Eligibility Groups) can be subject to mandatory enrollment in managed care, but states may elect to make exceptions for these or other individuals. Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

Population	V	E	Notes
Other Insurance--Medicaid beneficiaries who have other health insurance		X	*The exclusion applies only to enrollees receiving premium assistance*
Reside in Nursing Facility or ICF/IID- Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).		X	*Short-term residents of NFs are mandatorily enrolled; long-germ NF residents are exempt. Residents of ICF/IID are exempt.*
Enrolled in Another Managed Care Program-Medicaid beneficiaries who are enrolled in another Medicaid managed care program			
Eligibility Less Than 3 Months-- Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program			
Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).			
Retroactive Eligibility–Medicaid beneficiaries for the period of retroactive eligibility.			
Other (Please define):			

APPLE HEALTH MANAGED CARE

Citation	Condition or Requirement

1932(a)(4)
42 CFR 438.54

F. Enrollment Process

Based on whether mandatory and/or voluntary enrollment are applicable to your program (see E. Populations and Geographic Area and definitions in 42 CFR 438.54(b)), please complete the below:

1. For **voluntary** enrollment: (see 42 CFR 438.54(c))
   a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 54(c)(3).

   Newly eligible beneficiaries receive information about how to access the state's "Welcome to Apple Health" handbook on the Health Care Authority website. The handbook provides general information about Medicaid programs and services and gives information about how to enroll in Apple Health Managed Care if the beneficiary so desires.

   AI/AN individuals are provided with specific information about their ability to remain in fee-for-service for all health care services, as well as their managed care options for MCO managed care or Primary Care Case Management (PCCM – Described in a separate State Plan Amendment).

   If an AI/AN individual chooses to enroll in managed care, they must proactively enroll through the Health Benefit Exchange, ProviderOne portal or by calling the Medical Assistance Customer Service Center (MACSC).

   States with voluntary enrollment must have an enrollment choice period or passive enrollment. Please indicate which will apply to the managed care program:

   Voluntary individuals, other than AI/AN individuals, are passively enrolled into a managed care plan using the same process and plan assignment algorithms as described in Section 2, Mandatory Enrollment. The state notifies all clients of enrollment through an automatically generated letter. This letter provides a link to the Apple Health Client booklet. The Client booklet informs the client of plan options and how to change plans. If the enrollee wishes to disenroll from managed care, the enrollee may contact the Health Care Authority by phone, email, or in writing to request their managed care enrollment end. The enrollee is also provided this information through the Apple Health Model Handbook, provided by the MCO to enrollees.

APPLE HEALTH MANAGED CARE

Citation	Condition or Requirement

b. X If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(c)(1)(i) and 42 CFR 438.54(c)(2)(i), during which individuals who are subject to voluntary enrollment may make an active choice to enroll in the managed care program, or will otherwise continue to receive covered services through the fee-for-service delivery system.

i. Please indicate the length of the enrollment choice period:

Enrollment is continuously open for all managed care programs prospectively for the following month. AI/AN beneficiaries eligible for voluntary enrollment may contact the state's Medical Assistance Customer Service Center (MACSC) to enroll or to end managed care enrollment OR switch to a different MCO at any time. If voluntary enrollees end enrollment, they may re-enroll in managed care at any time prospectively for the following month.
Note: managed care enrollees may change MCOs monthly without cause.

c. ___ If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 38.54(c)(1)(ii) and 54(c)(2)(ii), for individuals who are subject to voluntary enrollment.

i. If so, please describe the algorithm used for passive enrollment and how the algorithm and the state's provision of information meets all of the requirements of 42 CFR 438.54(c)(4),(5),(6),(7), and (8).

Voluntary individuals, other than AI/AN individuals, are passively enrolled into a managed care plan using the same process and plan assignment algorithms as described in Section 2, Mandatory Enrollment. The state notifies all clients of enrollment through an automatically generated letter. This letter provides a link to the Apple Health Client booklet. The Client booklet informs the client of plan options and how to change plans. If the enrollee wishes to disenroll from Managed Care, the enrollee may contact the Health Care Authority by phone, email, or in writing to request their managed care enrollment end. The enrollee is also provided this information through the Apple Health Model Handbook, provided by the MCO to enrollees.

ii. Please indicate how long the enrollee will have to disenroll from the plan and return to the fee-for-service delivery system:

Voluntary enrollees may contact the Health Care Authority and request disenrollment at any time. Disenrollment will be effective the first of the following month.

APPLE HEALTH MANAGED CARE

Citation	Condition or Requirement

2. For **mandatory** enrollment: (see 42 CFR 438.54(d))

a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(d)(3).

Newly eligible beneficiaries are able to select a plan in the state's Health Benefit Exchange at the time they become eligible for Medicaid, and are enrolled the first of the month in which eligibility is determined. If the newly eligible beneficiary does NOT select a plan at the time eligibility is determined, the state assigns them to a plan based on the algorithm described in item c. below.

If a beneficiary wishes to disenroll from the plan to which they are assigned, they may do so calling MACSC, using the ProviderOne portal, or through the state's Health Benefit Exchange (HBE).

SSI blind and disabled adults and children become eligible and renew their eligibility through the Department of Social and Health Services (DSHS) Community Services Offices (CSOs). They receive notification of assignment to a managed care plan from the Health Care Authority (HCA) upon receipt of eligibility information from DSHS by HCA, or may enroll in managed care by contacting MACSC or through the ProviderOne Portal.

Additionally, newly eligible SSI beneficiaries who have been assigned to a managed care plan in which they do not wish to be enrolled may change plans through ProviderOne or by calling MACSC.

All other beneficiaries have the ability to search the HBE for a specific clinic or provider and then determine with which plans that clinic or provider contracts. The HBE also provides information about each of the MCOs available in the potential enrollee's service area by way of providing HEDIS information for each plan, as well as client survey information for each plan. Because most beneficiaries select a plan based on whether their primary care provider (PCP) is contracted, this additional information can help support that decision, or can provide direction for those beneficiaries who do not already have a PCP.

If the beneficiary does not select a plan during the eligibility determination process, the state assigns the beneficiary to a plan and sends the beneficiary notice of the assignment and information about how to access the state's "Welcome to Apple Health" beneficiary handbook for Apple Health Integrated Managed Care on the state's website. Also included are directions on how to change plans if the beneficiary wishes to choose a different plan.

SSI beneficiaries are assigned using the same methodology as all other beneficiaries and receive the same enrollee materials.

Newly eligible beneficiaries receive a notice from HCA that contains a link to the online "Welcome to Apple Health" booklet, which contains basic information about Medicaid, how to enroll in Apple Health Managed Care and other information. This booklet can be requested in paper form from HCA if the beneficiary prefers it in hard copy.

Beneficiaries also receive a handbook from the MCO produced from an HCA-developed template for Apple Health Managed Care as part of the welcome packet.

b. __ If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(d)(2)(i), during which individuals who are subject to mandatory enrollment may make an active choice to select a managed care plan or will otherwise be enrolled in a plan selected by the state's default enrollment process.

i. Please indicate the length of the enrollment choice period:

_____

c. X If applicable, please check here to indicate that the state uses a **default** enrollment process, as described in 42 CFR 438.54(d)(5), for individuals who are subject to mandatory enrollment.

i. If so, please describe the algorithm used for default enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (5), (7), and (8).

The state default assignment algorithm is based on network adequacy, and performance under two HEDIS Clinical Performance measures and one Administrative measure (Initial Health Screen).

In addition, in an effort to ensure a robust network of viable MCOs that, in turn, offer adequate networks of providers within each region, the state may limit default assignments to an MCO once it reaches a level of market share that could adversely affect the ability of other MCOs to meet network adequacy requirements. This cap does not affect:
(i) Voluntary plan choices by clients;
(ii) The Family Connect policy; or
(iii) The Plan Reconnect policy.

In addition, as noted below, clients retain the opportunity to change plans, regardless of the cap.

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Citation	Condition or Requirement

Note: managed care enrollment is continuously open; enrollees may change MCOs monthly without cause

The Family Connect policy is enrolling a family member into the same Apple Health - Integrated Managed Care plan that other family members are enrolled in. Family Connect policy was implemented in order to keep all family members in the same health plan; having family members with different health plans goes against industry standards and results in increased system issues and care coordination concerns.

"Plan Reconnect" means an individual who has regained eligibility for Apple Health - Integrated Managed Care and who was enrolled in an Apple Health contractor (Apple Health Managed Care or Apple Health - Integrated Managed Care) within the six (6) months immediately preceding reenrollment. The Reconnect policy ensures clients are connected with the same health care providers and eliminates confusion being assigned to a different plan. Many clients may lose eligibility, but then are reinstated within 6 months and this allows for a smooth transition.

d. __ If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(d)(2), for individuals who are subject to mandatory enrollment.

   i. If so, please describe the algorithm used for passive enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (6), (7), and (8).

APPLE HEALTH MANAGED CARE

Citation	Condition or Requirement

1932(a)(4) 3. State assurances on the enrollment process.
42 CFR 438.54

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

42 CFR 438.52

a. X The state assures that, per the choice requirements in 42 CFR 438.52:
   i. Medicaid beneficiaries with mandatory enrollment in an MCO will have a choice of at least two MCOs unless the area is considered rural as defined in 42 CFR 438.52(b)(3);
   ii. Medicaid beneficiaries with mandatory enrollment in a primary care case management system will have a choice of at least two primary care case managers employed by or contracted with the state;
   iii. Medicaid beneficiaries with mandatory enrollment in a PCCM entity may be limited to a single PCCM entity and will have a choice of at least two PCCMs employed by or contracted with the PCCM entity.

42 CFR 438.52

b. __ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs in accordance with 42 CFR 438.52(b). Please list the impacted rural counties:

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

42 CFR 438.56(g)

c. 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.

42 CFR 438.71

d. _X_ The state assures that all applicable requirements of 42 CFR 438.71 regarding developing and implementing a beneficiary support system that provides support to beneficiaries both prior to and after MCO, PCCM, or PCCM entity enrollment will be met.

1932(a)(4) **G.** Disenrollment
42 CFR 438.56

1. The state will __/ will not _X_ limit disenrollment for managed care.

2. The disenrollment limitation will apply for _____ (up to 12 months).

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

APPLE HEALTH MANAGED CARE

Citation	Condition or Requirement

4. Describe the state's process for notifying the Medicaid beneficiaries of their right to disenroll without cause during the 90 days following the date of their initial enrollment into the MCO, PCCM, or PCCM entity. *(Examples: state-generated correspondence, enrollment packets, etc.)*

   Beneficiaries are notified of the ability to disenroll from a managed care plan and change enrollment to another plan in online "Welcome to Apple Health" information they receive from the state upon eligibility determination. While enrollment in managed care is mandatory for most populations, the ability to change plans on a monthly basis is also available. Note: the state's "churn rate" for plan changes is less than 3% of total enrollment.

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

   Medicaid beneficiaries may disenroll (change plans) prospectively each month, without cause.

H. Information Requirements for Beneficiaries

1932(a)(5)(c)
42
42 CFR 438.50
42 CFR 438.10

X The state assures that its State Plan program is in compliance with

CFR 438.10 for information requirements specific to MCOs, PCCMs, and PCCM entity programs operated under section 1932(a)(1)(A)(i) State Plan Amendments.

