

Medicaid State Plan – Attachment 9

MACPro System SPAs

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24-0051	Effective December 31, 2024

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WA - Submission Package - WA2018MS0007O - (WA-18-0017) - Administration

Summary

Reviewable Units

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Related Actions

CMS-10434 OMB 0938-1188

Medicaid State Plan Administration

Organization

Designation and Authority

MEDICAID | Medicaid State Plan | Administration | WA2018MS0007O | WA-18-0017

Package Header

Package ID	WA2018MS0007O	SPA ID	WA-18-0017
Submission Type	Official	Initial Submission Date	9/24/2018
Approval Date	12/21/2018	Effective Date	7/1/2018
Superseded SPA ID	WA-15-0041		
	User-Entered		

A. Single State Agency

1. State Name: Washington
- ☒ 2. As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named here agrees to administer the Medicaid program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Centers for Medicare and Medicaid Services (CMS).
3. Name of single state agency:
Washington State Health Care Authority
4. This agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

B. Attorney General Certification:

- ☒ The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

Name	Date Created	
18-0017-AgencyOrganization-Att-1.1-A-AG-Certification	11/5/2018 5:05 PM EST	
18-0017-AgencyOrganization-AttorneyGeneralDelegationLetter	12/18/2018 1:30 PM EST	

C. Administration of the Medicaid Program

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

- ☒ 1. The single state agency is the sole administrator of the state plan (i.e. no other state or local agency administers any part of it). The agency administers the state plan directly, not through local government entities.
- ☐ 2. The single state agency administers portions of the state plan directly and other governmental entity or entities administer a portion of the state plan.

Designation and Authority

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D. Additional information (optional)

Medicaid State Plan Administration

Organization

Eligibility Determinations and Fair Hearings

MEDICAID | Medicaid State Plan | Administration | WA2018MS00070 | WA-18-0017

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A. Eligibility Determinations (including any delegations)

1. The entity or entities that conduct determinations of eligibility for families, adults, and individuals under 21 are:
- ☒ a. The Medicaid agency

☐ b. Delegated governmental agency
2. The entity or entities that conduct determinations of eligibility based on age, blindness, and disability are:
- ☐ a. The Medicaid agency

☒ b. Delegated governmental agency

☒ i. Single state agency under Title IV-A (TANF) (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands

☐ ii. An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

☒ iii. The Social Security Administration determines Medicaid eligibility for SSI beneficiaries

☐ iv. Other
3. Assurances:
- ☒ a. The Medicaid agency is responsible for all Medicaid eligibility determinations.

☒ b. There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).

☒ c. The Medicaid agency does not delegate authority to make eligibility determinations to entities other than government agencies which maintain personnel standards on a merit basis.

☒ d. The delegated entity is capable of performing the delegated functions.

Eligibility Determinations and Fair Hearings

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B. Fair Hearings (including any delegations)

- ☒ The Medicaid agency has a system of hearings that meets all of the requirements of 42 CFR Part 431, Subpart E.
 - ☒ The Medicaid agency is responsible for all Medicaid fair hearings.
1. The entity or entities that conduct fair hearings with respect to eligibility based on applicable modified adjusted gross income (MAGI) are:
- ☒ a. Medicaid agency
 - ☐ d. Delegated governmental agency
3. For all other Medicaid fair hearings (not related to an eligibility determination based on MAGI):
- ☒ All other Medicaid fair hearings are conducted at the Medicaid agency or at another state agency authorized under an ICA waiver.

Eligibility Determinations and Fair Hearings

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C. Evidentiary Hearings

The Medicaid agency uses local governmental entities to conduct local evidentiary hearings.

- ☐ Yes
- ☒ No

D. Additional information (optional)

Medicaid State Plan Administration

Organization

Organization and Administration

MEDICAID | Medicaid State Plan | Administration | WA2018MS00070 | WA-18-0017

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A. Description of the Organization and Functions of the Single State Agency

1. The single state agency is:

- ☒ a. A stand-alone agency, separate from every other state agency
- ☐ b. Also the Title IV-A (TANF) agency
- ☐ c. Also the state health department
- ☐ d. Other:

2. The main functions of the Medicaid agency and where these functions are located within the agency are described below. This description should be consistent with the accompanying organizational chart attachment. (If the function is not performed by the Medicaid agency, indicate in the description which other agency performs the function.)

a. Eligibility Determinations

The Health Care Authority (HCA) is designated as the single state agency and has final authority for eligibility determinations. According to Washington State law and as permitted by Medicaid law, HCA & the Department of Social and Health Services (DSHS - the Title IV-A Agency) have established an agreement regarding the provision of certain eligibility determinations for non-MAGI Medicaid programs. This agreement defines the responsibilities of HCA as the administrator of the Medicaid State Plan, and DSHS as the representative of the agency's interest along with HCA, for the Medicaid program. HCA oversees & monitors the program functions delegated to DSHS.

In HCA, the Medical Eligibility Determination Services (MEDS) section in the Medicaid Eligibility and Community Support (MECS) division is responsible for completing MAGI-based eligibility & post-enrollment determination for children & adults in Apple Health (including Alien Emergency Medical services for those eligible for Medicaid but for their immigration & citizenship status, under MAGI-based income methodology), Breast & Cervical Cancer Treatment Program, & family planning programs. The Office of Medicaid Eligibility & Policy (OMEP) in MECS develops Apple Health/Apple Health for Kids eligibility rules & policy, ensures eligibility systems support & enrolls foster care & adoption support children into Medicaid when DSHS has determined they are eligible.

Per agreement, HCA delegates to DSHS the management of non-MAGI-based eligibility determinations for the following programs: SSI & SSI-related programs for the aged, blind and disabled eligibility groups; Alien Emergency Medical services for those eligible for Medicaid but for their immigration & citizenship status, under non-MAGI-based income methodology; the Medicare Savings program; & long-term care programs.

b. Fair Hearings (including expedited fair hearings)

The Office of Legal Affairs (OLA), an office in the Division of Legal Services (DLS), provides legally trained staff to represent HCA in administrative hearings regarding denials of services (medical/dental/transportation/equipment) and provider overpayments, before the state Office of Administrative Hearings (OAH) and the Board of Appeals (BOA), which is a separate office in DLS. The Medical Eligibility Determination Services (MEDS) section in the Medicaid Eligibility & Community Support (MECS) division represents HCA in administrative hearings regarding eligibility for MAGI-based program eligibility (adult/children/family/Alien Emergency Medical), as well as eligibility for the Breast & Cervical Cancer Treatment Program, & family planning programs.

HCA has delegated to DSHS the function of representing the Medicaid agency at administrative hearings (including expedited hearings) regarding decisions made by DSHS related to non-MAGI eligibility determinations.

An individual can request de novo review of any decision (i.e., benefits & services, non-MAGI or MAGI-based eligibility determinations) by the HCA BOA, which is a separate office in DLS, not associated with any other office in DLS.

c. Health Care Delivery, including benefits and services, managed care (if applicable)

Health care delivery is managed in various sections of several divisions:

1. The Division of Behavioral Health and Recovery (DBHR)

- Mental health and substance use disorder treatment
- Medication-assisted treatment
- Emergency services and behavioral health crisis services
- Recovery support, substance use prevention, and mental health promotion services
- * Problem gambling disorders

2. Medicaid Program Operations and Integrity (MPOI)

- Community Services: Manages family health care services, non-emergency medical transportation, & Medicaid outreach conducted by federally recognized tribes, school districts, & local health jurisdictions. Provides management & oversight of the Interpreter Services contractor providing interpreters for medically necessary services
- Managed Care Programs: Coordinates & assures adherence to state & federal law & federal lock-in program rules. Manages & oversees contracted managed

care organizations delivering Medicaid services

- Medicaid Program Design & Implementation: Develops and implements new & innovative Medicaid programs such as Health Homes, 1115 waivers, & fully integrated health care services

3. Clinical Quality & Care Transformation (CQCT)

- * Pharmacy Operations: Manages the prescription drug program, directs overall pharmacy coverage policy & conducts pharmacy clinical reviews for fee-for-service prior authorizations.
- * Authorization Services: Processes authorizations for fee-for-service medical, dental, & DME pharmacy. Processes alien emergency medical applications & hospice-related requests.
- * Clinical Strategy & Operations: Provides care transformation, decision & clinical support

Per agreement, HCA delegates the management of the following to DSHS:

- Residential Habilitation Centers/Public Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID) (42 CFR 483.400)
- Privately operated, licensed boarding homes or nursing homes that have Medicaid certification as Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID) (42 CFR 483.400)
- Home & Community-Based Services (HCBS) programs including Medicaid Personal Care & the Community First Choice Program
- Certain Chronic Care Management services
- Long-term Care (adult family homes, boarding homes, & the community residential services & support programs) & nursing facility services

d. Program and policy support including state plan, waivers, and demonstrations (if applicable)

Program & policy support is managed in various sections of several divisions:

1. Policy division (POL)

- Paying for Value: Implements value-based purchasing policies
- Legislative Affairs & Analysis: Coordinates legislative activities
- Health Innovation & Reform: Strategy & policy to advance health system transformation & oversees implementation of Healthier Washington.
- Medicaid Transformation: Develops & supports Medicaid transformation within Healthier Washington.
- Analytics, Research & Measurement: Provides data & analytic support to inform & monitor policy & innovation.

2. Clinical Quality & Care Transformation (CQCT)

- * Pharmacy Operations: Manages the prescription drug program, directs overall pharmacy coverage policy & conducts pharmacy clinical reviews for fee-for-service prior authorizations
- * Health Services & Management: Develops Medicaid medical benefit policy & provides utilization management
- * Authorization Services: Processes authorizations for FFS medical, dental, & DME pharmacy. Processes alien emergency medical applications & hospice-related requests.
- * Clinical Strategy & Ops: Provides care transformation & performance measurement leadership, decision & clinical support
- * Health Technology Assessment Program: Reviews selected health technologies to develop coverage & reimbursement policies

3. Medicaid Eligibility and Community Support (MECS)

- Medical Eligibility Determination Services (MEDS): Completes eligibility & post-enrollment determination for children & adults in Apple Health, Breast & Cervical Cancer Treatment Program & Take Charge Family Planning
- Medical Assistance Customer Service Center (MACSC): Helps Apple Health clients & providers with questions & issues about Medicaid coverage, managed care, billing, claims & enrollment
- Office of Medicaid Eligibility & Policy (OMEPE): Develops Apple Health/Apple Health for Kids eligibility rules & policy, ensures eligibility systems support, conducts stakeholder outreach, & opens medical coverage for foster care and adoption support children

4. Medicaid Program Operations and Integrity (MPOI)

- Behavioral Health: Manages & monitors contracts for behavioral health services
- Medicaid Compliance Review & Analytics: Monitors fee-for-service & managed care providers to ensure contract compliance; provides clinical-based technical assistance to managed care organizations; investigates & resolves enrollee access to care & quality of care concerns; monitors & improves special programs; & triages critical incidents reported by health plans.
- Medicaid Program Design & Implementation: Develops & implements new & innovative Medicaid programs such as Health Homes, 1115 waivers, & fully integrated health care services.
- Program Integrity: Conducts audits & reviews of fee-for-service & managed care providers to prevent & recover improper payments

5. Division of Behavioral Health and Recovery (DBHR) supports:

- Mental health and substance use disorder treatment
- Medication-assisted treatment
- Emergency services and behavioral health crisis services
- Recovery support, substance use prevention, and mental health promotion services
- * Problem gambling disorders
- * Waiver programs

6. Division of Legal Services

- *Office of Rules & Publications: Manages rule making; maintains the Medicaid State Plan & manages the process to amend it

7. Office of Tribal Affairs & Analysis:

- Advises on government-to-government relationships with tribes
- Conducts training in government-to-government relationships with tribes & the policy reasons for these relationships.
- Works with tribes, the Indian Health Service, & Urban Indian Health Programs on issues and concerns.
- Develops program policies & rules

8. DSHS (per agreement):

- * 1915(b) & (c) waivers
- * Demonstration projects
- * ICF/ID

- *HCBS prgms
- *Long term care
- *Chronic care

e. Administration, including budget, legal counsel

Administration is managed in various sections of several divisions:

1. Financial Services (FS)
 - Budget preparations & expenditure monitoring
 - Accounting & payroll
 - Per-capita Medicaid forecasting
 - Managed care rate-setting methods for Medicaid clients
 - Setting fee-for-service rate schedules for physicians, dentists, hospitals, clinics, & others
2. The Division of Legal Services (DLS)
 - Office of Rules & Publications (ORP): Manages rule making (for Washington Administrative Code)&provider billing guide actions; maintains Medicaid State Plan & the amendment process
 - Office of Legal Affairs (OLA): Handles administrative hearings & appeals for denials of service & provider overpayments
 - Office of Contracts & Procurements (OCP): Provides guidance for contract/procurement/purchasing activities
 - Enterprise Risk Management Office (ERMO): Provides legal services & oversees HCA's risk management programs & the Board of Appeals (BOA)
3. Office of Tribal Affairs & Analysis:
 - Advises on government-to-government relationships with tribes in accordance with federal Medicaid requirements & chapter 43.376 RCW.
 - Conducts training in government-to-government relationships with tribes & the policy reasons for these relationships
 - Works with tribes, the Indian Health Service, & Urban Indian Health Programs on issues and concerns
 - Develops program policies & rules

f. Financial management, including processing of provider claims and other health care financing

Financial management is managed by various sections in several divisions:

1. Financial Services (FS)
 - Budget preparations & expenditure monitoring
 - Accounting & payroll
 - Per-capita Medicaid forecasting
 - Managed care rate-setting methods for Medicaid clients
 - Setting fee-for-service rate schedules for physicians, dentists, hospitals, clinics, & others
2. Medicaid Program Operations & Integrity (MPOI)
 - Business Operations & Claims Support: Provides timely & accurate adjudication of fee-for-service claims
 - Community Services: Medicaid outreach conducted by federally recognized tribes, school districts, & local health jurisdictions

g. Systems administration, including MMIS, eligibility systems

1. ProviderOne Operations & Services (P1OS)
 - Office of Medicaid Systems & Data: Operates & maintains ProviderOne (P1) (MMIS), manages the MMIS contract, provides system support to P1 business customers
 - Office of Provider Enrollment: Verifies provider eligibility to offer Medicaid services.
 - Office of Enterprise Data Management & Analytics (EDMA): Responsible for a variety of Medicaid state & federal reporting & enterprise data management/governance processes
 - Medicaid Information & Technology Architecture (MITA): Baselines organizational processes against the CMS MITA framework & develops initiatives intended to modernize WA State Medicaid systems.
 - ProviderOne Enhancement & Contract Performance: Manages the P1 operations & maintenance contract to ensure adherence to all federal/state requirements & manages the life cycle of numerous federal & state initiatives that require P1 enhancements.
2. Enterprise Technology Services (ETS)
 - *Provides information technology (IT) supports, installation, ordering & access for services
 - *Helps analyze business needs & recommends solutions
 - *Web & multimedia services, database services, application development & support, Agency networking & infrastructure services, IT portfolio management services, enterprise architecture services, & other strategic planning/decision making services, support for Amazon Web Services utilization, Health Information Technologies, enterprise application systems support, enterprise telephone systems, desktop support, service desk, IT business services, PAY1 & SEBB IT services, & security services.

h. Other functions, e.g., TPL, utilization management (optional)

1. Clinical Quality and Care Transformation (CQCT)
 - Health Services and Management: Develops Medicaid medical benefit policy & provides utilization management
 - Clinical Support: Provides care transformation & performance measurement leadership, decision support, clinical analytics, & clinical contract support
 - Prescription Drug Program: Identifies preferred drugs & increases awareness of cost-effective use of prescription drugs. (Non-Medicaid-funded)
 - Shared Decision Making Program: Runs certification process for Patient Decision Aids & leads efforts for statewide spread of shared decision making. (Non-Medicaid-funded)
 - Clinical Quality Performance Measurement: Provides leadership for Agency clinical & value-based measurement strategies, including oversight for Statewide Common Measure Set. (Non-Medicaid-funded)
2. Medicaid Program Operations and Integrity (MPOI)
 - Behavioral Health: Manages & monitors contracts with Behavioral Health Organizations, provides contractual oversight for behavioral health services which include mental health, substance use disorder inpatient & outpatient care, crisis response, & many other services.
 - Managed Care Programs: Coordinates & assures adherence to state & federal law, & federal lock-in program rules; manages & oversees contracted managed care organizations delivering Medicaid services.
 - Medicaid Compliance Review & Analytics: Monitors fee-for-service & managed care providers to ensure compliance with contractual requirements; provides clinical-based technical assistance to managed care organizations; investigates & resolves enrollee access to care issues & quality of care concerns; monitors &

- improves special programs; & triages critical incidents reported by health plans.
- Program Integrity: Conducts audits & reviews of fee-for-service & managed care providers to ensure compliance with Medicaid laws & contractual requirements & prevent and recover improper payments.
3. Communications (COM): helps with internal & external communications (including client communications), including strategic messaging & communications planning, media relations, & visual communications (including forms & publications); partners with Enterprise Technology Services to oversee HCA's website & intranet.
4. The Office of Audit & Accountability (OAA) provides independent & objective feedback about business operations to help ensure processes & internal controls comply with state & federal requirements; works closely with the Office of the Attorney General to investigate fraud & abuse that could result in higher health care costs.
5. Planning & Performance division (PPD): leads Lean activities, Performance Management Quarterly Target Reviews, sets standards for project management, & conducts Organizational Change Management activities.
6. The Employee Resources Division (ERD) includes:
- Mail & Imaging Services: Processes mail & images paper claims, forms, & eligibility documents to support HCA, the Health Benefit Exchange, & DSHS supporting Medicaid.
 - Facilities: Oversees building operations, maintenance, & reception to ensure continued & efficient functioning of infrastructure
 - Human Resources: Assists in hiring; provides information & access to employee training & development opportunities, manages performance development programs & collective bargaining agreements
 - Safety & Wellness: Oversees security, ergonomics, & the safety and wellness program

3. An organizational chart of the Medicaid agency has been uploaded:

Name	Date Created	
HCA Organization Chart with Sections	9/24/2018 12:52 PM EDT	

Organization and Administration

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B. Entities that Determine Eligibility or Conduct Fair Hearings Other than the Medicaid Agency

Title	Description of the functions the delegated entity performs in carrying out its responsibilities:
Single state agency under Title IV-A (TANF)	According to Washington State law and as permitted by Medicaid law, HCA & the Department of Social and Health Services (DSHS) have established an agreement regarding certain functions. This agreement defines the responsibilities of HCA, the Single State Agency, as the administrator of the Medicaid State Plan, and DSHS, Title IV-A Agency, as the representative of the agency's interest along with HCA, for the Medicaid program. HCA oversees & monitors the program functions delegated to DSHS. HCA delegates to DSHS the authority to determine eligibility for and to represent HCA's interest at administrative hearings (including expedited hearings) for eligibility regarding non-MAGI programs, including SSI & SSI-related programs for the Aged, Blind, or Disabled eligibility groups, Healthcare for Workers with Disabilities, Alien Emergency Medical for those not eligible under MAGI rules, the Medicare Savings Program, and long-term care programs.
The Social Security Administration	Pursuant to a 1634 agreement, the Department for Social Security Administration determines eligibility for Supplemental Security Income recipients.

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E. Coordination with Other Executive Agencies

The Medicaid agency coordinates with any other Executive agency related to any Medicaid functions or activities not described elsewhere in the Organization and Administration portion of the state plan (e.g. public health, aging, substance abuse, developmental disability agencies):.

- ☒ Yes
- ☐ No

Name of agency:	Description of the Medicaid functions or activities conducted or coordinated with another executive agency:
Office of Administrative Hearings	Conducts all initial (first level) administrative hearings
Department of Social and Health Services	Maintains the eligibility system of record for Medicaid & public assistance programs. In cases where DSHS takes action on behalf of HCA, the DSHS employee acts as an authorized agent (representative) of HCA. HCA delegates to DSHS the authority to administer the programs below. HCA retains policy making authority and responsibility to monitor & oversee DSHS' administration of these Medicaid services: * Eligibility determinations for non-MAGI-based programs (SSI & SSI-related programs for the aged, blind & disabled eligibility groups, Alien Emergency Medical for those not eligible under MAGI rules, the Medicare Savings Program, & long-term care programs). • Residential Habilitation Centers/Public Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID) (42 CFR 483.400). • Section 1915(b) and 1915(c) waivers (42 CFR 440.180). Note: HCA maintains overall responsibility for all waivers; DSHS manages certain waiver services. • Privately operated, licensed boarding homes or nursing homes that have Medicaid certification as Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID) (42 CFR 483.400) • Home and Community-Based Services (HCBS) programs within the State, including Medicaid Personal Care and the Community First Choice Program • Certain Chronic Care Management services • Approved Medicaid grants and

Name of agency:	Description of the Medicaid functions or activities conducted or coordinated with another executive agency: demonstration projects. Note: HCA maintains overall responsibility for all Medicaid grants and demonstration projects; DSHS manages certain grant and project services. • Long-term Care (adult family homes, boarding homes, and the community residential services and support programs) and nursing facility services. DSHS will administer and pay for administrative and programmatic services related to long-term care and nursing facility services • HCA recognizes DSHS as the State Survey Agency for Medicare and Medicaid Survey and Certification as described in the Federal State Operations Manual. State Medicaid Agency functions delegated to the DSHS State Survey Agency include: - o Minimum Data Set (MDS) review & analysis for calculating case mix adjusted Medicaid rates - o Administration of Medicaid enforcement & compliance remedies for deficient nursing facilities, including civil fines, collections, and formal & informal hearings - o Quality Improvements & Evaluation System - o The Quality Assurance Nurses (QAN) program, including case mix accuracy & utilization review of Nurse Aide registry (NATCEP) program - o Investigation of allegations of resident/client abuse, neglect, or misappropriation of nursing facility residents, including findings, as appropriate
Department of Health	Regulates provider licensure within scope-of-practice standards set in state law & addresses population-based public health issues.
Department of Corrections	Partners with HCA and the Department of Labor & Industries in the HCA-administered Health Technology Assessment program and Prescription Drug Program which set common standards for evidence-based practices.
Office of the Insurance Commissioner	Regulates & oversees Washington State's health insurance industry, including the licensing & oversight of all carriers & assurance of consumer protections.

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F. Additional information (optional)

Medicaid State Plan Administration

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Single State Agency Assurances

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A. Assurances

- ☒ 1. The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.
- ☒ 2. All requirements of 42 CFR 431.10 are met.
- ☒ 3. There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with 42 CFR 431.12. All requirements of 42 CFR 431.12 are met.
- ☒ 4. The Medicaid agency does not delegate, other than to its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.
- ☒ 5. The Medicaid agency has established and maintains methods of personnel administration on a merit basis in accordance with 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.
- ☒ 6. All requirements of 42 CFR Part 432, Subpart B are met, with respect to a training program for Medicaid agency personnel and the training and use of sub-professional staff and volunteers.

B. Additional information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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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Medicaid State Plan Administration

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Designation and Authority

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Approval Date	12/16/2022	Effective Date	10/1/2022
Superseded SPA ID	18-0017		
User-Entered			

A. Single State Agency

1. State Name: Washington
- ☒ 2. As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named here agrees to administer the Medicaid program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Centers for Medicare and Medicaid Services (CMS).
3. Name of single state agency:
Washington State Health Care Authority
4. This agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

B. Attorney General Certification:

- ☒ The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

Name	Date Created	
18-0017-AgencyOrganization-Att-1.1-A-AG-Certification	11/5/2018 5:05 PM EST	
18-0017-AgencyOrganization-AttorneyGeneralDelegationLetter	12/18/2018 1:30 PM EST	

C. Administration of the Medicaid Program

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

- ☒ 1. The single state agency is the sole administrator of the state plan (i.e. no other state or local agency administers any part of it). The agency administers the state plan directly, not through local government entities.
- ☐ 2. The single state agency administers portions of the state plan directly and other governmental entity or entities administer a portion of the state plan.

Designation and Authority

MEDICAID | Medicaid State Plan | Administration | WA2022MS0004O | WA-22-0016

Package Header

Package ID	WA2022MS0004O	SPA ID	WA-22-0016
Submission Type	Official	Initial Submission Date	10/3/2022
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Superseded SPA ID	18-0017		
User-Entered			

D. Additional information (optional)

Medicaid State Plan Administration

Organization

Eligibility Determinations and Fair Hearings

MEDICAID | Medicaid State Plan | Administration | WA2022MS00040 | WA-22-0016

Package Header

Package ID	WA2022MS00040	SPA ID	WA-22-0016
Submission Type	Official	Initial Submission Date	10/3/2022
Approval Date	12/16/2022	Effective Date	10/1/2022
Superseded SPA ID	18-0017		
User-Entered			

A. Eligibility Determinations (including any delegations)

1. The entity or entities that conduct determinations of eligibility for families, adults, and individuals under 21 are:
- ☒ a. The Medicaid agency

☐ b. Delegated governmental agency
2. The entity or entities that conduct determinations of eligibility based on age (65 or older), or having blindness or a disability are:
- ☐ a. The Medicaid agency

☒ b. Delegated governmental agency

☒ i. Single state agency under Title IV-A (TANF) (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands

☐ ii. An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

☒ iii. The Social Security Administration determines Medicaid eligibility for:

☒ (1) SSI beneficiaries

☐ (2) Optional state supplement recipients

☐ iv. Other
3. Assurances:
- ☒ a. The Medicaid agency is responsible for all Medicaid eligibility determinations.

☒ b. There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).

☒ c. The Medicaid agency does not delegate authority to make eligibility determinations to entities other than government agencies which maintain personnel standards on a merit basis.

☒ d. The delegated entity is capable of performing the delegated functions.

Eligibility Determinations and Fair Hearings

MEDICAID | Medicaid State Plan | Administration | WA2022MS0004O | WA-22-0016

Package Header

Package ID	WA2022MS0004O	SPA ID	WA-22-0016
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Approval Date	12/16/2022	Effective Date	10/1/2022
Superseded SPA ID	18-0017		
User-Entered			

B. Fair Hearings (including any delegations)

- ☒ The Medicaid agency has a system of hearings that meets all of the requirements of 42 CFR Part 431, Subpart E.
- ☒ The Medicaid agency is responsible for all Medicaid fair hearings.
1. The entity or entities that conduct fair hearings with respect to eligibility based on applicable modified adjusted gross income (MAGI) are:

☒ a. Medicaid agency

☐ d. Delegated governmental agency
3. For all other Medicaid fair hearings (not related to an eligibility determination based on MAGI):

☒ All other Medicaid fair hearings are conducted at the Medicaid agency or at another state agency authorized under an ICA waiver.

Eligibility Determinations and Fair Hearings

MEDICAID | Medicaid State Plan | Administration | WA2022MS0004O | WA-22-0016

Package Header

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Superseded SPA ID	18-0017		
	User-Entered		

C. Evidentiary Hearings

The Medicaid agency uses local governmental entities to conduct local evidentiary hearings.

- ☐ Yes
- ☒ No

D. Additional information (optional)

WA - Submission Package - WA2024MS0005O - (WA-24-0016) - Administration

Summary

Reviewable Units

Versions

Correspondence Log

Approval Letter

News

Related Actions

CMS-10434 OMB 0938-1188

Medicaid State Plan Administration

Organization

Designation and Authority

MEDICAID | Medicaid State Plan | Administration | WA2024MS0005O | WA-24-0016

Package Header

Package ID	WA2024MS0005O	SPA ID	WA-24-0016
Submission Type	Official	Initial Submission Date	3/26/2024
Approval Date	06/12/2024	Effective Date	2/1/2024
Superseded SPA ID	WA-22-0016		
	System-Derived		

A. Single State Agency

1. State Name: Washington
- ☒ 2. As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named here agrees to administer the Medicaid program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Centers for Medicare and Medicaid Services (CMS).
3. Name of single state agency:
Washington State Health Care Authority
4. This agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

B. Attorney General Certification:

- ☒ The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

Name	Date Created	
18-0017-AgencyOrganization-Att-1.1-A-AG-Certification	11/5/2018 5:05 PM EST	
18-0017-AgencyOrganization-AttorneyGeneralDelegationLetter	12/18/2018 1:30 PM EST	

C. Administration of the Medicaid Program

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

- ☒ 1. The single state agency is the sole administrator of the state plan (i.e. no other state or local agency administers any part of it). The agency administers the state plan directly, not through local government entities.
- ☐ 2. The single state agency administers portions of the state plan directly and other governmental entity or entities administer a portion of the state plan.

Designation and Authority

MEDICAID | Medicaid State Plan | Administration | WA2024MS00050 | WA-24-0016

Package Header

Package ID	WA2024MS00050	SPA ID	WA-24-0016
Submission Type	Official	Initial Submission Date	3/26/2024
Approval Date	06/12/2024	Effective Date	2/1/2024
Superseded SPA ID	WA-22-0016		
	System-Derived		

D. Additional information (optional)

Medicaid State Plan Administration

Organization

Eligibility Determinations and Fair Hearings

MEDICAID | Medicaid State Plan | Administration | WA2024MS00050 | WA-24-0016

Package Header

Package ID	WA2024MS00050	SPA ID	WA-24-0016
Submission Type	Official	Initial Submission Date	3/26/2024
Approval Date	06/12/2024	Effective Date	2/1/2024
Superseded SPA ID	WA-22-0016		
	System-Derived		

A. Eligibility Determinations (including any delegations)

1. The entity or entities that conduct determinations of eligibility for families, adults, and individuals under 21 are:
- ☒ a. The Medicaid agency

☐ b. Delegated governmental agency
2. The entity or entities that conduct determinations of eligibility based on age (65 or older), or having blindness or a disability are:
- ☐ a. The Medicaid agency

☒ b. Delegated governmental agency

☒ i. Single state agency under Title IV-A (TANF) (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands

☐ ii. An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

☒ iii. The Social Security Administration determines Medicaid eligibility for:

☒ (1) SSI beneficiaries

☐ (2) Optional state supplement recipients

☐ iv. Other
3. Assurances:
- ☒ a. The Medicaid agency is responsible for all Medicaid eligibility determinations.

☒ b. There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).

☒ c. The Medicaid agency does not delegate authority to make eligibility determinations to entities other than government agencies which maintain personnel standards on a merit basis.