1932(a)(5)(D)(b)
1903(m)
1905(t)(3)

I. List all benefits for which the MCO is responsible

Complete the chart below to indicate every State Plan-approved service that will be delivered by the MCO, and where each of those services is described in the state's Medicaid State Plan. For "other practitioner services", list each provider type separately. For rehabilitative services, habilitative services, EPSDT services and 1915(i), (j) and (k) services list each program separately by its own list of services. Add additional rows as necessary.

NOTE: The state's Managed Care Programs are not responsible for provision of 1915(i), (j) and (k) services, which are provided through separate programs with the Department of Social and Health Services and coordinated for MCO enrollees by the MCO with which the beneficiary is enrolled.

APPLE HEALTH MANAGED CARE

In the first column of the chart below, enter the name of each State Plan-approved service delivered by the MCO. In the second – fourth column of the chart, enter a State Plan citation providing the Attachment number, Page number, and Item number, respectively.

Note: The Services in Section 1 below are provided in all counties of the state.

Section 1 – Apple Health Managed Care

State Plan-Approved Service Delivered by the MCO	**Medicaid State Plan Citation**		
	Attachment #	**Page #**	**Item #**
Physician services including but not limited to: critical care, newborn care, neonatal intensive care, osteopathy, manipulative therapy, physical exams, physical care plan oversight, standby services, physician visits, inpatient services, outpatient services, bio-feedback training psychiatric services, optometry services, oral health exams and services, neurodevelopmental, performing and/or reading diagnostic tests, surgical services including bariatric surgery.	*3.1-A*	*17,18,18b, 9*	*5.a*
Anesthesia	*3.1-A*	*12, 27, 28, 28a*	*3.b, 10.i.E, 10.II.G, 10.III*
Ambulatory surgery center	*3.1-A*	*26*	*9.b*
Applied behavior analysis	*3.1-A*	*21, 21a*	*6.d.(7)*
Hearing aids	*3.1-A*	*33*	*12.c*
Contraceptives	*3.1-A*	*1*	*4.c*
Collabortive Care Model	*3.1-A*	*21b*	*6.d.(8)*
Drugs - prescribed	*3.1-A*	*4,30,31,32,32a, 32b*	*12.a*
Drugs - over the counter	*3.1-A*	*32a, 32b*	*12.a*
Durable medical equipment	*3.1-A*	*23*	*7.c*
Early, elective induction (before 39 weeks)	*4.19-A Part 1*	*12*	*C*
Early, elective induction (before 39 weeks)	*4.19-A Part 1*	*12*	*C*
Enteral and parenteral nutritional supplements and supplies, including prescribed infant formula	*3.1-A*	*23*	*7.c.*
Family planning	*3.1-A*	*1*	*4.c*
Fitting prosthetic & orthotic devices (medical appliances)	*3.1-A*	*23*	*7.c*
Genetic services other than prenatal diagnosis and genetic counseling including testing, counseling, and laboratory services.	*3.1-A*	*60*	*20.d*
Habilitative services – available to children and expansion-eligible adults only	*3.1-L*	*EHB7*	*ABP5*

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Home health	*3.1-A*	*3, 15, 22, 23, 24*	*7, 4.b.5, 7,*
Hospice	*3.1-A*	*7, 59, 59a, 59b*	*18*
Inpatient services	*3.1-A*	*11*	*1*
Laboratory, radiology, imaging	*3.1-A*	*1, 12*	*3*
Medical examinations, including wellness exams for adults & EPSDT for children; adult exams not in Plan	*3.1-A (EPSDT)*	*14*	*4.b*
Medication for Opioid Use Disorder (formerly known as Medication Assisted Treatment (MAT)	*3.1-A*	*18.b*	*5.a (12)*
Nutritional counseling	*3.1-A*	*13.b, 23*	
Nursing facility services	*3.1-A*	*13, 13a – 13d*	*4.a*
Outpatient mental health	*3.1-A*	*18*	*5.a (8)*
Pediatric concurrent care - see EPSDT hospice			
Pediatric palliative care - see EPSDT hospice			
Private duty nursing for children age 17 and younger	*3.1-A*	*3, 25*	
Renal failure treatment	*3.1-A*	*26*	*9.a*
Respiratory care	*3.1-A*	*8, 61*	*22*
Screening, brief intervention, & referral to treatment (SBIRT)	*3.1-A*	*35, 36*	*13.c*
Tobacco cessation counseling services for pregnant women	*3.1-A*	*1, 16.d*	*4.d*
Telemedicine	*4.19-B*	*45*	*XX*
Transplants	*3.1-E*	*1 – 6*	
Therapies – occupational, speech, physical	*3.1-A*	*4, 29*	*11*
Pharmacy – prescriptions	*3.1-A*	*30 – 32b*	*12.a*
Vision care	*3.1-A*	*20*	*6.b*
EPSDT services			
Oral health exams and services	*3.1-A*	*14*	*4.b.1*
Eye exams, refractions, eyeglasses	*3.1-A*	*14*	*4.b.2*
Hearing aids and other hearing devices	*3.1-A*	*15*	*4.b.3*
Outpatient mental health	*3.1-A*	*18*	*5.a (8)*
Outpatient physical therapy, occupational therapy, speech therapy	*3.1-A*	*15*	*4.b.4*
Home health	*3.1-A*	*15*	*4.b.5*
Hospice/palliative care	*3.1-A*	*16*	*4.b.6*
School-based health care	*3.1-A*	*16*	*4.b.7*

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Rehabilitative services			
Behavioral health care coordination and community integration	*3.1-A*	*43*	*13.d.1(b)ix*
Crisis intervention	*3.1-A*	*39*	*13.d.1(b)i*
Crisis stabilization	*3.1-A*	*39, 40*	*13.d.1(b)ii*
Intake evaluation, assessment, and screening for mental health	*3.1-A*	*40*	*13.d.1(b)iii*
Intake evaluation, assessment, and screening for substance use or problem gambling disorder	*3.1-A*	*40, 41*	*13.d.1(b)iv*
Medication for Opioid Use Disorder (formerly Medication Assisted Treatment (MAT)- the medication component of the treatment plan for treating an SUD, including prescribing or administering medication, except for methadone, in the SUD clinic setting	*3.1-A* *Supplement 4 to 3.1-A*	*18.b*	*5.a.(12)*
Medication management	*3.1-A*	*41*	*13.d. 1(b)v*
Medication monitoring	*3.1-A*	*41*	*13.d. 1(b)vi*
Mental health treatment interventions	*3.1-A*	*42*	*13.d.1(b)vii*
Peer support	*3.1-A*	*43*	*13.d. 1(b)viii*
Substance use disorder brief intervention	*3.1-A*	*44*	*13.d.1(b)x*
Substance use or problem gambling disorder treatment interventions	*3.1-A*	*45*	*13.d.1(b)xi*
Substance use disorder withdrawal management	*3.1-A*	*46*	*13.d.1(b)xii*
1915i Community Behavioral Health Support Servicws – Supportive Supervision & Oversight	*3.1-i*	*1, 28, 30, 54*	*1, 1, - 1*

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Other practitioners			
Advanced registered nurse practitioners, includes certified registered nurse anesthetists	*3.1-A*	*20*	*6.d*
Certified chemical dependency professionals & trainees	*3.1-A*	*20*	*6.d*
Chiropractors (for EPSDT only)	*3.1-A*	*20*	*6.d*
Counselors, social workers, others as described	*3.1-A*	*20*	*6.d*
Emergency medical services (EMS) providers	*3.1-A*	*21.c*	*6.d*
Lead behavior analyst therapists, licensed behavior analyst, licensed assistant behavior analysts, licensed certified behavior technicians	*3.1-A*	*21*	*6.d*
Licensed mental health practitioners: advanced social workers, independent clinical social workers, marriage & family therapists, mental health counselors, psychiatric advanced nurse practitioners, psychologists	*3.1-A*	*20*	*6.d*
Licensed non-nurse midwives	*3.1-A*	*20*	*6.d*
Naturopathic physicians (limited to physician-related primary care services)	*3.1-A*	*20*	*6.d*
Opticians	*3.1-A*	*20*	*6.d*
Optometrists	*3.1-A*	*20*	*6.d*
Pharmacists, pharmacy interns, pharmacy technicians	*3.1-A*	*20*	*6.d*
Physician assistants	*3.1-A*	*20*	*6.d*
Podiatrists	*3.1-A*	*20*	*6.d*
Psychologists	*3.1-A*	*20*	*6.d*

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Citation	Condition or Requirement
1932(a)(5)(D)(b)(4) 42 CFR 438.228	**J.** X The state assures that each MCO has established an internal grievance and appeal system for enrollees
1932(a)(5)(D)(b)(5) 42 CFR 438.62 42 CFR 438.68 42 CFR 438.206 42 CFR 438.207 42 CFR 438.208	**K.** Services, including capacity, network adequacy, coordination, and continuity X The state assures that all applicable requirements of 42 CFR 438.62, regarding continued service to enrollees, will be met. X The state assures that all applicable requirements of 42 CFR 438.68, regarding network adequacy standards, will be met. X The state assures that all applicable requirements of 42 CFR 438.206, regarding availability of services, will be met. X The state assures that all applicable requirements of 42 CFR 438.207, regarding assurances of adequate capacity and services, will be met. X The state assures that all applicable requirements of 42 CFR 438.208, regarding coordination and continuity of care, will be met.
1932(c)(1)(A) 42 CFR 438.330 42 CFR 438.340	**L**. X The state assures that all applicable requirements of 42 CFR 438.330 and 438.340, regarding a quality assessment and performance improvement program and state quality strategy, will be met.
1932(c)(2)(A) 42 CFR 438.350 42 CFR 438.354 42 CFR 438.364	**M**. X The state assures that all applicable requirements of 42 CFR 438.350, 438.354, and 438.364 regarding an annual external independent review conducted by a qualified independent entity, will be met.
1932 (a)(1)(A)(ii)	**N**. 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.

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Citation	Condition or Requirement

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's process for adding new Managed Care Organizations (MCOs) for the Apple Health Managed Care program is as follows:

- *The MCO that wishes to participate in Apple Health Managed Care may submit a letter of interest to the state along with all of the following documentation:*
  - *Certificate of registration from the Washington Office of the Insurance Commissioner (OIC) that allows the MCO to provide health care services under a risk-based contract*
  - *Acceptance of the terms and conditions of the Apple Health Managed Care contract*
  - *Proof of network adequacy in the service areas in which the MCO wishes to participate*
  - *Attestation that the MCO meets the quality standards for Apple Health Managed Care that have been established by the state for the currently participating Apple Health Managed Care MCOs*

If the state determines that there is a need for an additional MCO in the proposed service areas, the state conducts an onsite readiness review of the applicant's operations, including:

- *Customer service*
- *Grievance and appeal processes*
- *Subcontracting*
- *Quality and Performance Improvement (QAPI)*
- *Care coordination*

Network adequacy is validated in a separate process, as is financial viability to provide these services.

If the applicant meets the contract standards reviewed at the readiness review, the state issues an Apple Health Managed Care contract.