☒ d. The delegated entity is capable of performing the delegated functions.

Eligibility Determinations and Fair Hearings

MEDICAID | Medicaid State Plan | Administration | WA2024MS00050 | WA-24-0016

Package Header

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Superseded SPA ID	WA-22-0016		
	System-Derived		

B. Fair Hearings (including any delegations)

- ☒ The Medicaid agency has a system of hearings that meets all of the requirements of 42 CFR Part 431, Subpart E.
- ☒ The Medicaid agency is responsible for all Medicaid fair hearings.
1. The entity or entities that conduct fair hearings with respect to eligibility based on applicable modified adjusted gross income (MAGI) are:

☒ a. Medicaid agency

☐ d. Delegated governmental agency
3. For all other Medicaid fair hearings (not related to an eligibility determination based on MAGI):

☒ All other Medicaid fair hearings are conducted at the Medicaid agency or at another state agency authorized under an ICA waiver.

Eligibility Determinations and Fair Hearings

MEDICAID | Medicaid State Plan | Administration | WA2024MS00050 | WA-24-0016

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	System-Derived		

C. Evidentiary Hearings

The Medicaid agency uses local governmental entities to conduct local evidentiary hearings.

- ☐ Yes
- ☒ No

D. Additional information (optional)

Medicaid State Plan Administration

Organization

Organization and Administration

MEDICAID | Medicaid State Plan | Administration | WA2024MS00050 | WA-24-0016

Package Header

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Superseded SPA ID	WA-22-0016		
	System-Derived		

A. Description of the Organization and Functions of the Single State Agency

1. The single state agency is:

- ☒ a. A stand-alone agency, separate from every other state agency
- ☐ b. Also the Title IV-A (TANF) agency
- ☐ c. Also the state health department
- ☐ d. Other:

2. The main functions of the Medicaid agency and where these functions are located within the agency are described below. This description should be consistent with the accompanying organizational chart attachment. (If the function is not performed by the Medicaid agency, indicate in the description which other agency performs the function.)

a. Eligibility Determinations

The Health Care Authority (HCA) is designated as the single state agency and has final authority for eligibility determinations. According to Washington State law and as permitted by Medicaid law, HCA & the Department of Social and Health Services (DSHS - the Title IV-A Agency) have established an agreement regarding the provision of certain eligibility determinations for non-MAGI Medicaid programs. This agreement defines the responsibilities of HCA as the administrator of the Medicaid State Plan, and DSHS as the representative of the agency's interest along with HCA, for the Medicaid program. HCA oversees & monitors the program functions delegated to DSHS.

In HCA, the Medical Eligibility Determination Services (MEDS) section in the Medicaid Customer Service (MCS) division is responsible for completing MAGI-based eligibility & post-enrollment determination for children & adults in Apple Health (including Alien Emergency Medical services for those eligible for Medicaid but for their immigration & citizenship status, under MAGI-based income methodology), Breast & Cervical Cancer Treatment Program, & family planning programs. The Office of Medicaid Eligibility & Policy (OMEPE) in ITICEA develops Apple Health/Apple Health for Kids eligibility rules & policy, ensures eligibility systems support & enrolls foster care & adoption support children into Medicaid when DSHS has determined they are eligible.

Per agreement, HCA delegates to DSHS the management of non-MAGI-based eligibility determinations for the following programs: Healthcare for Workers with Disabilities; SSI & SSI-related programs for the aged, blind and disabled eligibility groups; Alien Emergency Medical services for those eligible for Medicaid but for their immigration & citizenship status, under non-MAGI-based income methodology; the Medicare Savings program; & long-term services & supports programs.

b. Fair Hearings (including expedited fair hearings)

The Medicaid agency, the Health Care Authority (HCA), oversees & administers the administrative (fair) hearings system in compliance with 42 CFR 431.10(e). HCA retains full oversight and does not delegate the ability to issue final decisions or waive its single state agency authority in administration of fair hearings & appeals.

HCA Board of Appeals (BOA) conducts hearings & issues final orders or contracts with the state's Office of Administrative Hearings (OAH) to conduct the fair hearing & issue an Initial Order by an Administrative Law Judge (ALJ). HCA chooses which appeals to send to OAH & which appeals to conduct internally. Under both systems, HCA retains full administrative control over the hearings with the ability to issue a final order. HCA can choose to keep or refer any case type. There are certain case types that always are heard directly by HCA. HCA also keeps any case related to ICF-IID certification. HCA allows OAH to hear most client eligibility & client service case types. That is because those cases are very routine in nature & the central panel agency is very equipped to conduct the hearing & issue an initial decision. This allows HCA's BOA to directly hear the most complex case types noted above. Nonetheless, in all instances, HCA retains final agency control of all administrative hearing decisions.

In all hearings, there is an HCA hearing representative representing the single state Medicaid agency. HCA's Office of Legal Affairs (OLA) in the division of Legal Services (DLS) represents HCA in hearings regarding Medicaid benefits/services, both non-MAGI & MAGI-based, Breast & Cervical Cancer, & family planning eligibility. HCA has delegated to the Department of Social & Health Services (DSHS) the function of representing the Medicaid agency at administrative hearings (including expedited hearings) regarding decisions made by DSHS related to non-MAGI eligibility determinations, NF discharges & adverse PASRR determinations.

The HCA hearing representative may choose to adopt the Initial Order or appeal it to the HCA BOA. If the HCA hearing representative chooses not to appeal an initial order, that order converts to a final order with the passage of time, which is the process by which the single state Medicaid agency adopts an initial order. All HCA hearing representatives receive training on their role representing HCA in fair hearings.

An initial order made by an ALJ can be reviewed by a review judge at any party's request. The review judge is within the HCA BOA & is an HCA employee. The review judge reviews initial orders and the hearing record de novo, exercising decision-making power as if hearing the case as a presiding officer. In some cases, review judges conduct hearings under state law as a presiding officer. After reviewing initial orders or conducting hearings, review judges enter final orders. The review judge must not have been involved in the initial HCA action. A final order is an order that is the final HCA decision. All appeals of initial decisions to the HCA BOA must be made within twenty-one days of service of the initial decision. Regardless of whether a party appeals or chooses not to appeal, all final administrative actions should be rendered within ninety (90) days of the date of the request for hearing.

The Medicaid appeals system is overseen by the HCA Chief Review Judge/Appeals Administrator (CRJ/AA). This position contracts with OAH & retains complete oversight of the OAH ALJ services provided to ensure compliance with the rules of the single state Medicaid agency.

The contract with OAH has performance requirements to ensure compliance with state & federal Medicaid laws, ensure that applicants & recipients receive timely hearings, & ensure due process. The CRJ/AA has the power to stop sending cases to OAH at any time if a performance issue is identified or to withhold payment.

c. Health Care Delivery, including benefits and services, managed care (if applicable)

Health care delivery is managed in various sections of several divisions:

1. Clinical Quality and Care Transformation (CQCT)

Makes clinical policy decisions to guide medical coverage, maintain quality standards & ensure evidence-based practices for clients' medical care, & support statewide care transformation. Includes:

- Pharmacy Services: Manages the prescription drug program, directs overall pharmacy coverage policy, & conducts pharmacy clinical reviews for prior authorizations in FFS.
- Health Services: Develops Medicaid medical & dental benefit policy & provides utilization management.
- Operations: Consists of: Authorization Services Office that processes authorizations for FFS medical, dental, & DME pharmacy, alien emergency medical applications, & removal of hospice coverage requests; Clinical Support that provides care transformation & performance measurement leadership, decision support, clinical analytics, & clinical contract support; the Health Technology Assessment Program that reviews selected health technologies to develop coverage & reimbursement policies for state-purchased health care programs.
- Data: Makes evidence-based decisions through its acquisition, ingestion, management, analysis, & governance of HCA's data assets.

2. Medicaid Programs Division (MPD)

Provides access to services. Includes:

- Business Operations: Leads overall management of the implementation, deployment, & reporting for National Standards for Culturally & Linguistically Appropriate Services in Health & Health Care for the agency.
- Medicaid Contracts & Compliance: Coordinates & assures adherence to state & federal law. Manages & oversees contracted managed care organizations delivering Medicaid services.
- Quality Oversight & Program Alignment: Oversees the Apple Health delivery system of care to ensure programs are administered as designed & result in quality outcomes.
- Strategic Design & Program Oversight: Develops & implements new Medicaid programs such as Health Homes, 1915 waivers, crisis services, & integrated health services.
- Community Services: Manages family health care services, nonemergency medical transportation, innovative & strategic federal reimbursement contracts, & provider-based language access services.

3. Division of Behavioral Health & Recovery (DBHR)

Provides program support for behavioral health. Includes:

- Substance use disorder prevention & mental health promotion
- Children, youth, & family behavioral health services
- Behavioral health programs & recovery supports
- Adult substance use disorder
- Adult & involuntary services
- Treatment & recovery programs

4. Medicaid Customer Service Division (MCS). MCS provides high-quality customer service to support clients' access to obtain health care, while also supporting the efficient utilization of Medicaid funding to provide care appropriately and efficiently. Includes:

- Coordination of Benefits & Claims Processing: Ensures Medicaid is the payer of last resort by preventing duplication of payment when more than one insurance plan or payer covers a person. Provides timely & accurate adjudication of FFS claims.
- Medical Assistance Customer Service Center (MACSC): Helps Apple Health clients & providers with questions & issues about Medicaid coverage, managed care, billing, & enrollment.

* Operations: Includes training development, quality assurance, & data support. Supports provider outreach & training, with a primary focus in assisting providers with Direct Data Entry in ProviderOne (P1) (MMIS), P1 user maintenance, billing guide updates, & general assistance with Apple Health procedures through the Provider Relations team.

*Medical Eligibility Determination Services (MEDS): Completes eligibility & post-enrollment determination for children & adults in Apple Health, Breast & Cervical Cancer Treatment Program, Take Charge Family Planning, & opens medical coverage for foster care & adoption support children.

d. Program and policy support including state plan, waivers, and demonstrations (if applicable)

Program & policy support is managed in various sections of several divisions:

1. Clinical Quality and Care Transformation (CQCT). Includes:

- Pharmacy Services
- Health Care Services
- Data

* Operations

2. Medicaid Customer Service Division (MCS). Includes:

- Coordination of Benefits & Claims Processing
- Medical Assistance Customer Service Center
- Medical Eligibility Determination Services
- Operations

3. Medicaid Programs Division (MPD). Includes:

- Business Operations
- Community Services
- Medicaid Contracts & Compliance
- Quality Oversight & Program Alignment
- Strategic Design & Program Oversight

4. Office of Tribal Affairs (OTA)

- Advises the agency on how to maintain its government-to-government relationships with tribes in accordance with federal Medicaid requirement & state law
- Works with tribes, the Indian Health Service, & Urban Indian Health Programs to understand their issues and concerns
- Develops agency program policies & rules that address those issues & concerns

5. Strategy, Policy & Innovation (SPI)

Helps guide state policy, strategy, and transformation efforts to achieve better health, better care, and lower costs. Includes:

- Health Policy & Programs
- Boards & Commissions
- Legislative Affairs and Analysis
- Health Equity

* Paying for Value

6. Division of Audit, Integrity, Oversight, & Enrollment (DAIOE)

Conducts audits and reviews of fee-for-service & managed care providers to ensure compliance with Medicaid laws & contractual requirements & prevent & recover improper payments. Provides independent & objective feedback about business operations to help ensure HCA's processes & internal controls comply with state & federal requirements. Enrolls & ensures the quality of providers. Includes:

- Office of Audit & Accountability
- Office of Compliance & Oversight

* Provider Enrollment

7. Division of Legal Services (DLS). DLS provides centralized administrative & legal support to all divisions to mitigate risk, comply with changing state & federal laws, & assist HCA in accomplishing its goals. Includes:

- * Office of the Chief Legal Officer
- * Board of Appeals
- * Enterprise Risk Management
- * Office of Legal Affairs
- * Office of Contracts & Procurement
- * Office of Rules & Publications (manages the State Plan Amendment process)

8. Department of Social and Health Services (DSHS) (per agreement):

- 1915(b), 1915 (c), and 1115 waivers
- Certain Chronic Care Management services
- Home & Community-Based Services programs including Medicaid Personal Care Services & the Community First Choice Program
- Residential Habilitation Centers/Public Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID)
- Privately operated, licensed assisted living facilities or nursing facilities that have Medicaid certification as Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID) (42 CFR 483.400)
- Long-term Services & Supports (adult family homes, assisted living, enhanced services facilities, boarding homes, & the community residential services & support programs) & nursing facility services. DSHS administers & pays for administrative & programmatic services related to long-term services & supports & nursing facility services.
- Program of All-Inclusive Care for the Elderly (PACE)

e. Administration, including budget, legal counsel

1. Office of the Director (OD)

OD provides visionary leadership for the broader health care marketplace to the agency's role as the state's largest purchaser of health care services & the behavioral health authority in accordance with HCA's statutory direction. OD is also responsible for overseeing the Leadership team & is responsible for overall agency vision, operations & providing strategic direction.

2. Central Services Administration (CSA)

CSA plans, directs, & coordinates supportive services & operations for the agency, ensuring smooth, efficient, & accountable operations. Includes:

- Division of Legal Services (DLS)
- Employee Resources Division (ERD)
- Planning & Performance Division (PPD)

3. Medicaid Services Administration (MSA)

MSA has primary responsibility for ensuring HCA offers high-quality, cost-effective care to Apple Health clients while adhering to federal Medicaid requirements. MSA also works with various administrations at the Department of Social & Health Services in administering Medicaid services to Apple Health clients. Includes:

- Medicaid Programs Division (MPD)

4. IT Innovation & Customer Experience Administration (ITICEA)

ITICEA aligns agency technology & people assets to enhance the programs and services offered by HCA in a way that leverages human-centered design principles to improve the health equity of Washingtonians. Includes:

- Enterprise Technology Services Division (ETS)
- Medicaid Customer Service Division (MCS)

* Office of Medicaid Eligibility & Policy (OMEP)

5. Division of Legal Services (DLS). Includes:

- Office of the Chief Legal Officer
- Board of Appeals (BOA)
- Enterprise Risk Management Office (ERMO)
- Office of Legal Affairs (OLA)
- Office of Contracts & Procurement (OCP)
- Office of Rules & Publications (ORP)

6. Financial Services Division (FSD)

FSD directs and executes the agency's financial-related activities & delivers a fiscal perspective in agency-wide decisions & strategies. Includes:

- Health care
- Accounting & payroll

- Financial Analytics
- Budget operations
- ERB Finance
- Federal financial reporting

7. Medicaid Customer Service Division (MCS). Includes:

- Coordination of Benefits (COB) & Claims Processing
- * Medical Assistance Customer Service Center (MACSC)
- Medical Eligibility Determination Services (MEDS)
- * Operations

8. Office of Tribal Affairs (OTA) (within the Office of the Director)

- Advises the agency on how to maintain its government-to-government relationships with tribes in accordance with federal Medicaid requirement & state law
- Works with tribes, the Indian Health Service, & Urban Indian Health Programs to understand their issues and concerns
- Develops agency program policies & rules that address those issues & concerns

9. Division of Audit, Integrity, Oversight, & Enrollment (DAIOE). Includes:

- Office of Audit & Accountability
- Office of Compliance & Oversight
- * Provider Enrollment

f. Financial management, including processing of provider claims and other health care financing

1. Financial Services Division (FSD) Includes:

- Health care
- Accounting & payroll
- Financial Analytics
- Budget operations
- ERB Finance
- Federal financial reporting

2. Medicaid Customer Service Division (MCS). Includes:

- Coordination of Benefits (COB) & Claims Processing
- Medical Assistance Customer Service Center (MACSC)
- Medical Eligibility Determination Services (MEDS)
- Operations

g. Systems administration, including MMIS, eligibility systems

1. IT Innovation and Customer Experience Administration (ITICEA)

ITICEA focuses on leveraging technology & person-centered design principles to enhance internal & external customer service, as well as focusing on shaping the health care work force. Includes:

- Enterprise Technology Services Division (ETS)
- Medicaid Customer Service Division (MCS)

* Office of Medicaid Eligibility & Policy

2. Enterprise Technology Services (ETS) division

ETS provides information technology (IT) systems & support to the agency as well as supporting major systems. Includes:

- Application Services
- Medicaid Services
- Infrastructure & End-User Services
- IT Policy & Planning
- Strategic Services
- Security Services

3. Medicaid Customer Service Division (MCS). Includes:

- Coordination of Benefits (COB) & Claims Processing
- Medical Assistance Customer Service Center (MACSC)
- Medical Eligibility Determination Services (MEDS)
- Operations

h. Other functions, e.g., TPL, utilization management (optional)

1. Communications Division (COM)

COM helps with internal & external communications, including strategic messaging & communications planning, media relations, constituent services, & visual communications, including forms and publications.

2. Employee Resources Division (ERD)

ERD creates conditions that support the success of all HCA employees through thoughtful space use, relevant & accessible administrative policies, safe & healthy work environments, efficient mail & imaging processes, trainings that enrich the workforce, & a culture of equity & belonging.

- Mail & Imaging Services: Processes mail & images paper claims, forms, & eligibility documents to support HCA, Health Benefit Exchange, & Department of Social & Health Services supporting Medicaid.
- Facilities: Oversees building operations, maintenance, shipping & receiving and reception to ensure an efficient & welcoming environment within the agency's physical spaces.
- Human Resources: Recruits the best people & helps them succeed. Delivers employee training & development, manages performance development programs and collective bargaining agreements, & helps people thrive at work so HCA can accomplish its mission.
- Safety & Wellness: Oversees security, ergonomics, & the safety and wellness program, including safety training & emergency preparedness efforts for the agency.

3. Employees & Retirees Benefits (ERB) division

ERB provides insurance coverage for eligible public & school employees, COBRA & Continuation of Coverage members, retirees & their families through two separate employer sponsored insurance programs. Oversees the design, procurement, operations (eligibility & enrollment) of more than a dozen different types of insurance benefits, as well as communication, customer support, & marketing related to the programs. Includes:

- Benefit Accounts – Customer Service, ACA 1095 reporting, Outreach & Training (support to employers)
- Benefit Strategy & Design
- Portfolio Management & Monitoring
- Policy, Rules, & Compliance

4. Planning & Performance Division (PPD)

PPD leads enterprise organizational development activities, including continuous process improvement, project & change management, & agency performance management.

3. An organizational chart of the Medicaid agency has been uploaded:

Name	Date Created	
24-0016 Agency Organization Chart Overview	3/25/2024 1:44 PM EDT	

Organization and Administration

MEDICAID | Medicaid State Plan | Administration | WA2024MS0005O | WA-24-0016

Package Header

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	System-Derived		

B. Entities that Determine Eligibility or Conduct Fair Hearings Other than the Medicaid Agency

Title	Description of the functions the delegated entity performs in carrying out its responsibilities:
Single state agency under Title IV-A (TANF)	According to Washington State law and as permitted by Medicaid law, HCA & the Department of Social and Health Services (DSHS) have established an agreement regarding certain functions. This agreement defines the responsibilities of HCA, the Single State Agency, as the administrator of the Medicaid State Plan, and DSHS, Title IV-A Agency, as the representative of the agency's interest along with HCA, for the Medicaid program. HCA oversees & monitors the program functions delegated to DSHS. HCA delegates to DSHS the authority to determine eligibility for and to represent HCA's interest at administrative hearings (including expedited hearings) for eligibility regarding non-MAGI programs, including SSI & SSI-related programs for the Aged, Blind, or Disabled eligibility groups, Healthcare for Workers with Disabilities, Alien Emergency Medical for those not eligible under MAGI rules, the Medicare Savings Program, and long-term care programs.
The Social Security Administration	Pursuant to a 1634 agreement, the Department for Social Security Administration determines eligibility for Supplemental Security Income recipients.

Organization and Administration

MEDICAID | Medicaid State Plan | Administration | WA2024MS0005O | WA-24-0016

Package Header

Package ID	WA2024MS0005O	SPA ID	WA-24-0016
Submission Type	Official	Initial Submission Date	3/26/2024
Approval Date	06/12/2024	Effective Date	2/1/2024
Superseded SPA ID	WA-22-0016		
	System-Derived		

E. Coordination with Other Executive Agencies

The Medicaid agency coordinates with any other Executive agency related to any Medicaid functions or activities not described elsewhere in the Organization and Administration portion of the state plan (e.g. public health, aging, substance abuse, developmental disability agencies):.

- ☒ Yes
- ☐ No

Name of agency:	Description of the Medicaid functions or activities conducted or coordinated with another executive agency:
Office of Administrative Hearings	Conducts all initial (first level) administrative hearings
Department of Health	Regulates provider licensure within scope-of-practice standards set in state law & addresses population-based public health issues.
Office of the Insurance Commissioner	Regulates & oversees Washington State's health insurance industry, including the licensing & oversight of all carriers & assurance of consumer protections.
Department of Corrections	Partners with HCA and the Department of Labor & Industries in the HCA-administered Health Technology Assessment program and Prescription Drug Program which set common standards for evidence-based practices. Partners with HCA in developing reentry program waiver.
Department of Social and Health Services (DSHS)	Maintains the eligibility system of record for Medicaid & public assistance programs. In cases where DSHS takes action on behalf of HCA, the DSHS employee acts as an authorized agent (representative) of HCA. HCA delegates to DSHS the authority to administer the programs below. HCA retains policy making authority and responsibility to monitor & oversee DSHS' administration of these Medicaid services: * Eligibility determinations for non-MAGI-based programs (SSI & SSI-related programs for the aged, blind & disabled eligibility groups, Healthcare for Workers with Disabilities, Alien Emergency Medical for those not eligible under MAGI rules, the Medicare Savings Program, & long-term services and supports programs). • Residential Habilitation

Name of agency:

Description of the Medicaid functions or activities conducted or coordinated with another executive agency:

Centers/Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID) (42 CFR 483.400).

- Section 1915(b), 1915(c) waivers (42 CFR 440.180), and 1115 waivers. Note: HCA maintains overall responsibility for all waivers; DSHS is the operating agency for certain waiver and State Plan services.
- Privately operated, licensed assisted living facilities or nursing facilities that have Medicaid certification as Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID) (42 CFR 483.400)
- Home and Community-Based Services (HCBS) programs within the State, including Medicaid Personal Care and the Community First Choice Program
- Certain Chronic Care Management services
- Approved Medicaid grants and demonstration projects. Note: HCA maintains overall responsibility for all Medicaid grants and demonstration projects; DSHS manages certain grant and project services.
- Long-term Services and Supports (adult family homes, assisted living, enhanced services facilities, boarding homes, and the community residential services and support programs) and nursing facility services. DSHS will administer and pay for administrative and programmatic services related to long-term services and supports and nursing facility services.
- HCA recognizes DSHS as the State Survey Agency for Medicare and Medicaid Survey and Certification as described in the Federal State Operations Manual. State Medicaid Agency functions delegated to the DSHS State Survey Agency include:
 - >Minimum Data Set (MDS) review & analysis for calculating case mix adjusted Medicaid rates
 - >Administration of Medicaid enforcement & compliance remedies for deficient or failed facility practice in nursing facilities, including civil fines, collections, and formal & informal hearings as delegated to DSHS.
 - > Quality Improvements & Evaluation System
 - > The Case Mix Accuracy Review (CMAR) program ensures accuracy of Nursing Home Assessments by reviewing the Minimum Data Set and of ensuring that federal regulations are followed. The Nurse Aide Training and Competency and Evaluation Program registry (NATCEP)

Name of agency:	Description of the Medicaid functions or activities conducted or coordinated with another executive agency: program ensures federal regulations for nurse aid training and certification are followed. In addition, the OBRA (Omnibus Reconciliation Act) Registry ensures NACs (Nursing Assisted Certified) meet the federal requirements to work in the Nursing Home Facilities. The LTCQIP (Long Term Care Quality Improvement Program) is a voluntary quality improvement initiative to provide technical assistance to LTC providers related to delivery of care systems and improve regulatory compliance. > Investigation of allegations of resident/client abuse, neglect, abandonment, or personal or financial exploitation in the nursing facility, adult family home, assisted living facility, or enhanced services facility, as well as Supported Living providers, as appropriate > Regulatory oversight of licensed or certified long term care providers including: Adult Family Homes, Assisted Living Facilities, Enhanced Services Facilities, Nursing Facilities, and Supported Living providers.
Department of Commerce	Promotes sustainable community and economic development by administering over 100 programs and several state boards and commissions focused on helping communities achieve positive growth. Partners with HCA to administer the behavioral health ombudsman program.
Department of Children, Youth, and Families (DCYF)	Delegated to administer Medicaid Targeted Case Management Services for children under age 21. HCA maintains overall responsibility for all Medicaid programs.

Organization and Administration

MEDICAID | Medicaid State Plan | Administration | WA2024MS0005O | WA-24-0016

Package Header

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F. Additional information (optional)

Medicaid State Plan Administration

Organization

Single State Agency Assurances

MEDICAID | Medicaid State Plan | Administration | WA2024MS00050 | WA-24-0016

Package Header

Package ID	WA2024MS00050	SPA ID	WA-24-0016
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	System-Derived		

A. Assurances

- ☒ 1. The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.
- ☒ 2. All requirements of 42 CFR 431.10 are met.
- ☒ 3. There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with 42 CFR 431.12. All requirements of 42 CFR 431.12 are met.
- ☒ 4. The Medicaid agency does not delegate, other than to its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.
- ☒ 5. The Medicaid agency has established and maintains methods of personnel administration on a merit basis in accordance with 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.
- ☒ 6. All requirements of 42 CFR Part 432, Subpart B are met, with respect to a training program for Medicaid agency personnel and the training and use of sub-professional staff and volunteers.

B. Additional information (optional)

To comply with Section 1902(a)(4) of the Social Security Act and 42 CFR 432.10, the Medicaid agency must establish and maintain methods of personnel administration on a merit basis in accordance with the regulations at 5 CFR Part 900, Subpart F; notwithstanding the reference to 5 USC 2301 in Assurance number 5 under Section A. Assurances.

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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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WA - Submission Package - WA2024MS0009O - (WA-24-0051) - Administration

CMS-10434 OMB 0938-1188

Medicaid State Plan Administration

General Administration

Reporting

Package Header

Package ID	WA2024MS0009O	SPA ID	WA-24-0051
Submission Type	Official	Initial Submission Date	12/30/2024
Approval Date	01/07/2025	Effective Date	12/31/2024
Superseded SPA ID	NEW		
	User-Entered		

A. General Reporting

The agency submits all reports in the form and with the content required by the Secretary and complies with any provisions that the Secretary finds necessary to verify and assure the correctness of all reports.

- ☒ 1. The agency assures that all requirements of 42 CFR 431.16 are met.

B. Annual Reporting on the Child and Adult Core Sets

- ☒ 1. The agency assures that all requirements of 42 CFR 437.10 through 437.15 are met.
- ☒ 2. The agency reports annually, by December 31, on:
- a. All measures on the Child Core Set that are identified by the Secretary pursuant to 42 CFR 437.10.
 - b. All behavioral health measures on the Adult Core Set that are identified by the Secretary pursuant to 42 CFR 437.10.

C. Additional Information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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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WA - Submission Package - WA2018MS0003O - (WA-18-0031) - Eligibility

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CMS-10434 OMB 0938-1188

Medicaid State Plan Eligibility

Non-Financial Eligibility

Citizenship and Non-Citizen Eligibility

MEDICAID | Medicaid State Plan | Eligibility | WA2018MS0003O | WA-18-0031

Package Header

Package ID	WA2018MS0003O	SPA ID	WA-18-0031
Submission Type	Official	Initial Submission Date	9/24/2018
Approval Date	11/16/2018	Effective Date	7/1/2018
Superseded SPA ID	13-0034		
User-Entered			

☒ The state provides Medicaid to citizens and nationals of the United States and certain non-citizens who meet all other Medicaid eligibility requirements under the state plan, consistent with requirements of 42 CFR 435.406, including during a reasonable opportunity period pending verification of their citizenship, national status or satisfactory immigration status.

A. Citizens, Nationals and Eligible Non-Citizens

The state provides Medicaid eligibility to otherwise eligible individuals:

1. Who are citizens or nationals of the United States; or
2. Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641) or who are non-citizens treated as refugees under other federal statutes for purposes of Medicaid eligibility, subject to the requirements at 8 U.S.C. §1612(b)(2), and are not restricted by section 403 of PRWORA (8 U.S.C. §1613); or who are non-citizens whose eligibility is required by 8 U.S.C. 1612(b)(2)(E) and (F); and
3. Who have declared themselves to be citizens or nationals of the United States, or non-citizens having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), 1902(ee) of the SSA and 42 CFR 435.406, 911, and 956.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

a. The agency provides for an extension of the reasonable opportunity period for non-citizens if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process.

- ☒ Yes
- ☐ No

☒ b. When a reasonable opportunity period is provided, the agency furnishes benefits to otherwise eligible individuals on the following date:

The date benefits are furnished is:

- ☐ i. The date of the application containing the declaration of citizenship or immigration status.
- ☒ ii. The first day of the month of application.

Citizenship and Non-Citizen Eligibility

MEDICAID | Medicaid State Plan | Eligibility | WA2018MS0003O | WA-18-0031

Package Header

Package ID	WA2018MS0003O	SPA ID	WA-18-0031
Submission Type	Official	Initial Submission Date	9/24/2018
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User-Entered			

B. Optional Coverage of Qualified Non-Citizens

The state provides Medicaid coverage to all otherwise-eligible Qualified Non-Citizens whose eligibility is not restricted by section 403 of PRWORA (8 U.S.C. §1613).

- ☒ Yes
- ☐ No

Citizenship and Non-Citizen Eligibility

MEDICAID | Medicaid State Plan | Eligibility | WA2018MS0003O | WA-18-0031

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	User-Entered		

C. Coverage of Lawfully Residing Individuals

The state elects the option to provide Medicaid coverage to otherwise eligible individuals, lawfully residing in the United States, as provided in section 1903(v)(4) of the Act.

☒ Yes

☐ No

☒ 1. Pregnant women

☒ 2. Individuals under a specified age:

☒ a. Individuals under age 21

☐ b. Individuals under age 20

☐ c. Individuals under age 19

3. An individual is considered to be lawfully residing in the United States if he or she is lawfully present and otherwise meets the eligibility requirements in the state plan.