4. X The selective contracting provision in not applicable to this State Plan.

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Appendix A: Compliance Dates (from Supplementary Information in 81 FR 27497, published 5/6/2016)

States must comply with all provisions in effect as of the issuance of this preprint. Additionally, the following compliance dates apply:

Compliance Dates	Sections
For rating periods for Medicaid managed care contracts beginning before July 1, 2017, states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in 42 CFR parts 430 to 481, edition revised as of October 1, 2015. **States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2017.**	§§ 438.3(h), 438.3(m), 438.3(q) through (u), 438.4(b)(7), 438.4(b)(8), 438.5(b) through (f), 438.6(b)(3), 438.6(c) and (d), 438.7(b), 438.7(c)(1) and (2), 438.8, 438.9, 438.10, 438.14, 438.56(d)(2)(iv), 438.66(a) through (d), 438.70, 438.74, 438.110, 438.208, 438.210, 438.230, 438.242, 438.330, 438.332, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424, 438.602(a), 438.602(c) through (h), 438.604, 438.606, 438.608(a), and 438.608(c) and (d)
For rating periods for Medicaid managed care contracts beginning before July 1, 2018, states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015. **States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2018.**	§§ 438.4(b)(3), 438.4(b)(4), 438.7(c)(3), 438.62, 438.68, 438.71, 438.206, 438.207, 438.602(b), 438.608(b), and 438.818
States must be in compliance with the requirements at § 438.4(b)(9) no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2019.	§ 438.4(b)(9)

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States must be in compliance with the requirements at § 438.66(e) no later than the rating period for Medicaid managed care contracts starting on or after the date of the publication of CMS guidance.	§ 438.66(e)
States must be in compliance with § 438.334 no later than 3 years from the date of a final notice published in the Federal Register.	§ 438.334
Until July 1, 2018, states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42	§§ 438.340, 438.350, 438.354, 438.356, 438.358, 438.360, 438.362, and 438.364
Compliance Dates	**Sections**
CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.	
States must begin conducting the EQR-related activity described in § 438.358(b)(1)(iv) (relating to the mandatory EQR-related activity of validation of network adequacy) **no later than one year from the issuance of the associated EQR protocol.**	§ 438.358(b)(1)(iv)
States may begin conducting the EQR-related activity described in § 438.358(c)(6) (relating to the optional EQR-related activity of plan rating) **no earlier than the issuance of the associated EQR protocol.**	§ 438.358(c)(6)

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1915(i) State Plan Home and Community-Based Services

Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below.

1. **Services.** *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

Community Behavioral Health Support Services – Supportive Supervision and Oversight

2. **Concurrent Operation with Other Programs.** *Completing this section does not authorize the provision of 1915(i) State plan HCBS under these authorities. In order to operate concurrently with another Medicaid authority, the state must receive CMS approval via that Medicaid authority for the concurrent program which is separate and distinct from this 1915(i) authority*. (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*:

***Select one*:**

☐	**Not applicable**
☐	**Applicable**
	Check the applicable authority or authorities:
☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *1915*(i) services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:* *(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);* *(b) the geographic areas served by these plans;* *(c) the specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the 1915(a) contract has been submitted or previously approved.*
	(a) Single Statewide MCO for Foster Care/Adoption Support/Alumni (Voluntary) is Coordinated Care of Washington (b) Geographic areas covered by this plan is Statewide. (c) This plan will provide the 1915i services outlined within this application. (d) Per Member/Per Month capitated arrangement or Service Based Enhancement. (e) Contract amendment to include 1915(i) language not yet submitted. The amendment will have an effective date of 7/1/2024, in alignment with the 1915(i) State Plan HCBS.

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☐	**Waiver(s) authorized under §1915(b) of the Act.**			
	Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:			
	The 1915(b)(1) waiver, WA 00-08.R11.02, will be submitted to CMS by 01/08/2024 for concurrent approval with the 1915(i) State Plan HCBS.			
	Specify the §1915(b) authorities under which this program operates (*check each that applies*):			
	☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
	☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)
☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*			
	(a) Amerigroup (now doing business as Wellpoint), Coordinated Care of Washington, Community Health Plan of Washington, Molina, and United Health Care (b) Geographic areas covered by these plans is Statewide (c) All 5 plans will provide the 1915i services outlined within this application (d) Per Member/Per Month capitated arrangement or Service Based Enhancement In addition to this 1915i HCBS State Plan Amendment (SPA) WA-24-0001, two other SPAs will be submitted by 01/08/2024. SPA WA 24-0002 adds CBBS to the managed care section of the State Plan (3.1-F Part 2) and eligibility SPA WA 24-0003 addresses income disregard language. These SPAs will need to be approved concurrently with this 1915(i) State Plan HCBS SPA WA-24-0001.			
☐	**A program authorized under §1115 of the Act.** *Specify the program*:			

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit.
(Select one):

☐	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	☐	The Medical Assistance Unit *(name of unit)*:	Washington State Health Care Authority (HCA), Medicaid Programs Division (MPD)
	☐	Another division/unit within the SMA that is separate from the Medical Assistance Unit	

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(Name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.

The State plan HCBS benefit is operated by *(name of agency)*
A separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.

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1. Distribution of State plan HCBS Operational and Administrative Functions.

✓ *(By checking this box, the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non- State Entity
1 Individual State plan HCBS enrollment	☐	☐	☐	☐
2 Eligibility evaluation	☐		☐	☐
3 Review of participant service plans	☐	☐	☐	☐
4 Prior authorization of State plan HCBS	☐	☐	☐	☐
5 Utilization management	☐	☐	☐	☐
6 Qualified provider enrollment	☐	☐	☐	☐
7 Execution of Medicaid provider agreement	☐	☐	☐	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☐	☐	☐	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☐	☐	☐	☐
10Quality assurance and quality improvement activities	☐	☐	☐	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

HCA, as the Medicaid State Agency, will maintain accountability, directly perform, and/or otherwise monitor all administrative functions of the State Plan HCBS benefit.

The other State Operating Agency is the Aging and Long-term Support Administration (ALTSA), within the Department of Social and Health Services (DSHS), or their delegated entity, the Area Agencies on Aging (AAA). The contracted entities are Managed Care Organizations (MCOs) contracted with the State Medicaid Agency. Many functions entail a partnership, with HCA maintaining ultimate oversight functions.

Function 3 and 5 – Service Plan Reviews and Utilization Management: Review of service plans will be a partnership, with HCA holding ultimate accountability and oversight from a quality assurance standpoint. For managed care, Utilization Management (UM) will be a function performed by the Managed Care Organizations. For fee for service (FFS), HCA program staff will be performing UM

functions. Oversight activities of Service Plan reviews corresponds to Quality Measure #1 Service Plans, a) address assessed needs of 1915(i) participants; b) are updated annually; and c) document choice of services and providers. Monitoring is on an annual basis or more frequently. For MCO UM, HCA's TEAMonitor and EQRO process does an annual file review and an additional policy/desk review on a three-year cycle. For FFS UM, the HCA program manager will do an annual review.

Function 4 – Prior Authorization: HCA determines eligibility. Once eligibility is determined, HCA approves enrollment into the HCBS program using a system edit indicator for HCBS services. For managed care, authorization will be a function of the MCOs. For FFS, HCA program staff will be accountable for authorization functions. Enrollment and eligibility functions are monitored annually (see #2 under quality measures). HCA system edits will deny/reject any FFS claims or MCO encounters on a monthly basis for HCBS services that do not have the HCBS program indicator indicating eligibility. Prior Authorization processes: for MCOs, the TEAMonitor and EQRO process does an annual review and an additional policy/desk review on a three-year cycle; for FFS, the HCA program manager will do an annual review.

Functions 6 – Qualified Provider Enrollment: For all Medicaid programs, providers are required to successfully complete the provider enrollment process and core provider agreements with HCA. For managed care, providers must also complete the credentialing process with the MCOs and must re-credential every three years. Monitoring: Monthly system edits will deny/reject any FFS provider claims or MCO encounters on a monthly basis from providers who are not properly enrolled with HCA into the ProviderOne system. For both FFS and managed care, ProviderOne enrollment entails a core provider agreement or equivalent and provider identification so that the provider is considered a known Medicaid provider. Credentialing - For MCOs, the TEAMonitor and EQRO process does a file review every three years. Credentialing is also reviewed by NCQA and all the MCOs are NCQA-accredited. For FFS, the HCA program manager will do al review on a 3-year cycle.

Function 10 – Quality Assurance/Improvement: – HCA will maintain oversight, coordination, and accountability for overall quality assurance of the HCBS benefit. However, roles and responsibilities often entail a close partnership between HCA and ALTSA, leveraging many existing pathways that ALTSA already has in place due to their role in delivering Long Term Services and Supports (LTSS). Corresponds to the Quality Improvement Strategy section. Quarterly HCBS committee meetings and annual Quality Review Report will be key to monitoring.

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(By checking the following boxes, the State assures that):

4. ☐ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
   - related by blood or marriage to the individual, or any paid caregiver of the individual
   - financially responsible for the individual
   - empowered to make financial or health-related decisions on behalf of the individual
   - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict-of-interest protections the state will implement):*

5. ☐ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

6. ☐ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

7. ☐ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

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Number Served

1. Projected Number of Unduplicated Individuals to Be Served Annually.
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	7/1/2024	6/30/2025	1200
Year 2			
Year 3			
Year 4			
Year 5			

2. ☐ **Annual Reporting.** *(By checking this box, the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

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Financial Eligibility

1. ☐ **Medicaid Eligible.** *(By checking this box, the state assures that):* Individuals receiving State Plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy** (*Select one*):

☑ The State does not provide State Plan HCBS to the medically needy.
☐ The State provides State Plan HCBS to the medically needy. (*Select one*):
☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services. ☐ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

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Evaluation/Reevaluation of Eligibility

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State Plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State Plan HCBS benefit are performed (*Select one*):

X	Directly by the Medicaid agency
☐	By Other (*specify State agency or entity under contract with the State Medicaid agency*):

2. **Qualifications of Individuals Performing Evaluation/Reevaluation**. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs- based eligibility for State plan HCBS. *(Specify qualifications):*

State Agency staff reviewing eligibility for 1915i services will have at a minimum a bachelor's degree in a health or social service field, with a history of direct services or training in community behavioral health. Staff are trained in the needs-based criteria outlined for this 1915(i) State Plan service and have demonstrated capacity to evaluate documentation to determine whether each referral meets these criteria. Staff will have access to state systems to verify that individuals are Medicaid- eligible and a current Washington resident.

3. Process for Performing Evaluation/Reevaluation. Describe the process for evaluating whether individuals meet the needs-based State Plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The evaluation and reevaluation process for determining the needs-based State Plan HCBS eligibility criteria for the 1915i program will be completed annually, unless a significant change in the participant's condition is determined, which would require an additional reevaluation. The process will utilize a two-step system for eligibility. This process is the same each year.

The functional information gathering will be completed by a Case Manager, completely independent and employed by the State or its delegate the Area Agencies on Aging (AAA), during an assessment that is conducted face-to-face, through telemedicine, or other information technology medium when warranted, using the Comprehensive Assessment Reporting Evaluation (CARE) tool. Individuals provide informed consent for the type of assessment that is conducted. Telemedicine or other technology medium is available for all individuals, and individuals are provided the opportunity for an in-person assessment in lieu of telemedicine or other technology.

The CARE tool includes an indicator that may trigger a referral by the Case Manager based on the identified needs- based criteria for 1915(i) services. If the individual meets the needs-based eligibility criteria under this State Plan and the individual agrees to the referral, the Case Manager will send the assessment and a referral to the MCO for review or directly to HCA for participants not in managed care.

For any assessment completed, the state elects to permit individuals to appoint a representative, who is not a paid caregiver to serve as a representative in connection with the provision of services and supports during the planning process. This includes the use of necessary on-site support staff. When the individual's chosen representative is also paid to provide care to the individual, and an alternate

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non-paid representative is unavailable, the participant's Case Manager may assist the individual during the evaluation process.

The MCO will review the CARE assessment and referral and collect other relevant information to confirm completeness of information. The MCO will provide this information to the State Medicaid Agency, which will make the determination of eligibility for 1915(i) services.