4. An individual is considered to be lawfully present in the United States if he or she is:

a. A qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);

b. A non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));

c. A non-citizen who has been paroled into the United States in accordance with 8 U.S.C.1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

d. A non-citizen who belongs to one of the following classes:

i. Granted temporary resident status in accordance with 8 U.S.C.1160 or 1255a, respectively;

ii. Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;

iii. Granted employment authorization under 8 CFR 274a.12(c);

iv. Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;

v. Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

vi. Granted Deferred Action status;

vii. Granted an administrative stay of removal under 8 CFR 241;

viii. Beneficiary of approved visa petition who has a pending application for adjustment of status;

e. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C.1231,or under the Convention Against Torture who:

i. Has been granted employment authorization; or

ii. Is under the age of 14 and has had an application pending for at least 180 days;

- f. Has been granted withholding of removal under the Convention Against Torture;
- g. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C.1101(a)(27)(J);
- h. Is lawfully present in American Samoa under the immigration laws of American Samoa; or
- i. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b)).
- j. Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (a) through (i) of this definition.
- ☐ k. Other

Citizenship and Non-Citizen Eligibility

MEDICAID | Medicaid State Plan | Eligibility | WA2018MS0003O | WA-18-0031

Package Header

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User-Entered			

D. Emergency Coverage

- ☒ The state assures that it provides limited Medicaid services for treatment of an emergency medical condition, not related to an organ transplant procedure, as defined in 1903(v)(3) of the Social Security Act and implemented at 42 CFR 440.255, to the following individuals who meet all Medicaid eligibility requirements, except documentation of citizenship or satisfactory immigration status and/or present an SSN:
1. Qualified non-citizens subject to the 5 year waiting period described in 8 U.S.C. 1613(a)

2. Non-qualified non-citizens, unless covered as a lawfully residing child or pregnant woman by the state under the option in accordance with 1903(v)(4) and implemented at 435.406(b).

E. Additional Information (optional)

The agency is implementing a pilot program from July 1, 2018 through June 30, 2019 designed to monitor requests for multiple reasonable opportunity periods (ROPs). The agency will provide an ROP to individuals who have declared to be a US citizen or to have satisfactory immigration status pending verification of such status, when the individual is otherwise eligible for Medicaid. The agency will approve a maximum of two ROPs for an individual during the 12-month pilot period.

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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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WA - Submission Package - WA2019MS0001O - (WA-19-0002) - Eligibility

Summary Reviewable Units Versions Correspondence Log Approval Letter News Related Actions

CMS-10434 OMB 0938-1188

Medicaid State Plan Eligibility

Income/Resource Methodologies

Eligibility Determinations of Individuals Age 65 or Older or Who Have Blindness or a Disability

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0001O | WA-19-0002

Package Header

Package ID	WA2019MS0001O	SPA ID	WA-19-0002
Submission Type	Official	Initial Submission Date	2/15/2019
Approval Date	05/03/2019	Effective Date	1/1/2019
Superseded SPA ID	9-29 91-22 92-6		
	User-Entered		

A. Eligibility Determinations of Individuals Who Are Age 65 or Older or Who Have Blindness or a Disability

Eligibility determinations of individuals who are age 65 or older or who have blindness or a disability are based on one of the following:

- ☒ 1. SSA Eligibility Determination State (1634 State)

The state has an agreement under section 1634 of the Social Security Act for the Social Security Administration to determine Medicaid eligibility of SSI beneficiaries. For all other individuals who seek Medicaid eligibility on the basis of being age 65 or older or having blindness or a disability, the state requires a separate Medicaid application and determines financial eligibility based on SSI income and resource methodologies.
- ☐ 2. State Eligibility Determination (SSI Criteria State)

The state requires all individuals who seek Medicaid eligibility on the basis of being age 65 or older or having blindness or a disability, including SSI beneficiaries, to file a separate Medicaid application, and determines financial eligibility based on SSI income and resource methodologies.
- ☐ 3. State Eligibility Determination (209(b) State)

The state requires all individuals who seek Medicaid eligibility on the basis of being age 65 or older or having blindness or a disability, including SSI beneficiaries, to file a separate Medicaid application, and determines financial eligibility using income and resource methodologies more restrictive than SSI.

B. Additional information (optional)

Medicaid State Plan Eligibility

Income/Resource Methodologies

Non-MAGI Methodologies

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0001O | WA-19-0002

Package Header

Package ID	WA2019MS0001O	SPA ID	WA-19-0002
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The state will apply the methodologies as described below, and consistent with 42 CFR 435.601, 435.602, and 435.831.

A. Basic Financial Methodology

- 1. The state applies the income and resource methodologies of the SSI program when determining eligibility for a population based on age (65 or older) or having blindness or a disability, with the exceptions described below in B. through G.
- 2. The state applies the financial methodologies of either the SSI program or the AFDC program in effect as of July 16, 1996 (whichever is most closely related) when determining eligibility for a population based on age (as a child), pregnancy, or status as a caretaker relative, with the exceptions described below in B. through G.

B. Use of Less Restrictive Methodologies

- 1. The state elects to apply income and/or resources methodologies that are less restrictive than those used under the cash assistance programs, in accordance with 42 CFR 435.601(d).

☒ Yes

☐ No
- 2. The less restrictive income and resource methodologies are described on the RU for each applicable eligibility group.

Non-MAGI Methodologies

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0001O | WA-19-0002

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C. Financial Responsibility of Relatives

1. In determining financial eligibility for an individual, the state does not include income and resources from anyone other than the individual's spouse, and for individuals under age 21 or who have blindness or disability, the individual's parent.
- a.The state includes the income and resources of a spouse or parent only when they are living with the individual in the same household, except as follows:
 - i. In the case of spouses who are age 65 or older or who have blindness or disability and who share the same room in a Medicaid institution, the state:
 - ☒ (1) Considers these couples either as living together or as living separately for the purpose of counting income and resources, whichever is more advantageous to the couple.
 - ☐ (2) Considers these couples as living separately for the purpose of counting income and resources.
 - ii. Where applicable, the state determines income and resource eligibility consistent with the spousal impoverishment rules of section 1924 of the Act, as described in the Resource Assessment and Eligibility reviewable unit.
 - b. In the case of individuals under age 21 for whom AFDC is the most closely related cash assistance program, the income and resources of parents and spouses are included only if the individual would have been considered a dependent under the state's approved AFDC state plan in effect as of July 16, 1996.

Non-MAGI Methodologies

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0001O | WA-19-0002

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	User-Entered		

D. Family Size

1. The family size of an individual for whom the SSI income and resource methodologies are used (as described in section A) includes the persons identified below:
- a. The individual applying, or
 - b. If the individual lives together with his or her spouse, the individual applying and the spouse, or
 - c. If the individual lives together with his or her parent(s) and the individual is under 21 or has blindness or a disability, the individual applying and the parent(s).
2. The family size of an individual for whom the AFDC income and resource methodologies are used (as described in section A.), includes the persons who would have been included in the family under the state's July 16, 1996 AFDC state plan, except where the state has elected to use the MAGI-like methodologies (as described in section E).
3. The state defines family size for one or more of the following FPL eligibility groups to include others beyond those identified in D.1. and D.2.
- ☐ Yes
- ☒ No

Non-MAGI Methodologies

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0001O | WA-19-0002

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	User-Entered		

E. Use of MAGI-like Methodologies

1. The state uses MAGI-like methodologies for one or more populations for whom the most closely related cash assistance program would be the AFDC program in effect as of July 16, 1996.

- ☐ Yes
- ☒ No

Non-MAGI Methodologies

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0001O | WA-19-0002

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	User-Entered		

F. Countable Income Deductions for the Medically Needy

In determining countable income for individuals who are age 65 or older or who have blindness or a disability, the state deducts:

1. Amounts that would be deducted in determining eligibility under SSI.
2. The highest amounts that would be deducted in determining eligibility for optional state supplements if these supplements are paid to all individuals who are receiving SSI or would be eligible for SSI except for their income.

Non-MAGI Methodologies

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0001O | WA-19-0002

Package Header

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G. Additional Information (optional)

Medicaid State Plan Eligibility

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0001O | WA-19-0002

Package Header

Package ID	WA2019MS0001O	SPA ID	WA-19-0002
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Approval Date	05/03/2019	Effective Date	1/1/2019
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Mandatory Coverage

A. The state provides Medicaid to mandatory groups of individuals. The mandatory groups covered are:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Infants and Children under Age 19		☒	☐	☐	APPROVED
Parents and Other Caretaker Relatives		☒	☐	☐	CONVERTED
Pregnant Women		☒	☐	☐	APPROVED
Deemed Newborns		☒	☐	☐	NEW
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care		☒	☐	☐	APPROVED
Former Foster Care Children		☒	☐	☐	APPROVED
Transitional Medical Assistance		☒	☐	☐	APPROVED
Extended Medicaid due to Spousal Support Collections		☒	☐	☐	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
SSI Beneficiaries		☒	☐	☐	NEW
Closed Eligibility Groups		☒	☐	☐	APPROVED
Individuals Deemed To Be Receiving SSI		☒	☐	☐	NEW
Working Individuals under 1619(b)		☒	☐	☐	APPROVED
Qualified Medicare Beneficiaries		☒	☐	☐	APPROVED
Qualified Disabled and Working Individuals		☒	☐	☐	NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Specified Low Income Medicare Beneficiaries		☒	☐	☐	APPROVED
Qualifying Individuals		☒	☐	☐	APPROVED

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0001O | WA-19-0002

Package Header

Package ID	WA2019MS0001O	SPA ID	WA-19-0002
Submission Type	Official	Initial Submission Date	2/15/2019
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B. The state elects the Adult Group, described at 42 CFR 435.119.

☒ Yes ☐ No

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Adult Group		☒	☐	☐	CONVERTED

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0001O | WA-19-0002

Package Header

Package ID	WA2019MS0001O	SPA ID	WA-19-0002
Submission Type	Official	Initial Submission Date	2/15/2019
Approval Date	05/03/2019	Effective Date	1/1/2019
Superseded SPA ID	WA-13-0030		
	System-Derived		

A. Options for Coverage

The state provides Medicaid to specified optional groups of individuals.

☒ Yes ☐ No

The optional eligibility groups covered in the state plan are (elections made in this screen may not be comprehensive during the transition period from the paper-based state plan to MACPro):

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Optional Coverage of Parents and Other Caretaker Relatives		☐	☐	☐	NEW
Reasonable Classifications of Individuals under Age 21		☒	☐	☐	APPROVED
Children with Non-IV-E Adoption Assistance		☒	☐	☐	APPROVED
Independent Foster Care Adolescents		☐	☐	☐	NEW
Optional Targeted Low Income Children		☐	☐	☐	NEW
Individuals above 133% FPL under Age 65		☐	☐	☐	APPROVED
Individuals Needing Treatment for Breast or Cervical Cancer		☒	☐	☐	APPROVED
Individuals Eligible for Family Planning Services		☐	☐	☐	NEW
Individuals with Tuberculosis		☐	☐	☐	NEW
Individuals Electing COBRA Continuation Coverage		☐	☐	☐	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Individuals Eligible for but Not Receiving Cash Assistance		☐	☐	☐	APPROVED

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Individuals Eligible for Cash Except for Institutionalization		☒	☐	☐	APPROVED
Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules		☒	☐	☐	APPROVED
Optional State Supplement Beneficiaries		☐	☐	☐	NEW
Individuals in Institutions Eligible under a Special Income Level		☒	☐	☐	NEW
PACE Participants		☒	☐	☐	NEW
Individuals Receiving Hospice		☒	☐	☐	NEW
Children under Age 19 with a Disability		☐	☐	☐	NEW
Age and Disability-Related Poverty Level		☐	☐	☐	NEW
Work Incentives		☐	☐	☐	APPROVED
Ticket to Work Basic		☒	☐	☐	APPROVED
Ticket to Work Medical Improvements		☒	☐	☐	APPROVED
Family Opportunity Act Children with a Disability		☐	☐	☐	NEW
Individuals Receiving State Plan Home and Community-Based Services		☐	☐	☐	NEW
Individuals Receiving State Plan Home and Community-Based Services Who Are Otherwise Eligible for HCBS Waivers		☐	☐	☐	NEW

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0001O | WA-19-0002

Package Header

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System-Derived			

B. Medically Needy Options for Coverage

The state provides Medicaid to specified groups of individuals who are medically needy.

☒ Yes ☐ No

The medically needy eligibility groups covered in the state plan are:

1. Mandatory Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Medically Needy Pregnant Women		☒	☐	☐	NEW
Medically Needy Children under Age 18		☒	☐	☐	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Protected Medically Needy Individuals Who Were Eligible in 1973		☒	☐	☐	NEW

2. Optional Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Medically Needy Reasonable Classifications of Individuals under Age 21		☒	☐	☐	NEW
Medically Needy Parents and Other Caretaker Relatives		☐	☐	☐	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Medically Needy Populations Based on Age, Blindness or Disability		☒	☐	☐	APPROVED

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0001O | WA-19-0002

Package Header

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C. Additional Information (optional)

Effective January 1, 2019, Washington no longer covers the Medicaid eligibility group for individuals who qualify on the basis of receiving optional state supplement payments (1902(a)(10)(A)(ii)(XI) 42 CFR 435.232 and 435.434).

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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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WA - Submission Package - WA2020MS0001O - (WA-20-0006) - Eligibility

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Medicaid State Plan Eligibility

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2020MS0001O | WA-20-0006

Package Header

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Approval Date	06/03/2020	Effective Date	1/1/2020
Superseded SPA ID	WA-19-0002		
User-Entered			

A. Options for Coverage

The state provides Medicaid to specified optional groups of individuals.

☒ Yes ☐ No

The optional eligibility groups covered in the state plan are (elections made in this screen may not be comprehensive during the transition period from the paper-based state plan to MACPro):

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Optional Coverage of Parents and Other Caretaker Relatives		☐	☐	☐	NEW
Reasonable Classifications of Individuals under Age 21		☒	☐	☐	APPROVED
Children with Non-IV-E Adoption Assistance		☒	☐	☐	APPROVED
Independent Foster Care Adolescents		☐	☐	☐	NEW
Optional Targeted Low Income Children		☐	☐	☐	NEW
Individuals above 133% FPL under Age 65		☐	☐	☐	APPROVED
Individuals Needing Treatment for Breast or Cervical Cancer		☒	☐	☐	APPROVED
Individuals Eligible for Family Planning Services		☐	☐	☐	NEW
Individuals with Tuberculosis		☐	☐	☐	NEW
Individuals Electing COBRA Continuation Coverage		☐	☐	☐	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Individuals Eligible for but Not Receiving Cash Assistance		☒	☐	☐	APPROVED
Individuals Eligible for Cash Except for Institutionalization		☒	☐	☐	APPROVED
Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules		☒	☐	☐	APPROVED
Optional State Supplement Beneficiaries		☐	☐	☐	NEW
Individuals in Institutions Eligible under a Special Income Level		☒	☐	☐	NEW
PACE Participants		☒	☐	☐	NEW
Individuals Receiving Hospice		☒	☐	☐	NEW
Children under Age 19 with a Disability		☐	☐	☐	NEW
Age and Disability-Related Poverty Level		☐	☐	☐	NEW
Work Incentives		☒	☒	☐	APPROVED
Ticket to Work Basic		☒	☐	☐	APPROVED
Ticket to Work Medical Improvements		☒	☐	☐	APPROVED
Family Opportunity Act Children with a Disability		☐	☐	☐	NEW
Individuals Receiving State Plan Home and Community-Based Services		☐	☐	☐	NEW
Individuals Receiving State Plan Home and Community-Based Services Who Are Otherwise Eligible for HCBS Waivers		☐	☐	☐	NEW

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2020MS0001O | WA-20-0006

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Superseded SPA ID	WA-19-0002		
User-Entered			

B. Medically Needy Options for Coverage

The state provides Medicaid to specified groups of individuals who are medically needy.

☒ Yes ☐ No

The medically needy eligibility groups covered in the state plan are:

1. Mandatory Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Medically Needy Pregnant Women		☒	☐	☐	NEW
Medically Needy Children under Age 18		☒	☐	☐	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Protected Medically Needy Individuals Who Were Eligible in 1973		☒	☐	☐	NEW

2. Optional Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Medically Needy Reasonable Classifications of Individuals under Age 21		☒	☐	☐	NEW
Medically Needy Parents and Other Caretaker Relatives		☐	☐	☐	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Medically Needy Populations Based on Age, Blindness or Disability		☒	☐	☐	APPROVED

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2020MS0001O | WA-20-0006

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C. Additional Information (optional)

Effective January 1, 2019, Washington no longer covers the Medicaid eligibility group for individuals who qualify on the basis of receiving optional state supplement payments (1902(a)(10)(A)(ii)(XI) 42 CFR 435.232 and 435.434).

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Eligibility Groups - Options for Coverage

Work Incentives

MEDICAID | Medicaid State Plan | Eligibility | WA2020MS0001O | WA-20-0006

Individuals with a disability with income below 250% of the FPL, who would qualify for SSI except for earned income.

Package Header

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Superseded SPA ID	WA-02-011		
	User-Entered		

The state covers the optional Work Incentives eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

- 1. Have earned income.
- 2. Meet the SSI definition of disability, but for earned income.
- 3. Meet income and resource standards following a two-step process, which includes:
 - a. Step One - A comparison of family net income to 250% FPL; and
 - b. Step Two - A comparison of individual net income and resources to the SSI standards, excluding earned income.

Work Incentives

MEDICAID | Medicaid State Plan | Eligibility | WA2020MS0001O | WA-20-0006

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Superseded SPA ID	WA-02-011		
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B. Step One Financial Methodologies and Income Test

1. Financial methodologies

- a. SSI methodologies are used in calculating family income. Please refer as necessary to Non-MAGI Methodologies, completed by the state.
- b. Less restrictive methodologies are used in calculating countable income.
- ☒ Yes
- ☐ No

The less restrictive income methodologies are:

☒ All income is disregarded. No income test is applied.

2. Income Test

Family net income must be less than 250% FPL. Please refer as necessary to Non-MAGI Methodologies for the definition of family size.

Work Incentives

MEDICAID | Medicaid State Plan | Eligibility | WA2020MS0001O | WA-20-0006

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C. Step Two Financial Methodologies and Income/Resource Test

1. Financial methodologies

- a. SSI methodologies are used in calculating income and resources, except that earned income is not counted. Please refer as necessary to Non-MAGI Methodologies, completed by the state.
- b. Less restrictive methodologies are used in calculating countable income.

Yes

No

The less restrictive income methodologies are:

- All income is disregarded. No income test is applied.

c. Less restrictive methodologies are used in calculating countable resources.

Yes

No

The less restrictive resource methodologies are:

- All resources are disregarded. No resource test is applied.

2. Income Test

- For individuals who pass Step One, in Step Two, the individual's unearned income (plus deemed income, if appropriate) must be less than one of the following income standards:
- a. The SSI income standard.

b. The income standard of the state supplement program.

3. Resource Test

The individual's resources must be less than the SSI resource standard.

Work Incentives

MEDICAID | Medicaid State Plan | Eligibility | WA2020MS0001O | WA-20-0006

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D. Premiums and Cost Sharing

Requirements for premiums and cost sharing for this group are found in the premium and cost sharing sections of the state plan.

Work Incentives

MEDICAID | Medicaid State Plan | Eligibility | WA2020MS0001O | WA-20-0006

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E. Additional Information (optional)

Requirements for premiums and cost sharing for this group are found in the premium and cost sharing sections as well as Attachment 2.6-A of the state plan.

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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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WA - Submission Package - WA2019MS0004O - (WA-20-0030) - Eligibility

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CMS-10434 OMB 0938-1188

Medicaid State Plan Eligibility

Income/Resource Methodologies

Eligibility Determinations of Individuals Age 65 or Older or Who Have Blindness or a Disability

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Package Header

Package ID	WA2019MS0004O	SPA ID	WA-20-0030
Submission Type	Official	Initial Submission Date	6/30/2020
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	User-Entered		

A. Eligibility Determinations of Individuals Who Are Age 65 or Older or Who Have Blindness or a Disability

Eligibility determinations of individuals who are age 65 or older or who have blindness or a disability are based on one of the following:

- ☒

1. SSA Eligibility Determination State (1634 State)

The state has an agreement under section 1634 of the Social Security Act for the Social Security Administration to determine Medicaid eligibility of SSI beneficiaries. For all other individuals who seek Medicaid eligibility on the basis of being age 65 or older or having blindness or a disability, the state requires a separate Medicaid application and determines financial eligibility based on SSI income and resource methodologies.
- ☐

2. State Eligibility Determination (SSI Criteria State)

The state requires all individuals who seek Medicaid eligibility on the basis of being age 65 or older or having blindness or a disability, including SSI beneficiaries, to file a separate Medicaid application, and determines financial eligibility based on SSI income and resource methodologies.
- ☐

3. State Eligibility Determination (209(b) State)

The state requires all individuals who seek Medicaid eligibility on the basis of being age 65 or older or having blindness or a disability, including SSI beneficiaries, to file a separate Medicaid application, and determines financial eligibility using income and resource methodologies more restrictive than SSI.

B. Additional information (optional)

Medicaid State Plan Eligibility

Income/Resource Methodologies

Non-MAGI Methodologies

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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The state will apply the methodologies as described below, and consistent with 42 CFR 435.601, 435.602, and 435.831.

A. Basic Financial Methodology

- 1. The state applies the income and resource methodologies of the SSI program when determining eligibility for a population based on age (65 or older) or having blindness or a disability, with the exceptions described below in B. through G.
- 2. The state applies the financial methodologies of either the SSI program or the AFDC program in effect as of July 16, 1996 (whichever is most closely related) when determining eligibility for a population based on age (as a child), pregnancy, or status as a caretaker relative, with the exceptions described below in B. through G.

B. Use of Less Restrictive Methodologies

- 1. The state elects to apply income and/or resources methodologies that are less restrictive than those used under the cash assistance programs, in accordance with 42 CFR 435.601(d).

☒ Yes

☐ No
- 2. The less restrictive income and resource methodologies are described on the RU for each applicable eligibility group.

Non-MAGI Methodologies

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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C. Financial Responsibility of Relatives

1. In determining financial eligibility for an individual, the state does not include income and resources from anyone other than the individual's spouse, and for individuals under age 21 or who have blindness or disability, the individual's parent.
- a.The state includes the income and resources of a spouse or parent only when they are living with the individual in the same household, except as follows:
 - i. In the case of spouses who are age 65 or older or who have blindness or disability and who share the same room in a Medicaid institution, the state:
 - ☒ (1) Considers these couples either as living together or as living separately for the purpose of counting income and resources, whichever is more advantageous to the couple.
 - ☐ (2) Considers these couples as living separately for the purpose of counting income and resources.
 - ii. Where applicable, the state determines income and resource eligibility consistent with the spousal impoverishment rules of section 1924 of the Act, as described in the Resource Assessment and Eligibility reviewable unit.
 - b. In the case of individuals under age 21 for whom AFDC is the most closely related cash assistance program, the income and resources of parents and spouses are included only if the individual would have been considered a dependent under the state's approved AFDC state plan in effect as of July 16, 1996.

Non-MAGI Methodologies

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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D. Family Size

1. The family size of an individual for whom the SSI income and resource methodologies are used (as described in section A) includes the persons identified below:
- a. The individual applying, or
 - b. If the individual lives together with his or her spouse, the individual applying and the spouse, or
 - c. If the individual lives together with his or her parent(s) and the individual is under 21 or has blindness or a disability, the individual applying and the parent(s).
2. The family size of an individual for whom the AFDC income and resource methodologies are used (as described in section A.), includes the persons who would have been included in the family under the state's July 16, 1996 AFDC state plan, except where the state has elected to use the MAGI-like methodologies (as described in section E).
3. The state defines family size for one or more of the following FPL eligibility groups to include others beyond those identified in D.1. and D.2.
- ☒ Yes
 - ☐ No
 - ☒ a. Qualified Medicare Beneficiaries (described in section 1902(a)(10)(E)(i) of the Act)
 - ☒ b. Specified Low Income Medicare Beneficiaries (described in section 1902(a)(10)(E)(iii) of the Act)
 - ☒ c. Qualifying Individuals (described in section 1902(a)(10)(E)(iv) of the Act)
 - ☒ d. Qualified Disabled and Working Individuals (described in section 1902(a)(10)(E)(ii) of the Act)
 - ☐ e. Age and Disability-Related Poverty Level (described in section 1902(a)(10)(A)(ii)(X) of the Act)
 - ☐ f. Work Incentives (described in section 1902(a)(10)(A)(ii)(XIII) of the Act)
 - ☐ g. Family Opportunity Act Children with a Disability (described in section 1902(a)(10)(A)(ii)(XIX) of the Act)
 - ☐ h. Individuals Receiving State Plan Home and Community-Based Services (described in 42 CFR 435.219)
4. The state uses the same definition of family size for the selected FPL eligibility groups.
- ☒ Yes
 - ☐ No
5. For the selected FPL eligibility groups, family size is defined as follows:
- ☒ a. Family is defined as the individual, the individual's spouse and the individual's children under age 18 living together in the same household. If the individual is a child, the child's parents and siblings under age 18 are also included in the household if living together.
- Optional description:**
- ☐ b. The state uses another definition of family.

Non-MAGI Methodologies

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Package Header

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Superseded SPA ID	WA-19-0002		
	User-Entered		

E. Use of MAGI-like Methodologies

1. The state uses MAGI-like methodologies for one or more populations for whom the most closely related cash assistance program would be the AFDC program in effect as of July 16, 1996.

- ☐ Yes
- ☒ No

Non-MAGI Methodologies

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F. Countable Income Deductions for the Medically Needy

In determining countable income for individuals who are age 65 or older or who have blindness or a disability, the state deducts:

1. Amounts that would be deducted in determining eligibility under SSI.
2. The highest amounts that would be deducted in determining eligibility for optional state supplements if these supplements are paid to all individuals who are receiving SSI or would be eligible for SSI except for their income.

Non-MAGI Methodologies

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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Superseded SPA ID	WA-19-0002		
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G. Additional Information (optional)

Medicaid State Plan Eligibility

Income/Resource Standards

Medically Needy Income Level

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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Superseded SPA ID	WA-05-002		
	User-Entered		

A. Income Level Used

1. The state employs a single income level for the medically needy.
2. The income level varies based on differences between shelter costs in urban and rural areas.

☐ Yes

☒ No

3. The level used is:

Household size	Standard
1	\$467.00
2	\$592.00
3	\$667.00
4	\$742.00
5	\$858.00
6	\$975.00
7	\$1125.00
8	\$1242.00
9	\$1358.00
10	\$1483.00

The state uses an additional incremental amount for larger household sizes.

☐ Yes

☒ No

The dollar amounts increase automatically each year

☐ Yes

☒ No

Medically Needy Income Level

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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B. Basis for Income Level

1. Minimum Income Level

The minimum income level for this eligibility group is the lower of the state's July 1996 AFDC payment standard or the state's income standard for the Parents and Other Caretaker Relatives eligibility group.
2. Maximum Income Level

The maximum income level for this eligibility group is 133 1/3 percent of the higher of the state's 1996 AFDC payment standard or the state's income standard for the Parents and Other Caretaker Relatives eligibility group.

Medically Needy Income Level

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Superseded SPA ID	WA-05-002		
	User-Entered		

C. Additional Information (optional)

Medicaid State Plan Eligibility

Income/Resource Standards

Handling of Excess Income (Spenddown)

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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User-Entered			

If countable income exceeds the income standard, the state must deduct from income medical expenses incurred by the individual or family or financially responsible relatives that are not subject to payment by a third party, in accordance with 42 CFR 435.831 and 42 CFR 435.121.

A. Budget Periods

Income in excess of the appropriate income standard is considered available for payment of medical or remedial care expenses in budget periods that do not exceed six months.

1. In determining income eligibility, countable income is reduced by the amount of incurred medical or remedial care expenses during the budget period specified below:

- ☐ a. One budget period of:
- ☒ b. More than one budget period, as described below:

☒ i. Community budget period

Length of budget period:

- ☒ (1) 6 months
- ☐ (2) 5 months
- ☐ (3) 4 months
- ☐ (4) 3 months
- ☐ (5) 2 months
- ☐ (6) 1 month

- ☒ ii. Institutional budget period

Length of budget period:

- ☒ (1) 6 months
- ☐ (2) 5 months
- ☐ (3) 4 months
- ☐ (4) 3 months
- ☐ (5) 2 months
- ☐ (6) 1 month

- ☒ iii. Other budget period

Name of other budget period:	Length of budget period:	Description:
Institutional optional budget period	(4) 3 months	Beneficiary may choose a 3 month budget period, if advantageous to them.
Community optional budget period	(4) 3 months	Beneficiary may choose a 3 month budget period, if advantageous to them.

2. The state includes part or all of the retroactive period in the budget period.

- ☒ Yes
- ☐ No

Handling of Excess Income (Spenddown)

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B. Types of Eligible Expenses

1. In determining incurred expenses to be deducted from income, the state includes:

- Medicare, Medicaid, and other health insurance premiums and enrollment fees.
- Cost sharing, including copayments, coinsurance, and deductibles, imposed by Medicare, Medicaid or other health insurance.
- Expenses for necessary medical and remedial services recognized by state law but not included in the state plan.
- Expenses for necessary medical and remedial services included in the state plan, including those that exceed limitations on the amount, duration, and scope of services.

2. The state also includes medical institutional expenses projected to the end of the budget period at the Medicaid reimbursement rate.

- ☒ Yes
- ☐ No

3. Incurred expenses subject to payment by a third party are not deducted unless the third party is a public program (other than Medicaid) of a state and the program is financed by the state.

Handling of Excess Income (Spendedown)

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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User-Entered			

C. Timeframe of Deduction of Expenses

In determining incurred expenses to be deducted from income, the state deducts:

1. For retroactive budget periods and a budget period that includes both retroactive and prospective budget, the state deducts:

a. Eligible expenses incurred during the budget period, whether paid or unpaid.

b. Payments made during the budget period on eligible expenses incurred at any time prior to the budget period, if not previously deducted in establishing eligibility.

c. Unpaid eligible expenses, which have not been deducted previously in establishing eligibility, and were incurred:

☒ i. At any time prior to the budget period.