The State Medicaid Agency staff will review the submission for accuracy and completeness and make the determination as to whether the individual meets eligibility criteria. After the individual is found eligible, the MCO will authorize 1915i services to a qualified provider. For re-evaluation, this same process will occur no less than annually. For FFS, this process is the same, except that the State Medicaid Agency clinical program manager staff take the role of the MCO.

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4. X Reevaluation Schedule. *(By checking this box, the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. X **Needs-based HCBS Eligibility Criteria.** *(By checking this box, the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

Needs Based Criteria:
The Individual is assessed to have a need for assistance, demonstrated by the need for:
a) Hands on assistance with at least one Activities of Daily Living (ADLs) defined in WAC 388-106-0210, one of which may be body care and may include one or more of the following:

A. Bathing: Self-Performance is Physical Help/part of bathing and support provided is one personal physical assist
B. Personal Hygiene: Self-Performance is Extensive Assistance, support provided is one-person physical assist
C. Body Care: Self-Performance is Needs or Received/Needs
D. Eating: Self-Performance is Supervision, support provided is one-person physical assist
E. Toileting: Self-Performance is Extensive Assistance, support provided is one-person physical assist
F. Dressing: Self-Performance is Extensive Assistance, support provided is one-person physical assist
G. Transfers: Self-Performance is Extensive Assistance, support provided is one personal physical assist
H. Bed Mobility and Turning and Repositioning: Self- Performance is Limited Assistance, support provided is one-person physical assist

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I. Walk in Room, Locomotion in Room, or Locomotion Outside: Self-Performance is Extensive Assistance: support provided is one-person physical assist
J. Medication Management: Self-Performance is Assistance Required Daily

or

b) supervision with three or more qualifying ADLs

If any of these activities did not occur because the individual was unable or there was no provider available, this counts toward eligibility.

AND also meets Risk Criteria below:

Risk Criteria:

Individual has the following combination of risk factors:

1. Has behavioral or clinical complexity that requires the level of supplementary or specialized services and staffing available only under the Community Behavioral Health Support services benefit, as evidenced by at least one or more of the following within the past year:

    a. Multiple assaultive incidents related to a behavioral health condition during inpatient or long-term care that can only be prevented with a high level of staffing and/or skilled staff intervention.

    b. Self-endangering behaviors related to a behavioral health condition that would result in bodily harm if not prevented with a high level of staffing and/or skilled staff intervention.

    c. Intrusiveness (e.g., rummaging, unawareness of personal boundaries) related to a behavioral health condition that places the individual at risk of assault by others if not prevented with a high level of staffing and/or skilled staff intervention.

    d. Chronic psychiatric symptoms that cause distress to and escalate the individual and/or other residents to crisis if not monitored and redirected by staff. Without intervention, this could result in institutional care within a psychiatric inpatient setting.

    e. Sexual inappropriateness related to a behavioral health condition that requires skilled staff intervention to redirect to maintain safety of the individual and other vulnerable adults.

    f. A history of any of the above behaviors, which are currently only prevented by additional skilled staff intervention.

AND also meets #2 and/or #3 below:

2. History of being unsuccessful in community living settings, as evidenced by at least one or more of the following:

    a. History of multiple failed stays in residential settings within the past 2 years.

    b. In imminent danger of losing a current community living setting due to behaviors related to behavioral health condition(s).

    c. Frequent caregiver turnover due to behaviors related to behavioral health condition(s) within past 2 years.

    d. Without current Community Behavioral Health Support services would be at imminent risk of losing long-term care placement setting.

AND/OR

3. Past psychiatric history, where significant functional improvement has not been effectively maintained due to the lack of Community Behavioral Health Support services and/or supports, as evidenced by at least one or more of the following:

   a. 2 or more inpatient psychiatric hospitalizations in the last 12 months

   b. An inpatient stay in a community hospital (acute or psychiatric) or free-standing evaluation and treatment facility for 30 days or more in the last 12 months, with barriers to discharge related to behavioral health condition(s)

   c. Discharge from a state psychiatric hospital or long term 90/180-day inpatient psychiatric setting in the last 12 months

   d. Without Community Behavioral Health Support services would likely be at imminent risk of requiring inpatient level of care

6. **X** **Needs-based Institutional and Waiver Criteria.** *(By checking this box, the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State Plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State Plan HCBS needs-Based eligibility criteria	**NF (& NF LOC** Waivers)**	**ICF/IID (& ICF/IID LOC waivers)**	**Applicable Hospital* (& Hospital LOC waivers)**
Needs-Based Criteria: The individual is assessed to have a need for assistance, demonstrated by the need for: a) Hands on assistance with at least one Activities of Daily Living (ADLs) defined in WAC 388-106-0210, one 0f which may include one or more of the following: A. Bathing: Self-Performance is Physical Help/part of bathing and Support provided is one Personal physical assist. B. Personal Hygiene: Self-Performance is Extensive assistance, support provided is one person	Individual meets Nursing facility Level of care is Fully specified in WAC 388-106-0355 Nursing Facility Level of Care (NFLOC) is based On the following Factors: 1. one of the following applies: a. Care is required to be provided by or under the supervision of a registered nurse or a licensed practical nurse on a daily basis; or b. The individual has an unmet or	ICF/IID Level of Care as described in Washington Administrative Code (WAC) Chapter 388-828-4400 for adults (16 years of age and older) and Chapter 388-828-3080 for children (birth through 15 years of age). For individuals age birth to fifteen, DDA determines ICF/IID Level of Care score by adding the acuity scores for each question in the IDF/IID Level of Care Assessment for Children. DDA determines you to be eligible for ICF/IID Level of Care when you met at least one of the following: 1. You are age birth through five years old and the total of your acuity scores are five or more; or 2. You are age six through fifteen years old and the total of your acruity scores are seven or more. For ages sixteen or older, DDA	Admission criteria for an inpatient psychiatric stay: Managed Care Organizations follow NCQA standards and utilize nationally recognized level of care utilization management tools to authorize inpatient psychiatric stays. Inpatient psychiatric admission criteria include the need for inpatient treatment because: * The individual is in immenent

<table>
<tr>
<td>Physical assist

C. Body Care: Self-Performance is Needs or Received/Needs

D. Eating: Self-Performance is Supervision, support provided is one-person physical assist

E. Toileting: Self-Performance is Extensive Assistance, support provided is one-person physical assist

F. Dressing: Self-Performance is Extensive Assistance, support provided is one-person physical assist

G. Transfers: Self-Performance is Extensive Assistance, support provided is one personal physical assist

H. Bed Mobility and Turning and Repositioning: Self-Performance is Limited Assistance, support provided is one-person physical assist

I. Walk in Room, Locomotion in Room, or Locomotion Outside: Self-Performance is Extensive Assistance: support provided is one-person physical assist

J. Medication Management: Self-Performance is Assistance Required Daily

or

b) supervision with three or more qualifying ADLs

AND meets Risk Criteria Below:
Risk Criteria:

Individual has the following combination of risk factors:

1. Has behavioral or clinical complexity that requires the level of</td>
<td>Partially met need with at least three of the following activities of daily living. For each ADL a minimum level of assistance is required in self-performance and/or support provided (self-performance and support provided is defined below).

The minimum level of assistance required for each ADL is:
-Eating: Support provided is setup; or
-Toileting and bathing: Self performance is supervision; or
-Transfer, bed mobility, and ambulation: Self performance is supervision and support provided is setup; or
-Medication management: Self performance is assistance required; or
-If the need for assistance in any activities listed in this section did not occur because the individual was unable or no provider was available to assist, that need is counted for the purpose in determining functional eligibility; or
c. The individual has an unmet or partially met need with at least two of the following:</td>
<td>Determines eligibility for ICF/IID level of-care from your SIS scores. Eligibility for ICF/IID level-of-care requires that scores that meet at least one of the following:
(1) A percentile rank over nine percent for three or more of the six subscales in the SIS support needs scale.
(2) A percentile rank over twenty-five percent for two or more of the six subscales in the SIS support needs scale.
(3) A percentile rank over fifty percent in at least one of the six subscales in the SIS support needs scale.
(4) A support score of one or two for any of the questions listed in the SIS exceptional medical support needs scale.
(5) A support score of one or two for at least one of the following items in the SIS exceptional behavior support needs scale:
(a) Prevention of assaults or injuries to others.
(b) Prevention of property destruction (e.g., fire setting, breaking furniture).
(c) Prevention of self-injury.
(d) Prevention of PICA (ingestion of inedible substances).
(e) Prevention of suicide attempts.
(f) Prevention of sexual aggression; or
(g) Prevention of wandering.
(6) A support score of two for any of the questions listed in the SIS exceptional behavior support needs scale; or
(7) Any of the qualifying scores for one or more of the following SIS questions:
<table>
<tr><th>Question # of SIS support needs scale</th><th>Text of question</th><th>Your score for "Type of support" is:</th><th>And your score for "Frequency of support" is:</th></tr>
<tr><td>A2</td><td>Bathing and take care of personal hygiene and grooming needs</td><td>2 or more</td><td>4</td></tr>
<tr><td></td><td></td><td>3 or more</td><td>2</td></tr>
<tr><td>A3</td><td>Using the toilet</td><td>2 or more</td><td>4</td></tr>
<tr><td></td><td></td><td>3 or more</td><td>2</td></tr>
<tr><td>A4</td><td>Dressing</td><td>2 or more</td><td>4</td></tr>
<tr><td></td><td></td><td>3 or more</td><td>2</td></tr>
<tr><td>A5</td><td>Preparing food</td><td>2 or more</td><td>4</td></tr>
<tr><td></td><td></td><td>3 or more</td><td>2</td></tr>
<tr><td>A6</td><td>Eating food</td><td>2 or more
3 or more</td><td>4
2</td></tr>
</table>
</td>
<td>Danger to self or others (as evidenced by imminent risk of additional attempt of suicide/ homicide or to seriously harm self or others, current plan for suicide/homicide or serious harm to self or others, command auditory hallucinations for suicide/homicide or serious harm to self or others, etc.);
The individual is ‘gravely disabled’ in which a person, as a result of a behavioral health disorder is (a) in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety; or the individual has a behavioral health disorder characterized by</td>
</tr>
</table>

supplementary or specialized services and staffing available only under the Community Behavioral Health Support services benefit, as evidenced by at least one or more of the following within the past year:

a. Multiple assaultive incidents related to a behavioral health condition during inpatient or long-term care that can only be prevented with a high level of staffing and/or skilled staff intervention,

b. Self-endangering behaviors related to a behavioral health condition that would result in bodily harm if not prevented with a high level of staffing and/or skilled staff intervention,

c. Intrusiveness (e.g. rummaging, unawareness of personal boundaries) related to a behavioral health condition that places the individual at risk of assault by others if not prevented with a high level of staffing and/or skilled staff intervention,

d. Chronic psychiatric symptoms that cause distress to and escalate the individual and/or other residents to crisis if not monitored and redirected by staff,

activities of daily living:

The minimum level of assistance required for each ADL is:
-Eating: Self performance is supervision and support provided one-person physical assist; or
-Toileting: Self performance is extensive assistance and support provided is one-person physical assist; or
-Bathing: Self performance is limited assistance and support provided is one-person physical assist; or
-Transfer and Mobility: Self performance is extensive assistance and support provided is one person physical assist; or
-Bed Mobility: includes limited assistance in self-performance and the need for turning and repositioning; and support provided is one-person physical assist;
-Medication Management: Assistance required daily in self-performance; or
-If the need for assistance in any activities listed in this section did not occur because the individual was unable or no provider was

A7	Taking care of clothes, including laundering	2 or more	2 or more
		3 or more	1
A8	Housekeeping and cleaning	2 or more	2 or more
		3 or more	1
B6	Shopping and purchasing goods and services	2 or more	2 or more
		3 or more	1
C1	Learning and using problem-solving strategies	2 or more	3 or more
		3 or more	2
C5	Learning self-management strategies	2 or more	3 or more
		3 or more	2
E1	Taking medications	2 or more	4
		3 or more	2
E2	Ambulating and moving about	2 or more	4
		3 or more	2
E3	Avoiding health and safety hazards	2 or more	3 or more
		3 or more	2
E6	Maintaining a nutritious diet	2 or more	2 or more
		3 or more	1
E8	Maintaining emotional well-being	2 or more	3 or more
		3 or more	2
F1	Using appropriate social skills	2 or more	3 or more
		3 or more	2
G7	Managing money and personal finances	2 or more	2 or more
		3 or more	1

- severe psychiatric or behavioral symptoms (including hallucinations or delusions that are very bothersome to the individual or are associated with severe pressure to respond or act, severely disorganized speech, severe mania, depression, anxiety or comorbid substance use disorder, etc.) accompanied by severe dysfunction in daily living (as evidenced by complete neglect of self-care, complete withdrawal from all social interactions, complete inability to maintain any appropriate aspect of personal responsibility in any adult roles, etc.); or

The individual will not participate in treatment voluntarily and requires involuntary commitment, needs physical restraint, seclusion, or other involuntary control, is significantly delirious, or has

e. Sexual inappropriateness related to a behavioral health condition that requires skilled staff intervention to redirect to maintain safety of the individual and other vulnerable adults. f. A history of any of the above behaviors, which are currently only prevented by additional skilled staff intervention AND also meets #2 and/or #3 below: 2. History of being unsuccessful in community living settings, as evidenced by at least one or more of the following: a. History of multiple failed stays in residential settings within the past 2 years b. In imminent danger of losing a current community living setting due to behaviors related to behavioral health condition(s) c. Frequent caregiver turnover due to behaviors related to behavioral health condition(s) within past 2 years d. Without current Community Behavioral Health Support services would be at imminent	available to assist, that need is counted for the purpose in determining functional eligibility; or d. The individual has a cognitive impairment and requires supervision due to one or more of the following: Disorientation, memory impairment, impaired decision making, or wandering and have an unmet or partially met need with at least one or more of the following: The minimum level of assistance required for each ADL is: -Eating: Self performance is supervision and support provided one-person physical assist; or -Toileting: Self performance is extensive assistance and support provided is one-person physical assist; or -Bathing: Self performance is limited assistance and support provided is one-person physical assist; or -Transfer and Mobility: Self performance is extensive assistance and support provided is one-person physical assist; or -Bed Mobility:		a severe behavioral health disorder that requires around-the clock psychiatric care to evaluate, stabilize, and treat the individual.

risk of losing long-term care placement setting AND/OR 3. Past psychiatric history, with no significant functional improvement that can be maintained without Community Behavioral Health Support services and/or supports, as evidenced by at least one or more of the following: a. 2 or more inpatient psychiatric hospitalizations in the last 12 months b. An inpatient stay in a community hospital (acute or psychiatric) or free-standing evaluation and treatment facility for 30 days or more in the last 12 months, with barriers to discharge related to behavioral health condition(s) c. Discharge from a state psychiatric hospital and long term 90/180-day inpatient psychiatric setting in the last 12 months d. Without Community Behavioral Health Support services would likely be at imminent risk of requiring inpatient level of care	includes limited assistance in self-performance and the need for turning and repositioning; and support provided is one-person physical assist; -Medication Management: Assistance required daily in self-performance; or -If the need for assistance in any activities listed in this section did not occur because the individual was unable or no provider was available to assist, that need is counted for the purpose in determining functional eligibility.		

Long Term Care/Chronic Care Hospital **LOC=level of care

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7. **X** **Target Group(s).** The state elects to target this 1915(i) State Plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 180 days prior to the end of this 5-year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.745(a)(2)(vi)(A). (*Specify target group(s)*):

Community Behavioral Health Support Services are available to persons 18 or over, Medicaid, and are eligible for who have a primary diagnosis of one of the following are considered behavioral health diagnoses that "serious mental illness", and/or diagnosis related to traumatic brain injury.

ICD-10 Code	DIAG_DESC
F060	Psychotic disorder w hallucin due to known physiol condition
F062	Psychotic disorder w delusions due to known physiol cond
F0630	Mood disorder due to known physiological condition, unsp
F0631	Mood disorder due to known physiol cond w depressv features
F0632	Mood disord d/t physiol cond w major depressive-like epsd
F0633	Mood disorder due to known physiol cond w manic features
F0634	Mood disorder due to known physiol cond w mixed features
F064	Anxiety disorder due to known physiological condition
F070	Personality change due to known physiological condition
S062X9S	Diffuse Traumatic Brain INJ W/LOC UNS DUR SEQ
F200	Paranoid schizophrenia
F201	Disorganized schizophrenia
F202	Catatonic schizophrenia
F203	Undifferentiated schizophrenia
F205	Residual schizophrenia
F2081	Schizophreniform disorder
F2089	Other schizophrenia
F209	Schizophrenia, unspecified
F21	Schizotypal disorder
F22	Delusional disorders
F23	Brief psychotic disorder
F24	Shared psychotic disorder
F250	Schizoaffective disorder, bipolar type
F251	Schizoaffective disorder, depressive type
F258	Other schizoaffective disorders
F259	Schizoaffective disorder, unspecified
F28	Oth psych disorder not due to a sub or known physiol cond
F29	Unsp psychosis not due to a substance or known physiol cond
F3010	Manic episode without psychotic symptoms, unspecified
F3011	Manic episode without psychotic symptoms, mild
F3012	Manic episode without psychotic symptoms, moderate
F3013	Manic episode, severe, without psychotic symptoms
F302	Manic episode, severe with psychotic symptoms
F303	Manic episode in partial remission
F304	Manic episode in full remission
F308	Other manic episodes
F309	Manic episode, unspecified
F310	Bipolar disorder, current episode hypomanic
F3110	Bipolar disord, crnt episode manic w/o psych features, unsp
F3111	Bipolar disord, crnt episode manic w/o psych features, mild
F3112	Bipolar disord, crnt episode manic w/o psych features, mod
F3113	Bipolar disord, crnt epsd manic w/o psych features, severe
F312	Bipolar disord, crnt episode manic severe w psych features

F3130	**Bipolar disord, crnt epsd depress, mild or mod severt, unsp**
F3131	Bipolar disorder, current episode depressed, mild
F3132	Bipolar disorder, current episode depressed, moderate
F314	Bipolar disord, crnt epsd depress, sev, w/o psych features
F315	Bipolar disord, crnt epsd depress, severe, w psych features
F3160	Bipolar disorder, current episode mixed, unspecified
F3161	Bipolar disorder, current episode mixed, mild
F3162	Bipolar disorder, current episode mixed, moderate
F3163	Bipolar disord, crnt epsd mixed, severe, w/o psych features
F3164	Bipolar disord, crnt episode mixed, severe, w psych features
F3170	Bipolar disord, currently in remis, most recent episode unsp
F3171	Bipolar disord, in partial remis, most recent epsd hypomanic
F3172	Bipolar disord, in full remis, most recent episode hypomanic
F3173	Bipolar disord, in partial remis, most recent episode manic
F3174	Bipolar disorder, in full remis, most recent episode manic
F3175	Bipolar disord, in partial remis, most recent epsd depress
F3176	Bipolar disorder, in full remis, most recent episode depress
F3177	Bipolar disord, in partial remis, most recent episode mixed
F3178	Bipolar disorder, in full remis, most recent episode mixed
F3181	Bipolar II disorder
F3189	Other bipolar disorder
F319	Bipolar disorder, unspecified
F320	Major depressive disorder, single episode, mild
F321	Major depressive disorder, single episode, moderate
F322	Major depressv disord, single epsd, sev w/o psych features
F323	Major depressv disord, single epsd, severe w psych features
F324	Major depressv disorder, single episode, in partial remis
F325	Major depressive disorder, single episode, in full remission
F328	Other depressive episodes
F3281	Premenstrual dysphoric disorder
F3289	Other specified depressive episodes
F329	Major depressive disorder, single episode, unspecified
F32A	Depression, unspecified
F330	Major depressive disorder, recurrent, mild
F331	Major depressive disorder, recurrent, moderate
F332	Major depressv disorder, recurrent severe w/o psych features
F333	Major depressv disorder, recurrent, severe w psych symptoms
F3340	Major depressive disorder, recurrent, in remission, unsp
F3341	Major depressive disorder, recurrent, in partial remission
F3342	Major depressive disorder, recurrent, in full remission
F338	Other recurrent depressive disorders
F339	Major depressive disorder, recurrent, unspecified
F340	Cyclothymic disorder
F341	Dysthymic disorder
F348	Other persistent mood [affective] disorders
F3481	Disruptive mood dysregulation disorder
F3489	Other specified persistent mood disorders
F349	Persistent mood [affective] disorder, unspecified
F39	Unspecified mood [affective] disorder
F4000	Agoraphobia, unspecified
F4001	Agoraphobia with panic disorder
F4002	Agoraphobia without panic disorder
F4010	Social phobia, unspecified
F4011	Social phobia, generalized
F40240	Claustrophobia
F408	Other phobic anxiety disorders

F410	**Panic disorder [episodic paroxysmal anxiety]**
F411	Generalized anxiety disorder
F42	Obsessive-compulsive disorder
F422	Mixed obsessional thoughts and acts
F423	Hoarding disorder
F424	Excoriation (skin-picking) disorder
F428	Other obsessive-compulsive disorder
F429	Obsessive-compulsive disorder, unspecified
F4310	Post-traumatic stress disorder, unspecified
F4311	Post-traumatic stress disorder, acute
F4312	Post-traumatic stress disorder, chronic
F440	Dissociative amnesia
F441	Dissociative fugue
F442	Dissociative stupor
F444	Conversion disorder with motor symptom or deficit
F445	Conversion disorder with seizures or convulsions
F446	Conversion disorder with sensory symptom or deficit
F447	Conversion disorder with mixed symptom presentation
F4481	Dissociative identity disorder
F4489	Other dissociative and conversion disorders
F449	Dissociative and conversion disorder, unspecified
F450	Somatization disorder
F451	Undifferentiated somatoform disorder
F4520	Hypochondriacal disorder, unspecified
F4521	Hypochondriasis
F4522	Body dysmorphic disorder
F4529	Other hypochondriacal disorders
F4541	Pain disorder exclusively related to psychological factors
F4542	Pain disorder with related psychological factors
F458	Other somatoform disorders
F459	Somatoform disorder, unspecified
F481	Depersonalization-derealization syndrome
F489	Nonpsychotic mental disorder, unspecified
F603	Borderline personality disorder
F633	Trichotillomania
F6381	Intermittent explosive disorder
F6389	Other impulse disorders
F639	Impulse disorder, unspecified
F6810	Factitious disorder imposed on self, unspecified
F6811	Factit disord imposed on self, with predom psych signs/symp
F6812	Factit disord impsd on self, with predom physcl signs/symp
F6813	Factit disord impsd on self,w comb psych & physcl signs/symp
F688	Other specified disorders of adult personality and behavior
F910	Conduct disorder confined to family context
F911	Conduct disorder, childhood-onset type
F912	Conduct disorder, adolescent-onset type
F918	Other conduct disorders
F919	Conduct disorder, unspecified
F930	Separation anxiety disorder of childhood
F938	Other childhood emotional disorders
F939	Childhood emotional disorder, unspecified
F940	Selective mutism
F941	Reactive attachment disorder of childhood
F942	Disinhibited attachment disorder of childhood
F948	Other childhood disorders of social functioning
F949	Childhood disorder of social functioning, unspecified

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State Plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase- in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

(By checking the following box, the State assures that):

1. **X Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

2. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State Plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State Plan HCBS:

i.	**Minimum number of services**. The minimum number of 1915(i) State Plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is: 1	
ii.	**Frequency of services**. The state requires (select one):	
	X	**The provision of 1915(i) services at least monthly**
	☐	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

(By checking the following box, the State assures that):

1. ☐ **Home and Community-Based Settings.** The State Plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.*

DESCRIPTION OF RESIDENTIAL SETTINGS:

Services will be provided in a home or community-based setting, which does not include a nursing facility, hospital providing long-term care services, institution for mental diseases, or an intermediate care facility for intellectually disabled. Settings include the participant's home and the following settings have been determined to meet the HCBS setting requirements established in 42 CFR 441.710 (a).