☐ ii. Prior to the third month before the month of application, but no earlier than:

☐ iii. No earlier than the third month before the month of application.
2. For prospective budget period(s), the state deducts:

a. Eligible expenses incurred during the budget period, whether paid or unpaid.

b. Payments made during the budget period on eligible expenses incurred at any time prior to the budget period, if not previously deducted in establishing eligibility.

c. Unpaid eligible expenses that are carried over from the prior budget period and have not been deducted previously in establishing eligibility.

Handling of Excess Income (Spendedown)

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D. Order of Deduction of Expenses

Incurred medical or remedial care expenses are deducted in the following order:

- ☒ 1. By the type of service, in the following order:
 - a. Premiums, deductibles, coinsurance and co-payments.
 - b. Expenses for necessary medical or remedial care services that are recognized under state law but not included in the State Plan.
 - c. Expenses for necessary medical or remedial care services that are included in the state Plan that exceed agency limitations on amount, duration, or scope of services.
 - d. Expenses for necessary medical or remedial care services that are included in the state Plan that are within the agency limitations on amount, duration, or scope of services.
- ☐ 2. In chronological order by the date of the service, or the date cost sharing payments are due.
- ☐ 3. In chronological order by the date the bill is submitted to the state by the individual.

Handling of Excess Income (Spenddown)

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E. Reasonable Limitations

The state sets reasonable limits on the amount to be deducted for expenses.

- ☐ Yes
- ☒ No

Handling of Excess Income (Spenddown)

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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User-Entered			

F. Spenddown Payments Made by Individuals

The state permits individuals to pay-in their spenddown liability.

- ☐ Yes
- ☒ No

Handling of Excess Income (Spenddown)

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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	User-Entered		

G. Additional Information (optional)

Medicaid State Plan Eligibility

Income/Resource Standards

Medically Needy Resource Level

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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	User-Entered		

A. Medically Needy Resource Level Structure

1. The state employs a single resource level for the medically needy.
2. The resource level is equal to or higher than the lowest resource standard used under the most closely related cash assistance program.

Medically Needy Resource Level

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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	User-Entered		

B. Resource Level Used

The level used is:

Household size	Standard
1	\$2000.00
2	\$3000.00

The state uses an additional incremental amount for larger household sizes.

- ☒ Yes
- ☐ No

Incremental Amount:
\$50.00

Medically Needy Resource Level

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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C. Additional Information (optional)

Medicaid State Plan Eligibility

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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Superseded SPA ID	WA-19-0002		
	System-Derived		

Mandatory Coverage

A. The state provides Medicaid to mandatory groups of individuals. The mandatory groups covered are:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Infants and Children under Age 19		☒	☐	☐	APPROVED
Parents and Other Caretaker Relatives		☒	☐	☐	CONVERTED
Pregnant Women		☒	☐	☐	APPROVED
Deemed Newborns		☒	☐	☐	NEW
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care		☒	☐	☐	APPROVED
Former Foster Care Children		☒	☐	☐	APPROVED
Transitional Medical Assistance		☒	☐	☐	APPROVED
Extended Medicaid due to Spousal Support Collections		☒	☐	☐	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
SSI Beneficiaries		☒	☐	☐	NEW
Closed Eligibility Groups		☒	☐	☐	APPROVED
Individuals Deemed To Be Receiving SSI		☒	☐	☐	NEW
Working Individuals under 1619(b)		☒	☐	☐	APPROVED
Qualified Medicare Beneficiaries		☒	☒	☐	APPROVED
Qualified Disabled and Working Individuals		☒	☐	☐	NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Specified Low Income Medicare Beneficiaries		☒	☒	☐	APPROVED
Qualifying Individuals		☒	☒	☐	APPROVED

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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	System-Derived		

B. The state elects the Adult Group, described at 42 CFR 435.119.

☒ Yes ☐ No

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Adult Group		☒	☐	☐	CONVERTED

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Qualified Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Individuals with income equal to or less than 100% of the FPL, who are entitled to Medicare Part A, and who qualify for Medicare cost-sharing.

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	User-Entered		

The state covers the mandatory qualified Medicare beneficiaries group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are entitled to hospital insurance benefits under part A of title XVIII (Medicare Part A), including individuals who have purchased a premium to enroll in Part A.
2. Have income and resources at or below the standard for this group.

Qualified Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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	User-Entered		

B. Financial Methodologies

1. SSI methodologies are used in calculating household income. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

- ☒ Yes
- ☐ No

The less restrictive income methodologies are:

☒ Census Bureau wages are disregarded.

Description of disregard:

Wages paid by the Census Bureau for temporary employment related to census activities are excluded.

☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
Income tax obligation	Unearned income withheld, prior receipt by the individual, for income tax purposes, or otherwise withheld beyond the individual's control, is considered exempt when determining eligibility
MSP	When determining the available income of an individual for the QMB or SLMB program the agency shall exclude from countable income an amount equal to that expended on medical expenses.

3. Less restrictive methodologies are used in calculating countable resources.

- ☒ Yes
- ☐ No

The less restrictive resource methodologies are:

☒ A specified type of resource is disregarded:

Name of resource type:	Description:
Independence Account - earnings while enrolled in MBI	Designated separate account that consists only of earnings resulting from work activity while enrolled in the Ticket and BBA work incentives eligibility groups.
Sales contract resource	Effective August 1, 1993, to the extent that it is not transferred, a sales contract on property that was the principal place of residence at the time of institutionalization is an exempt resource. The contract must provide a reasonable rate of return: 1) the interest is consistent with prevailing rates at the time of the sale; and 2) the payment of amount owed is anticipated within the lifetime of the client but does not exceed thirty years. Both interest and principal received in the form of payments are considered unearned income, unless otherwise exempted.
IDA account	All funds in IDA accounts funded under the Assets for Independence Act
20 days	Non-cash resources, which cannot be expected to be converted into cash within 20 working days, are not considered available to the extent that an ongoing bona fide effort to convert them into cash is unsuccessful.

Name of resource type:	Description:
Holocaust survivor	When determining the countable resources for a Holocaust survivor, exclude recoveries of insurance proceeds or other assets.

Qualified Medicare Beneficiaries

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	User-Entered		

C. Income Standard Used

The amount of the income standard for this group is 100% FPL.

D. Resource Standard Used

The resource standard is the same used to determine eligibility for the Medicare Part D full-benefit low-income subsidy (LIS) (but without regard to the life insurance policy exclusion applied in LIS resource eligibility determinations). This standard is three times the SSI resource standard, adjusted annually in accordance with the consumer price index.

E. Medical Assistance Provided

Medical assistance is limited to payment of co-insurance and deductibles for Medicare Parts A, B and C and payment for the premiums for Medicare Parts A and B.

Medical assistance begins the first day of the month following the month in which the individual is determined to qualify for this eligibility group.

Qualified Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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	User-Entered		

F. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Specified Low Income Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Individuals with income above 100% and below 120% of the FPL who are entitled to Medicare Part A, who qualify for payment of Medicare Part B premiums.

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Superseded SPA ID	WA-10-007		
	User-Entered		

The state covers the mandatory specified low income Medicare beneficiaries group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Would qualify as Qualified Medicare Beneficiaries (described in section 1905(p)(1) of the Act), except that their income exceeds the income level for that eligibility group.
2. Have income below the income standard and resources at or below the resource standard for this group.

Specified Low Income Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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	User-Entered		

B. Financial Methodologies

1. SSI methodologies are used in calculating household income. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

- ☒ Yes
- ☐ No

The less restrictive income methodologies are:

- ☒ Census Bureau wages are disregarded.

Description of disregard:

Wages paid by the Census Bureau for temporary employment related to census activities are excluded.

- ☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
Income tax obligation	Unearned income withheld, prior receipt by the individual, for income tax purposes, or otherwise withheld beyond the individual's control, is considered exempt when determining eligibility
MSP	When determining the available income of an individual for the QMB or SLMB program the agency shall exclude from countable income an amount equal to that expended on medical expenses.

3. Less restrictive methodologies are used in calculating countable resources.

- ☒ Yes
- ☐ No

The less restrictive resource methodologies are:

- ☒ A specified type of resource is disregarded:

Name of resource type:	Description:
Independence Account - earnings while enrolled in MBI	Designated separate account that consists only of earnings resulting from work activity while enrolled in the Ticket and BBA work incentives eligibility groups.
Sales contract resource	Effective August 1, 1993, to the extent that it is not transferred, a sales contract on property that was the principal place of residence at the time of institutionalization is an exempt resource. The contract must provide a reasonable rate of return: 1) the interest is consistent with prevailing rates at the time of the sale; and 2) the payment of amount owed is anticipated within the lifetime of the client but does not exceed thirty years. Both interest and principal received in the form of payments are considered unearned income, unless otherwise exempted.
IDA account	All funds in IDA accounts funded under the Assets for Independence Act
20 days	Non-cash resources, which cannot be expected to be converted into cash within 20 working days, are not considered available to the extent that an ongoing bona fide effort to convert them into cash is unsuccessful.

Name of resource type:	Description:
Holocaust survivor	When determining the countable resources for a Holocaust survivor, exclude recoveries of insurance proceeds or other assets.

Specified Low Income Medicare Beneficiaries

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	User-Entered		

C. Income Standard Used

Family income must be above 100% FPL and below 120% FPL.

D. Resource Standard Used

The resource standard is the same used to determine eligibility for the Medicare Part D full-benefit low-income subsidy (LIS) (but without regard to the life insurance policy exclusion applied in LIS resource eligibility determinations). This standard is three times the SSI resource standard, adjusted annually in accordance with the consumer price index.

E. Medical Assistance Provided

Medical assistance is limited to payment for Medicare Part B premiums.

Specified Low Income Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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F. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Qualifying Individuals

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Individuals with income at or above 120% and below 135% of the FPL who are entitled to Medicare Part A, who qualify for payment of Medicare Part B premiums.

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Package ID	WA2019MS0004O	SPA ID	WA-20-0030
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Superseded SPA ID	WA-10-007		
	User-Entered		

The state covers the mandatory qualifying individuals group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet all of the following criteria:

1. Would qualify as Qualified Medicare Beneficiaries (described in section 1905(p)(1) of the Act), except that their income exceeds the income level for that eligibility group.
2. Are not otherwise eligible for Medicaid under the state plan.
3. Have income below the income standard and resources at or below the resource standard for this group.

Qualifying Individuals

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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	User-Entered		

B. Financial Methodologies

1. SSI methodologies are used in calculating household income. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

- ☒ Yes
- ☐ No

The less restrictive income methodologies are:

- ☒ Census Bureau wages are disregarded.

Description of disregard:

Wages paid by the Census Bureau for temporary employment related to census activities are excluded.

- ☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
Income tax obligation	Unearned income withheld, prior receipt by the individual, for income tax purposes, or otherwise withheld beyond the individual's control, is considered exempt when determining eligibility

3. Less restrictive methodologies are used in calculating countable resources.

- ☒ Yes
- ☐ No

The less restrictive resource methodologies are:

- ☒ A specified type of resource is disregarded:

Name of resource type:	Description:
Independence Account - earnings while enrolled in MBI	Designated separate account that consists only of earnings resulting from work activity while enrolled in the Ticket and BBA work incentives eligibility groups.
Sales contract resource	Effective August 1, 1993, to the extent that it is not transferred, a sales contract on property that was the principal place of residence at the time of institutionalization is an exempt resource. The contract must provide a reasonable rate of return: 1) the interest is consistent with prevailing rates at the time of the sale; and 2) the payment of amount owed is anticipated within the lifetime of the client but does not exceed thirty years. Both interest and principal received in the form of payments are considered unearned income, unless otherwise exempted.
IDA account	All funds in IDA accounts funded under the Assets for Independence Act
20 days	Non-cash resources, which cannot be expected to be converted into cash within 20 working days, are not considered available to the extent that an ongoing bona fide effort to convert them into cash is unsuccessful.
Holocaust survivor	When determining the countable resources for a Holocaust survivor, exclude recoveries of insurance proceeds or other assets.

Qualifying Individuals

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Package Header

Package ID	WA2019MS0004O	SPA ID	WA-20-0030
Submission Type	Official	Initial Submission Date	6/30/2020
Approval Date	02/10/2021	Effective Date	4/1/2020
Superseded SPA ID	WA-10-007		
	User-Entered		

C. Income Standard Used

Family income must be at or above 120% FPL and below 135% FPL.

D. Resource Standard Used

The resource standard is the same used to determine eligibility for the Medicare Part D full-benefit low-income subsidy (LIS) (but without regard to the life insurance policy exclusion applied in LIS resource eligibility determinations). This standard is three times the SSI resource standard, adjusted annually in accordance with the consumer price index.

E. Medical Assistance Provided

Medical assistance is limited to payment for Medicare Part B premiums.

Qualifying Individuals

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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	User-Entered		

F. Additional Information (optional)

Medicaid State Plan Eligibility

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Package Header

Package ID	WA2019MS0004O	SPA ID	WA-20-0030
Submission Type	Official	Initial Submission Date	6/30/2020
Approval Date	02/10/2021	Effective Date	4/1/2020
Superseded SPA ID	WA-20-0006		
User-Entered			

A. Options for Coverage

The state provides Medicaid to specified optional groups of individuals.

☒ Yes ☐ No

The optional eligibility groups covered in the state plan are (elections made in this screen may not be comprehensive during the transition period from the paper-based state plan to MACPro):

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Optional Coverage of Parents and Other Caretaker Relatives		☐	☐	☐	NEW
Reasonable Classifications of Individuals under Age 21		☒	☐	☐	APPROVED
Children with Non-IV-E Adoption Assistance		☒	☐	☐	APPROVED
Independent Foster Care Adolescents		☐	☐	☐	NEW
Optional Targeted Low Income Children		☐	☐	☐	NEW
Individuals above 133% FPL under Age 65		☐	☐	☐	APPROVED
Individuals Needing Treatment for Breast or Cervical Cancer		☒	☐	☐	APPROVED
Individuals Eligible for Family Planning Services		☐	☐	☐	NEW
Individuals with Tuberculosis		☐	☐	☐	NEW
Individuals Electing COBRA Continuation Coverage		☐	☐	☐	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Individuals Eligible for but Not Receiving Cash Assistance		☒	☒	☐	APPROVED

Eligibility Group Name		Covered In State Plan	Include RU In Package 	Included in Another Submission Package	Source Type 
Individuals Eligible for Cash Except for Institutionalization		☒	☒	☐	APPROVED
Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules		☒	☒	☐	APPROVED
Optional State Supplement Beneficiaries		☐	☐	☐	NEW
Individuals in Institutions Eligible under a Special Income Level		☒	☐	☐	NEW
PACE Participants		☒	☐	☐	NEW
Individuals Receiving Hospice		☒	☐	☐	NEW
Children under Age 19 with a Disability		☐	☐	☐	NEW
Age and Disability-Related Poverty Level		☐	☐	☐	NEW
Work Incentives		☒	☒	☐	APPROVED
Ticket to Work Basic		☒	☒	☐	APPROVED
Ticket to Work Medical Improvements		☒	☒	☐	APPROVED
Family Opportunity Act Children with a Disability		☐	☐	☐	NEW
Individuals Receiving State Plan Home and Community-Based Services		☐	☐	☐	NEW
Individuals Receiving State Plan Home and Community-Based Services Who Are Otherwise Eligible for HCBS Waivers		☐	☐	☐	NEW

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Package Header

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Approval Date	02/10/2021	Effective Date	4/1/2020
Superseded SPA ID	WA-20-0006		
User-Entered			

B. Medically Needy Options for Coverage

The state provides Medicaid to specified groups of individuals who are medically needy.