Settings include:

a) Private homes
b) Licensed Assisted Living Facilities (ALF) that hold an:
   i. Assisted Living contract
   ii. Adult Residential Care contract
   iii. Enhanced Adult Residential Care contract
c) Adult Family Homes (AFH)
d) Enhances Services Facilities (ESF)

Services may also be provided when participants are accessing community resources or in their place of employment.

Ongoing evaluation of all settings for HCBS characteristics

The state evaluates settings for HCBS characteristics during the monitoring process completed by ALTSA's Residential Care Services (RCS) Division. During this process, sites or homes receive an on-site review, interviews are completed with participants, staff, and administrators as appropriate to the setting, and a visual review of the home or facility, and participant record reviews are completed.

This information is entered into a database which creates a report that is used to track and trend issues that arise regarding these, and all, participant rights. This information is used by the RCS Management Team, HCS Management Team, and the HCA/ALTSA waiver management committee to address systemic issues through Quality Improvement projects. When systemic issues are identified, the state will develop and implement an improvement plan to address systemic issues, including training of providers, revision of laws and rules, and strengthening of licensing requirements.

Remediation

For individual settings that fail to meet any of the HCBS requirements, outcomes of the licensing/certification processes include citations and/or enforcement actions taken on non-compliant providers (such as plans of correction, shortened timelines for certification, fines, and certification/license revocation). If a setting that provides 1915(i) services receives a corrective action plan (CAP) related to 1915(i) services, that issue will be remediated as identified in the approved CAP.

If a provider is unable or unwilling to come into compliance with the HCBS rules (or other rules and regulations that pose a health or safety risk to residents), RCS revokes the license of the facility. HCS then follows a person-centered approach to assist participants to relocate to a facility of the participant's choice.

Person-Centered Planning & Service Delivery

(By checking the following boxes, the state assures that):

1. **X** There is an independent assessment of individuals determined to be eligible for the State Plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. **X** Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State Plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. **X** The person-centered service plan is reviewed and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. **X** Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications*

The assessment will be completed by ALTSA, the operating agency of the HCBS programs, face-to-face, through telemedicine, or other information technology medium when warranted.

Registered Nurse (RN): licensed under Chapter 18.79 RCW

Case Manager:

In addition to meeting the following minimum qualifications, staff must pass a background check prior to being hired and receive mandatory training prior to completing any evaluations/service plans.

Service plans are developed by case managers who can be a registered nurse licensed in the state, or a social service specialist. For social service specialists, minimum qualifications are as follows:

- A master's degree in social services, human services, behavioral sciences, or an allied field and two years of paid social service experience performing functions equivalent to a social service specialist 2;

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OR

- A bachelor's degree in social services, human services, behavioral sciences, or an allied field and three years of paid social service experience performing functions equivalent to a social service specialist 2;

Note: A two-year master's degree in one of the above fields that included a practicum will be substituted for one year of paid social service.

Note: Employees must successfully complete the formal training course sponsored by their division within one year of their employment.

Note: Equivalent social service experience includes the previous classes of caseworker 3 or higher; OR

A bachelor's degree and three years of experience as a caseworker 3, social worker 1A or B, social worker 2, casework supervisor trainee, casework supervisor, juvenile rehabilitation supervisor 1 or juvenile rehabilitation counselor 2 in state service.

5. **Responsibility for Development of Person-Centered Service Plan**. There are qualifications (that are reasonably related to developing service plans) for participants responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

Development of the person-centered service plan will be done by ALTSA, the operating agency of HCBS programs:

Registered Nurse (RN): licensed under Chapter 18.79 RCW

Case Manager:

In addition to meeting the following minimum qualifications, staff must pass a background check prior to being hired and receive mandatory training prior to completing any evaluations/service plans.

Service plans are developed by case managers who can be a Registered Nurse, licensed in the state, or a social service specialist. For social service specialists, minimum qualifications are as follows:

A master's degree in social services, human services, behavioral sciences, or an allied field and two years of paid social service experience performing functions equivalent to a social service specialist 2;

OR

A bachelor's degree in social services, human services, behavioral sciences, or an allied field and three years of paid social service experience performing functions equivalent to a social service specialist 2;

Note: A two-year master's degree in one of the above fields that included a practicum will be substituted for one year of paid social service.

Note: Employees must successfully complete the formal training course sponsored by their division within one year of their employment.

Note: Equivalent social service experience includes the previous classes of caseworker 3 or higher;

OR

A bachelor's degree and three years of experience as a caseworker 3, social worker 1A or B, social worker 2, casework supervisor trainee, casework supervisor, juvenile rehabilitation supervisor 1 or juvenile rehabilitation counselor 2 in state service.

6. **Supporting the Participant in Development of Person-Centered Service Plan**. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(specify: (a) the*

supports and information made available, and (b) the participant's authority to determine who is included in the process):

(a) Prior to enrollment, the state provides participants an assessment, information about services and supports, including HCBS settings requirements, and assistance needed to make an informed choice about the program. Upon enrollment, appropriate information and assistance is provided by either the case manager or others selected by the individual to ensure that the individual or individual's representative is able to understand, manage, and select their service provider and supports. Information is communicated to the participant in a manner and language understandable by the participant, including needed auxiliary aids and/or translation services.

(b) In the development of the person-centered service plan, participants choose who to include in the process.

7. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

The person-centered planning process includes a review of all available qualified providers. Information and assistance are provided to ensure that the individual, or individual's representative, is able to understand and select their service provider. Information is communicated to the participant in a manner and language understandable by the participant, including needed auxiliary aids and/or translation services.

Participants select a provider from available contracted providers.

8. **Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency.** *(Describe the process by which the person-centered service plan is made subject to approval of the Medicaid agency):*The person-centered service plan is developed using the CARE assessment application, with information entered in CARE by the participant and Case Manager during the assessment process.

When the assessment indicates the individual may meet the needs-based eligibility criteria and would benefit from services under this State Plan, the Case Manager will provide information and options to the participant. With agreement from the individual, the assessment, care plan recommendation, and referral will be sent to the MCO, or directly to HCA for participants in the FFS program. The MCO will review the documentation for completeness and forward information on to the Medicaid agency.

The Medicaid agency will review the submission for accuracy and completeness and determine if the participant meets the eligibility criteria. The eligibility determination is then communicated back to the Case Manager to finalize the person-centered service plan , including ensuring the plan meets all requirements of 42 CFR 441.725. The Medicaid Agency maintains oversight of person-centered care plans, in partnership with the Operating agency as described in #5 of the Quality Measures below.

The review process of the person-centered service plans is outlined under 1.a-c of the Quality Improvement Strategy section of the application. ALTSA/Home and Community Services Division (HCS) Quality Assurance Unit, with HCA oversight, will conduct annual record reviews using a representative sample using a 95% confidence interval with a 5% margin of error. Review methodology will look at the following: a) does the service plan address assessed needs of 1915(i) participants; b) are the service plans updated annually; and c) does the service plan document.

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choice of services and providers. Results will be jointly reviewed by ALTSA/HCS Division and HCA to identify areas of deficiency and to inform quality improvement strategies. Non- compliance will be determined by the performance measure falling below 86%. HCA and ALTSA/HCS Division are leveraging an already existing joint committee called the "Waiver Management Committee" to meet on a quarterly basis and ensure coordination is cohesive and aligned.

9. **Maintenance of Participant-Centered Service Plan Forms**. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

☐	Medicaid agency	☐	Operating agency	☐	Case manager
X	Other (*specify):*	Partnering state agency DSHS/ALTSA			

Services

1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Community Behavioral Health Support Services - Supportive supervision and oversight
Service Definition (Scope)*:*	
Community Behavioral Health Support Services: Individually tailored services designed to assist participants in restoring or acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Community Behavioral Health Support Services may include supportive supervision/oversight, which is described as follows: Supportive supervision and oversight is in-person monitoring, redirection, diversion, and cueing of the participant to prevent at-risk behavior that may result in harm to the participant or to others. These interventions are not related to the provision of personal care. Provides individuals with assistance to build skills and resiliency to support stabilized living and community integration. These interventions are coordinated as appropriate with other support services, to include behavioral health services provided by a behavioral health agency and/or behavior support services or other community supports as appropriate. Supportive supervision should include integration of behavior support and/or crisis plans to help ensure community stability and an escalation process for collaborative care, including following CFR 441.710(a)(vi)(F)(1) through (8) when necessary.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	

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Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration, and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard State Plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
	N/A
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Adult Family Home (AFH)	Licensed under Chapter 388-76 WAC		
Adult Residential Care (ARC) Facility	Assisted Living Facilities with a contract to provide ARC services and are licensed under Chapter 18.20 RCW and Chapter 388-78A WAC		
Enhanced Adult Residential Care (EARC) Facility	Assisted Living Facilities with a contract to provide EARC services and are licensed under Chapter 18.20 RCW and Chapter 388-78A WAC		
Enhanced Services Facilities	Licensed under Chapter 70.97 RCW and Chapter 388-107 WAC		
Assisted Living Facility	Licensed under Chapter 18.20 RCW and Chapters 388-78A and 388-110 WAC		

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Adult Family Home	Managed Care Organization/HCA	Every three years

Enhanced Adult Residential Care facility	MCO/HCA	Every three years
Assisted Living Facility	MCO/HCA	Every three years
Enhanced Services Facilities	MCO/HCA	Every three years

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	**X**	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	

Service Definition (Scope)*:*

1.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.
(Choose each that applies):

☐	Categorically needy *(specify limits):*
	N/A
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*

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Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	**X**	Provider managed

2. ☐ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box, the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State Plan HCBS, who are relatives of the individual. There are additional policies and controls if the State makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS.

(Specify (a) who may be paid to provide State Plan HCBS; (b) the specific State Plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. **Election of Participant-Direction**. (S*elect one):*

X	The state does not offer opportunity for participant-direction of State Plan HCBS.
☐	Every participant in State Plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
☐	Participants in State Plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

2. **Description of Participant-Direction. (Provide an overview of the opportunities for participant-***direction under the State Plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

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3. Limited Implementation of Participant-Direction. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to state wideness requirements. Select one):*

☐	Participant direction is available in all geographic areas in which State plan HCBS are available.
☐	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State Plan HCBS are available. (*Specify the areas of the state affected by this option)*:

4. Participant-Directed Services. *(Indicate the State Plan HCBS that may be participant-directed, and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

5. Financial Management. (*Select one):*

☐	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
☐	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State Plan.

6.☐☐ Participant–Directed Person-Centered Service Plan. *(By checking this box, the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State Plan HCBS that the individual will be responsible for directing.
- Identifies the methods by which the individual will plan, direct or control services, including
- whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget.
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual.
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

7. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

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8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can select, manage, and dismiss State Plan HCBS providers). (*Select one):*

○	The state does not offer opportunity for Participant-Employer Authority.	
☐	Participants may elect Participant-Employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

○	The state does not offer opportunity for participants to direct a budget.
☐	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

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Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. **Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.**

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement	***1a. Service Plans address assessed needs of 1915(i) participants***
Discovery	
Discovery Evidence *(Performance Measure)*	The number and percent of service plans for 1915(i) participants that address all assessed needs by the provision of state plan services or by other means. ***N****=Number of participant service plans that address all assessed needs by the provision of state plan services or by other means* ***D****=Number of participant service plans reviewed*
Discovery Activity *(Source of Data & sample size)*	**Source:** Records review conducted off site **Sample size:** A representative sample using a 95% confidence interval with a 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	ALTSA/HCS
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(1) ALTSA/HCS, with HCA oversight, will conduct periodic reviews of performance measures to determine compliance with applicable Washington State rules and the quality improvement strategy. (2) Reviews will be conducted through an off-site records review process and data analysis. (3) Data and reports related to this performance measure will be jointly reviewed by ALTSA/HCS and HCA to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Non-compliance will be determined by the performance measure falling below 86%. Remediation activities may include targeted training and revision of administrative processes and procedures. This is in addition to individual remediation strategies.
Frequency *(Of Analysis and Aggregation)*	Annually

Requirement	*1b. Service Plans are updated annually*
Discovery	
Discovery Evidence *(Performance Measure)*	The number and percent of service plans reviewed and updated prior to annual review date. ***N*** *= Number of service plans reviewed and updated prior to annual review date* ***D*** *= Number of service plans reviewed*
Discovery Activity *(Source of Data & sample size)*	**Source:** Records review conducted off site **Sample size**: A representative sample using a 95% confidence interval with a 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	ALTSA/HCS
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(1) ALTSA/HCS with HCA oversight, will conduct periodic reviews of performance measures to determine compliance with applicable Washington State rules and the quality improvement strategy. (2) Reviews will be conducted through an off-site records review process and data analysis. (3) Data and reports related to this performance measure will be jointly reviewed by ALTSA/HCS and HCA to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Non-compliance will be determined by the performance measure falling below 86%. Remediation activities may include targeted training and revision of administrative processes and procedures.
Frequency *(Of Analysis and Aggregation)*	Annually

Requirement	*1c. Service Plans document choice of services and providers*
Discovery	
Discovery Evidence *(Performance Measure)*	The number and percent of participants who were provided an informed choice of services and providers by the Case Manager. ***N*** *= Number of participants with documentation that the Case Manager informed them of their choices related to state plan services and provider types* ***D*** *= Number of participants reviewed*
Discovery Activity *(Source of Data & sample size)*	**Source:** Records review conducted off site **Sample Size:** A representative sample using a 95% confidence interval with a 5% margin of error

	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	ALTSA/HCS
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(1) ALTSA/HCS, with HCA oversight, will conduct periodic reviews of performance measures to determine compliance with applicable Washington State rules and the quality improvement strategy. (2) Reviews will be conducted through an off-site records review process and data analysis. (3) Data and reports related to this performance measure will be jointly reviewed by ALTSA/HCS and HCA to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Non-compliance will be determined by the performance measure falling below 86%. Remediation activities may include targeted training and revision of administrative processes and procedures. This is in addition to individual remediation strategies.
	Frequency *(Of Analysis and Aggregation)*	Annually

2. Eligibility Requirements: (a) an evaluation for 1915(i) State Plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved State Plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved State Plan for 1915(i) HCBS.

Requirement	***2a. An evaluation for 1915(i) State Plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of applicants that received an evaluation for 1915(i) services. ***N**=Number of 1915(i) HCBS assessments completed.* ***D**=Total number of referrals received.*
Discovery Activity *(Source of Data & sample size)*	**Source:** Records review conducted off site **Sample Size:** A representative sample using a 95% confidence interval with a 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	HCA

	Frequency	Annually, with additional analysis as needed
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(1) HCA will conduct periodic reviews of performance measures to determine compliance with applicable Washington State rules and the quality improvement strategy. (2) Reviews will be conducted through an off-site records review process and data analysis. (3) Data and reports related to this performance measure will be reviewed by HCA to identify areas of deficiency, required improvement, and to assure completion of remediation efforts. Non-compliance will be determined by the performance measure falling below 86%. Remediation activities may include targeted training and revision of administrative processes and procedures. This is in addition to individual remediation strategies.
	Frequency *(Of Analysis and Aggregation)*	Annually, with additional analysis as needed
Requirement		***2b. The processes and instruments described in the approved State Plan for determining 1915(i) eligibility are applied appropriately.***
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of participants whose eligibility was determined using the appropriate processes and instruments. ***N*** *= All participants reviewed who were found eligible, using the appropriate processes and instruments* ***D*** *= All participants records reviewed who had an eligibility determination*
	Discovery Activity *(Source of Data & sample size)*	**Source:** Records review conducted off site **Sample Size:** A representative sample using a 95% confidence interval with a 5% margin of error
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The Health Care Authority (HCA) in partnership with the Managed Care Organizations MCOs)
	Frequency	Annually, with additional analysis as needed
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(1) HCA in partnership with the MCOs will conduct periodic reviews of performance measures to determine compliance with applicable Washington State rules and the quality improvement strategy. Contract requirements with the MCOs will also be considered. (2) Reviews will be conducted through an off-site records review process and data analysis. (3) Data and reports related to this performance measure will be jointly reviewed by HCA to identify areas of deficiency, required improvement and to assure

		completion of remediation efforts. Non-compliance will be determined by the performance measure falling below 86%. Remediation activities may include targeted training and revision of administrative processes and procedures. Remediation activities may also include HCA's revision of contract requirements with the MCOs, as well as corrective action for not adhering to contract requirements or expectations. This is in addition to individual remediation strategies.
	Frequency *(Of Analysis and Aggregation)*	Annually, with additional analysis as needed

Requirement		***2c. The 1915(i)-benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.***
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of individuals re-evaluated for 1915(i) eligibility annually. ***N:*** *Number and percent of updated ongoing referrals, documenting an annual re-evaluation of eligibility.* ***D:*** *Number of Care re-assessments due for re-evaluation.*
	Discovery Activity *(Source of Data & sample size)*	**Source:** Records review conducted off site **Sample size:** A representative sample using a 95% confidence interval with a 5% margin of error
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	ALTSA/HCS
	Frequency	Annually, with additional analysis as needed
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(1) ALTSA/HCS, with HCA oversight, will conduct periodic reviews of performance measures to determine compliance with applicable Washington State rules and the quality improvement strategy. (2) Reviews will be conducted through an off-site records review process and data analysis. (3) Data and reports related to this performance measure will be jointly reviewed by ALTSA/HCS and HCA to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Non-compliance will be determined by the performance measure falling below 86%. Remediation activities may include targeted training and revision of administrative processes and procedures. This is in addition to individual remediation strategies.
	Frequency *(Of Analysis and Aggregation)*	Annually

3. Providers meet required qualifications.

Requirement	*3. Providers meet required qualifications.*
Discovery	
Discovery Evidence *(Performance Measure)*	The number and percent of service providers who require licensure &/or certification that meet contract standards at time of initial contract or renewal. ***N*** *= All contracted providers reviewed that require licensure &/or certification that meet contract standards.* ***D*** *= All contracted providers reviewed that require licensure &/or certification*
Discovery Activity *(Source of Data & sample size)*	**Source:** Records review off site of reports from MCOs (for managed care participants) and report from HCA's provider enrollment system (for FFS participants) **Sample Size:** A representative sample using a 95% confidence interval with a 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	HCA
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(1) HCA will conduct periodic reviews of performance measures to determine compliance with applicable Washington State rules and the quality improvement strategy. Contract requirements with the MCOs will also be considered. (2) Reviews will be conducted through an off-site process and data analysis. (3) Data and reports related to this performance measure will be reviewed by HCA to identify areas of deficiency, required improvement and to assure completion of remediation efforts. If any provider is not in compliance with minimum requirements, HCA will issue corrective action. Non-compliance with approved corrected action will lead HCA/MCOs to seek alternative services for participants served by that provider, and HCA will inform the state's appropriate licensing authority for possible action.
Frequency *(Of Analysis and Aggregation)*	Annually

4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).

Requirement	***Settings meet the home and community-based setting requirements as specified in this state plan and in accordance with 42 CFR 441.710(a)(1) and (2).***
Discovery	
Discovery Evidence *(Performance Measure)*	The total number of participants whose setting, prior to authorization and ongoing, meets the home and community-based settings requirements in accordance with 42 CFR 441.710(a)(1) and (2).

	***N**=Total number of participant records reviewed whose settings, prior to authorization and ongoing, meets the home and community-based settings requirement.* ***D**=Total number of participant records reviewed.*
Discovery Activity *(Source of Data & sample size)*	**Source:** ALTSA/RCS survey data **Sample Size:** A representative sample using a 95% confidence interval with a 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	ALTSA/HCS
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	ALTSA/RCS has direct oversight of residential facilities and licensing. If a provider does not meet requirements, RCS engages progressive corrective actions, which could lead to revoking of the license. In such situations, ALTSA/RCS will coordinate with HCA to ensure compliance with state plan requirements. Data and reports related to this performance measure will be reviewed by HCA to identify areas of deficiency. Refusal to comply with this performance measure will lead HCA/MCOs to seek alternative services for participants served by that provider.
Frequency *(of Analysis and Aggregation)*	Annually

5. The SMA retains authority and responsibility for program operations and oversight.

Requirement	***5. The State Medicaid Agency retains authority and responsibility for program operations and oversight.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of aggregated performance measure reports, trends, and remediation efforts reviewed by HCA. ***N:** Number of aggregated performance measure reports, trends, and remediation efforts reviewed by HCA.* ***D:** Number of all performance measure reports, trends, and remediation efforts required by this state plan.*
Discovery Activity *(Source of Data & sample size)*	**Source:** Records review off site of reports from ALTSA, MCOs (for managed care participants), and HCA systems **Sample Size:** 100% of all reports/performance measure findings data sources
Monitoring Responsibilities	HCA

	(Agency or entity that conducts discovery activities)	
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(1) A quality review team within HCA and ALTSA/HCS will conduct a comprehensive review of performance measure reports, trends, and remediation efforts. (2) Remediation activities may include targeted training/technical assistance, revision of policies/processes, review of contract language with MCOs and potential changes to contract requirements, etc. This is in addition to individual remediation strategies. (3) An annual Quality Improvement Plan will be developed and will be updated/revised annually.
	Frequency *(of Analysis and Aggregation)*	Annually

6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

Requirement		***6. The State Medicaid Agency maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.***
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of clean claims paid within 90 days. ***N:*** *Number of clean claims paid or denied within 90 days for services, broken out by MCO claims and FFS claims.* ***D:*** *Total number clean claims received for services furnished by qualified providers, broken out by MCO claims and FFS claims.*
	Discovery Activity *(Source of Data & sample size)*	**Source:** Records review off site of reports from MCOs (for managed care participants) and report from HCA's ProviderOne system (for FFS participants) **Sample Size:** 100% of all reports required for the reporting period
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	HCA
	Frequency	Annually, with additional analysis as needed
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required*	(1) HCA will conduct periodic reviews of performance measures to determine compliance with applicable Washington State rules and the quality improvement strategy. Contract requirements with the Managed Care Organizations (MCOs) will also be considered. (2) Reviews will be conducted through an off-site process and data analysis.

timeframes for remediation)	(3) Data and reports related to this performance measure will be reviewed by HCA to identify areas of deficiency, required improvement, and to assure completion of remediation efforts. If an MCO is not in compliance with minimum requirements, HCA will issue corrective action. If there are deficiencies within the Fee-for-service program, remediation activities may include targeted training/technical assistance or revision of policies/processes for system and fiscal staff.
Frequency *(of Analysis and Aggregation)*	Annually, with additional analysis as needed

7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

Requirement	***7a. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery	
Discovery Evidence *(Performance Measure)*	The number and percent of participants informed of where to report abuse, neglect, and exploitation. ***N =*** *Number of participants who received information on where to report abuse, neglect, and exploitation* ***D =*** *Number of records reviewed*
Discovery Activity *(Source of Data & sample size)*	**Source:** Records review conducted off site **Sample Size:** Less than 100% (representative sample) Confidence Interval = 5%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	ALTSA/HCS
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(1) ALTSA/HCS, with HCA oversight, will conduct periodic reviews of performance measures to determine compliance with applicable Washington State rules and the quality improvement strategy. (2) Reviews will be cond (3) ucted through an off-site records review process and data analysis. (4) Data and reports related to this performance measure will be jointly reviewed by ALTSA/HCS and HCA to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Remediation activities must be completed within 60 days, including informing the participant of where to report abuse, neglect, and abuse.
Frequency *(of Analysis and Aggregation)*	Annually

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Requirement	***7b. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery	
Discovery Evidence *(Performance Measure)*	The number and percent of identified critical incidents that were properly reported to Adult Protective Services (APS) **N =** *Number of APS referrals completed* **D =** *Number of records reviewed where a referral to APS was needed.*
Discovery Activity *(Source of Data & sample size)*	**Source:** Records review conducted off site **Sample Size:** Less than 100% (representative sample) Confidence Interval = 5%
Monitoring Responsibilities *(Agency or Entity that conducts discovery activities)*	ALTSA/HCS
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(3) ALTSA/HCS, with HCA oversight, will conduct periodic reviews of performance measures to determine compliance with applicable Washington State rules and the quality improvement strategy. (4) Reviews will be conducted through an off-site records review process and data analysis. (3) Data and reports related to this performance measure will be jointly reviewed by ALTSA/HCS and HCA to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Remediation activities must be completed within 60 days. The Quality Assurance team also reports all incidents that were identified and not reported.
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***7c.: The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery	
Discovery Evidence *(Performance Measure)*	The number and percent of deaths investigated where appropriate follow-up action was taken. **N =** *Number of deaths investigated where appropriate follow-up action was taken* **D =** *Number of deaths investigated*
Discovery Activity	Source: Records review conducted off site Sample Size:100%

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(Source of Data & sample size)	
Monitoring Responsibilities *(Agency or Entity that conducts discovery activities)*	ALTSA/HCS
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required Timeframes for remediation)*	(1) ALTSA/HCS Division, with HCA oversight, will conduct periodic reviews of performance measures to determine compliance with applicable Washington State rules and the quality improvement strategy. (2) Reviews will be conducted through a review process and data analysis of Adult Protective Services Fatality Review data. (3) Data and reports related to this performance measure will be jointly reviewed by ALTSA/HCS and HCA to identify areas of deficiency and methods for making improvements.
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***7d. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery	
Discovery Evidence *(Performance Measure)*	Percent of participant's records reviewed with no instances of the use of seclusion or restraints ***N=****Number of participant's records with no instances of the use of seclusion or restraints* ***D=****Number of participant's records reviewed*
Discovery Activity *(Source of Data & sample size)*	**Source:** Records review conducted off site **Sample Size:** Less than 100% (representative sample) Confidence Interval = 5%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	ALTSA/HCS
Frequency	Annually
Remediation	

	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(1) ALTSA, with HCA oversight, will conduct periodic reviews of performance measures to determine compliance with applicable Washington State rules and the quality improvement strategy. (2) Data analysis will be conducted using administrative data. (3) Data and reports related to this performance measure will be jointly reviewed by ALTSA/HCS and HCA to identify areas for improvement. Remediation activities must be completed within 60 days and may include unreported instances of seclusion or restraints will be reported to APS/RCS and (4) Identified instances of seclusion or restraints will be addressed by APS.
	Frequency *(of Analysis and Aggregation)*	Annually
Requirement		***7e. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of APS investigations completed within mandatory timeframe ***N*** *= Number of APS investigations completed within mandatory timeframes* **D =** *Number of APS investigations*
	Discovery Activity *(Source of Data & sample size)*	**Source:** Administrative data **Sample Size:** Less than 100% (representative sample) Confidence Interval = 5%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	APS
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(1) ALTSA, with HCA oversight, will conduct periodic reviews of performance measures to determine compliance with applicable Washington State rules and the quality improvement strategy. (2) Data analysis will be conducted using administrative data. (3) Data and reports related to this performance measure will be jointly reviewed by ALTSA/HCS and HCA to identify trends and areas for improvement. Remediation activities may include targeted training and revision of administrative processes and procedures.
	Frequency *(of Analysis and Aggregation)*	Annually

System Improvement

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

The quality management approach:

a. The state draws and monitors a representative sample of the participant's records.
b. All Quality Assurance (QA) issues are remediated at an individual level. Remediation actions and timelines are recorded and tracked by HCA. For all issues in which the state does not meet the 86% compliance, the state conducts a quality improvement project initiated at HCA or ALTSA depending on the performance measure.
c. QA monitoring reports allow patterns/trends to be tracked at both the regional and statewide level. The state analyzes these trends/patterns annually and develop a Quality Assurance annual report.
d. Ongoing discovery and remediation are facilitated by regular reporting and communications among HCA, MCO), ALTSA, and other stakeholders including service providers and agencies.
e. An annual QA Quality Review Report is prepared at the close of each audit cycle. This report is reviewed in detail with the Medicaid Agency Waiver Oversight Committee, HCA management, and the ALTSA/HCS Management Team of all QA audit activities and the status and recommendations for system improvements.
f. Data is analyzed for trends and the formulation of recommendations for system improvements. Partners included in this process are HCA, MCOs, ALTSA HCS and RCS, service providers, APS, ProviderOne, the Department of Health (DOH), and participants.
g. HCA/ALTSA and partners' proficiency improvement plans are prioritized, and changes are implemented, based on HCA/ALTSA strategic goals, stakeholder input, and available resources. System improvements may include training, process revision, and policy clarification.
h. The improvement process includes a re-evaluation component to see if improvements have been made after system changes have been implemented. Adjustments to the system are made based on the re-evaluation findings.

2. Roles and Responsibilities

HCA, as the Medicaid State Agency, will maintain oversight, coordination, and accountability for overall quality assurance of the HCBS benefit. However, roles and responsibilities often entail a close partnership between HCA and ALTSA, leveraging many existing pathways that ALTSA already has in place due to their role in delivering Long Term Services and Supports (LTSS).

HCA measures items 2a, 2b, 3, 5, and 6 from the performance measures above.

ALTSA monitors performance measures 1a, 1b, 1c, 2c, 4, 7a, 7b, and 7c as well as the oversight and functions outlined below:

- The HCS Quality Assurance unit is responsible for monitoring the three state regional areas for each review cycle. This unit uses a standardized monitoring process which includes:
  - Verifying that remediation has occurred, and
  - Providing final reports for analysis and action.

- RCS provides licensing, certification, regulatory oversight, and conducts inspections of adult family homes, assisted living facilities, and

enhanced services facilities at least every 18 months to ensure they meet licensing requirements and are in compliance with federal and state laws and rules. In addition to licensing inspections, RCS investigates complaints received from residents or the public and takes action to ensure that resident rights are not being violated. If a setting violates an individual's personal rights of privacy, dignity, choice, and respect, the provider is cited and must develop a corrective action plan to address the issues.

- The Complaint Resolution Unit (CRU) in RCS investigates licensed residential providers. The CRU receives reports of abuse, abandonment, neglect, or financial exploitation by phone, fax, letter, or in-person. RCS may take enforcement actions based on the findings from licensing inspections and complaint investigations. Enforcement actions range from civil fines to license revocation to referral of criminal allegations to law enforcement.

- The Adult Protective Services (APS) Unit investigates and makes official findings on any accusations of abuse, neglect, or exploitation of vulnerable adults. APS investigations may include guardianships, protection orders, and placement on the registry when substantiated findings of abuse, neglect, or exploitation are made against an individual participant.

ALTSA and HCA also partner to ensure strong oversight and coordination of the HCBS Committee (also called the Waiver Management Committee). This committee ensures regular opportunities for discussion and oversight between the state Medicaid agency and the operating agency regarding Home and Community Based Services. The committee meets at least quarterly to review all functions delegated to the operating agency, current quality assurance activities and performance, pending waiver or State Plan activity (e.g., amendments, renewals, etc.), potential waiver/state plan and rule changes and quality improvement activities.

3. Frequency

Annually

4. Method for Evaluating Effectiveness of System Changes

The Quality Improvement Strategy is evaluated and adjusted prior to the beginning of each yearly review cycle, at the time of a state plan amendment, and at renewal. Workgroups consisting of HCA program managers, ALTSA program managers, MCOs, and fair hearing coordinators evaluate the quality assurance strategy/program.

Modifications/expectations are developed based on changes in federal or state rules and regulations, HCA's and ALTSA's policy and procedures, CMS assurances and sub assurances, input from technical consultants, participants, providers, and data from various reports including recommendations from the previous review cycle. The quality improvement strategy is reviewed and approved by the HCA and ALTSA executive management team and the Medicaid Agency Waiver Management Committee.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

COORDINATION OF TITLE XIX WITH PART B OF TITLE XVIII

The following method is used to provide the entire range of benefits under Part B of title XVIII to the groups of Medicare-eligible individuals indicated:

[X] A. Buy-in agreements with the Secretary of HHS. This agreement covers:

1. [ ] Individuals receiving SSI under title ZVI or State supplementation, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

   [ ] Yes [ ] No

2. [ ] Individuals receiving SSI under title XVI, State supplementation, or a money payment under the State's approved title IV-A plan, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

   [ ] Yes [ ] No

3. [X] All individuals eligible under the State's approved title XIX plan.

[ ] B. Group premium payment arrangement entered into with the Social Security Administration. This arrangement covers the following groups:

[X] C. Payment of deductible and coinsurance costs. Such payments are made in behalf of the following groups:

All Medicare-Eligible individuals who are also eligible under this Title XIX Plan.

This relates only to comparability of devices - benefits under XVIII to what groups- not how XIX pays. ... if State has buy-in (which covers premium), it does not check #3 for same group-only if it does #3 for another group; e.g. does #1 for money payment receipts and #3 for non-$-receipts. How it handles deductibles and coinsurance for money payment receipts is a matter for reimbursement attachment.

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