☒ Yes ☐ No

The medically needy eligibility groups covered in the state plan are:

1. Mandatory Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Medically Needy Pregnant Women		☒	☐	☐	NEW
Medically Needy Children under Age 18		☒	☐	☐	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Protected Medically Needy Individuals Who Were Eligible in 1973		☒	☐	☐	NEW

2. Optional Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Medically Needy Reasonable Classifications of Individuals under Age 21		☒	☐	☐	NEW
Medically Needy Parents and Other Caretaker Relatives		☐	☐	☐	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Medically Needy Populations Based on Age, Blindness or Disability		☒	☒	☐	APPROVED

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Package Header

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Superseded SPA ID	WA-20-0006		
	User-Entered		

C. Additional Information (optional)

Effective January 1, 2019, Washington no longer covers the Medicaid eligibility group for individuals who qualify on the basis of receiving optional state supplement payments (1902(a)(10)(A)(ii)(XI) 42 CFR 435.232 and 435.434).

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Individuals Eligible for but Not Receiving Cash Assistance

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Individuals who are eligible for but not receiving federal cash assistance or an optional state supplement.

Package Header

Package ID	WA2019MS0004O	SPA ID	WA-20-0030
Submission Type	Official	Initial Submission Date	6/30/2020
Approval Date	02/10/2021	Effective Date	4/1/2020
Superseded SPA ID	WA-91-22		
	User-Entered		

The state covers the optional Individuals Eligible for but Not Receiving Cash Assistance eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Meet the eligibility requirements of at least one of the following cash assistance programs:
- ☒ a. SSI

☐ b. Optional State Supplement

☐ c. AFDC
2. Do not receive cash assistance under these programs.

Individuals Eligible for but Not Receiving Cash Assistance

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Package Header

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Superseded SPA ID	WA-91-22		
	User-Entered		

B. Individuals Covered

1. The state covers all individuals who meet the characteristics described in section A.

- ☒ Yes
- ☐ No

Individuals Eligible for but Not Receiving Cash Assistance

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Package Header

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Superseded SPA ID	WA-91-22		
	User-Entered		

C. Financial Methodologies

1. In calculating household income and resources for individuals who are seeking eligibility on the basis of being age 65 or older or having blindness or disability, SSI methodologies are used. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

3. Less restrictive methodologies are used in calculating countable income.

- ☒ Yes
- ☐ No

The less restrictive income methodologies are:

☒ Census Bureau wages are disregarded.

Description of disregard:

Wages paid by the Census Bureau for temporary employment related to census activities are excluded.

☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
Income tax obligation	Unearned income withheld, prior receipt by the individual, for income tax purposes, or otherwise withheld beyond the individual's control, is considered exempt when determining eligibility

4. Less restrictive methodologies are used in calculating countable resources.

- ☒ Yes
- ☐ No

The less restrictive resource methodologies are:

☒ A specified type of resource is disregarded:

Name of resource type:	Description:
Independence Account - earnings while enrolled in MBI	Designated separate account that consists only of earnings resulting from work activity while enrolled in the Ticket and BBA work incentives eligibility groups.
Sales contract resource	Effective August 1, 1993, to the extent that it is not transferred, a sales contract on property that was the principal place of residence at the time of institutionalization is an exempt resource. The contract must provide a reasonable rate of return: 1) the interest is consistent with prevailing rates at the time of the sale; and 2) the payment of amount owed is anticipated within the lifetime of the client but does not exceed thirty years. Both interest and principal received in the form of payments are considered unearned income, unless otherwise exempted.
IDA account	All funds in IDA accounts funded under the Assets for Independence Act
20 days	Non-cash resources, which cannot be expected to be converted into cash within 20 working days, are not considered available to the extent that an ongoing bona fide effort to convert them into cash is unsuccessful.

Name of resource type:	Description:
Holocaust survivor	When determining the countable resources for a Holocaust survivor, exclude recoveries of insurance proceeds or other assets.

Individuals Eligible for but Not Receiving Cash Assistance

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Package Header

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Superseded SPA ID	WA-91-22		
	User-Entered		

D. Income Standard Used

The income standard used is the standard of the most closely related cash assistance program.

E. Resource Standard Used

The resource standard used is the standard of the most closely related cash assistance program.

Individuals Eligible for but Not Receiving Cash Assistance

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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	User-Entered		

F. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Individuals Eligible for Cash Except for Institutionalization

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Individuals who would be eligible for federal cash assistance or an optional state supplement, except for institutionalization.

Package Header

Package ID	WA2019MS0004O	SPA ID	WA-20-0030
Submission Type	Official	Initial Submission Date	6/30/2020
Approval Date	02/10/2021	Effective Date	4/1/2020
Superseded SPA ID	WA 91-22		
	User-Entered		

The state covers the optional Individuals Eligible for Cash Except for Institutionalization eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are in a medical institution.
2. Would meet the eligibility requirements for at least one of the following cash assistance programs, but for the lower income standards used to determine eligibility for institutionalized individuals:

☒ a. SSI

☐ b. Optional State Supplement

☒ c. AFDC

Individuals Eligible for Cash Except for Institutionalization

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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Superseded SPA ID	WA 91-22		
	User-Entered		

B. Individuals Covered

1. The state covers all individuals who meet the characteristics described in section A.

- ☒ Yes
- ☐ No

Individuals Eligible for Cash Except for Institutionalization

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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Superseded SPA ID	WA 91-22		
	User-Entered		

C. Financial Methodologies

1. In calculating household income and resources for individuals who are seeking eligibility on the basis of being age 65 or older or having blindness or disability, SSI methodologies are used. Please refer as necessary to Non-MAGI Methodologies, completed by the state.
2. In calculating household income and resources for populations for which AFDC is the most closely related program, the following methodology(ies) are used:
- ☐ a. MAGI-like methodologies. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

☒ b. AFDC methodologies. Please refer as necessary to Non-MAGI Methodologies, completed by the state.
3. Less restrictive methodologies are used in calculating countable income.
- ☒ Yes

☐ No

The less restrictive income methodologies are:

- ☒ The difference between one income standard and another is disregarded.

☐ Between the following percentages of the FPL:

☐ Between the medically needy income limit and a percentage of the FPL:

☐ Between the SSI Federal Benefit Rate and:

☒ Between other income standards:

Between this standard:

TANF payment standard by family size

and this standard:

AFDC payment standard by family size
- ☒ The following less restrictive methodologies are used:
- | Name of methodology: | Description: |
|-----------------------|---|
| community income | Effective July 1, 1986, if the community income received in the name of the non-applicant or ineligible spouse, living in a separate residence, exceeds the community income received in the name of the applicant/recipient spouse, the applicant/recipient spouse's interest in that excess is considered unavailable to the applicant/recipient. |
| income tax obligation | Unearned income withheld, prior receipt by the individual, for income tax purposes, or otherwise withheld beyond the individual's control, is considered exempt when determining eligibility |
| FBR and CN | Disregard income equal to the difference between the Federal Benefit Rate and the Categorically Needy Income Level for individuals and couples as in effect on January 1, 2002 |
4. Less restrictive methodologies are used in calculating countable resources.

☒ Yes

☐ No
- The less restrictive resource methodologies are:
- ☒ A specified type of resource is disregarded:
- https://macpro.cms.gov/suite/tempo/records/item/wx3_IL4_I3tU-K3fpHgVHrSVQH5jI6UbV6fRlXofCAeo4fdnEQ9w_Gd7WfNxY_BKkgh1U11kTq0P6V...

51/85

Name of resource type:	Description:
property sales contract	Effective August 1, 1993, to the extent that it is not transferred, a sales contract on property that was the principal place of residence at the time of institutionalization is an exempt resource. The contract must provide a reasonable rate of return: 1) the interest is consistent with prevailing rates at the time of the sale; and 2) the payment of amount owed is anticipated within the lifetime of the client but does not exceed thirty years. Both interest and principal received in the form of payments are considered unearned income, unless otherwise exempted.

☒ A beneficiary of a "qualified state long-term care insurance partnership" policy (partnership policy), as defined in section 1917(b)(1)(C) of the Social Security Act and 45 CFR 144.200 et seq., is provided a resource disregard, equal to the amount of the insurance benefit payments made to or on behalf of the individual from the partnership policy.

☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
One-half resources	Effective January 1, 1989, it is presumed that one-half of the total resources held jointly by the husband and wife, or held separately by the applicant/recipient, are owned by each spouse (TN 89-2, Approved 8/17/90)
Independence Account - earnings while enrolled in MBI	Designated separate account that consists only of earnings resulting from work activity while enrolled in the Ticket and BBA work incentives eligibility groups.
IDA account	All funds in IDA accounts funded under the Assets for Independence Act
20 days	Non-cash resources, which cannot be expected to be converted into cash within 20 working days, are not considered available to the extent that an ongoing bona fide effort to convert them into cash is unsuccessful.
Holocaust survivor	When determining the countable resources for a Holocaust survivor, exclude recoveries of insurance proceeds or other assets.
Non-exempt resources	Non-exempt resources in excess of the Medically Needy resource levels can, at the individuals option, be reduced by allowable incurred expenses as long as such expenses have not been used to reduce excess income.

Individuals Eligible for Cash Except for Institutionalization

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Package Header

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Superseded SPA ID	WA 91-22		
	User-Entered		

D. Income Standard Used

The income standard used is the standard of the most closely related cash assistance program.

E. Resource Standard Used

The resource standard used is the standard of the most closely related cash assistance program.

Individuals Eligible for Cash Except for Institutionalization

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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F. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Individuals who would be eligible for Medicaid if they were in an institution and who receive home and community-based services.

Package Header

Package ID	WA2019MS0004O	SPA ID	WA-20-0030
Submission Type	Official	Initial Submission Date	6/30/2020
Approval Date	02/10/2021	Effective Date	4/1/2020
Superseded SPA ID	WA 08-027		
	User-Entered		

The state operates the Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Would be eligible for Medicaid if in a medical institution.
2. But for the provision of home and community-based services under a waiver granted under section 1915(c), (d) or (e) of the Act:
 - a. For waivers granted under 1915(c), the individuals would otherwise require the level of care furnished in a hospital, a nursing facility or an intermediate care facility for individuals with intellectual disabilities.
 - b. For waivers granted under 1915(d) or (e), the individuals would otherwise require the level of care furnished in a hospital or nursing facility.
3. Will receive the waived services.

Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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Package ID	WA2019MS0004O	SPA ID	WA-20-0030
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Approval Date	02/10/2021	Effective Date	4/1/2020
Superseded SPA ID	WA 08-027		
	User-Entered		

B. Income and Resource Methodologies

1. The income and resource methodologies used for this group are those used to determine eligibility for a state plan group under which the individual would be eligible if in an institution.

2. Less restrictive methodologies are used in calculating countable income.

- ☒ Yes
- ☐ No

The less restrictive income methodologies are:

☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
community income	Effective July 1, 1986, if the community income received in the name of the non-applicant or ineligible spouse, living in a separate residence, exceeds the community income received in the name of the applicant/recipient spouse, the applicant/recipient spouse's interest in that excess is considered unavailable to the applicant/recipient.
income tax obligation	Unearned income withheld, prior receipt by the individual, for income tax purposes, or otherwise withheld beyond the individual's control, is considered exempt when determining eligibility

3. Less restrictive methodologies are used in calculating countable resources.

- ☒ Yes
- ☐ No

The less restrictive resource methodologies are:

☒ A specified type of resource is disregarded:

Name of resource type:	Description:
Independence Account - earnings while enrolled in MBI	Designated separate account that consists only of earnings resulting from work activity while enrolled in the Ticket and BBA work incentives eligibility groups.

☒ A beneficiary of a "qualified state long-term care insurance partnership" policy (partnership policy), as defined in section 1917(b)(1)(C) of the Social Security Act and 45 CFR 144.200 et seq., is provided a resource disregard, equal to the amount of the insurance benefit payments made to or on behalf of the individual from the partnership policy.

Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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	User-Entered		

C. Income and Resource Standards

The income and resource standards used for this group are those used to determine eligibility for a state plan group under which the individual would be eligible if in an institution.

Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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Superseded SPA ID	WA 08-027		
	User-Entered		

D. Additional Information (optional)

Eligibility Groups - Options for Coverage

Work Incentives

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Individuals with a disability with income below 250% of the FPL, who would qualify for SSI except for earned income.

Package Header

Package ID	WA2019MS0004O	SPA ID	WA-20-0030
Submission Type	Official	Initial Submission Date	6/30/2020
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Superseded SPA ID	WA-20-0006		
	User-Entered		

The state covers the optional Work Incentives eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

- 1. Have earned income.
- 2. Meet the SSI definition of disability, but for earned income.
- 3. Meet income and resource standards following a two-step process, which includes:
 - a. Step One - A comparison of family net income to 250% FPL; and
 - b. Step Two - A comparison of individual net income and resources to the SSI standards, excluding earned income.

Work Incentives

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Package Header

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Superseded SPA ID	WA-20-0006		
	User-Entered		

B. Step One Financial Methodologies and Income Test

1. Financial methodologies

a. SSI methodologies are used in calculating family income. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

b. Less restrictive methodologies are used in calculating countable income.

☒ Yes

☐ No

The less restrictive income methodologies are:

☒ All income is disregarded. No income test is applied.

2. Income Test

Family net income must be less than 250% FPL. Please refer as necessary to Non-MAGI Methodologies for the definition of family size.

Work Incentives

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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Superseded SPA ID	WA-20-0006		
User-Entered			

C. Step Two Financial Methodologies and Income/Resource Test

1. Financial methodologies

- a. SSI methodologies are used in calculating income and resources, except that earned income is not counted. Please refer as necessary to Non-MAGI Methodologies, completed by the state.
- b. Less restrictive methodologies are used in calculating countable income.
- ☒ Yes
- ☐ No

The less restrictive income methodologies are:

- ☒ All income is disregarded. No income test is applied.
- c. Less restrictive methodologies are used in calculating countable resources.
- ☒ Yes
- ☐ No

The less restrictive resource methodologies are:

- ☒ All resources are disregarded. No resource test is applied.
- ☒ The state uses a less restrictive methodology with respect to the treatment of resources set aside in specified types of accounts.
- ☒ Resources set aside in Independence/Freedom accounts
- Description:**
- Designated separate account that consists only of earnings resulting from work activity while enrolled in the Ticket and BBA work incentives eligibility groups.

2. Income Test

- For individuals who pass Step One, in Step Two, the individual's unearned income (plus deemed income, if appropriate) must be less than one of the following income standards:
- ☐ a. The SSI income standard.
- ☒ b. The income standard of the state supplement program.

3. Resource Test

The individual's resources must be less than the SSI resource standard.

Work Incentives

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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D. Premiums and Cost Sharing

Requirements for premiums and cost sharing for this group are found in the premium and cost sharing sections of the state plan.

Work Incentives

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Package Header

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	User-Entered		

E. Additional Information (optional)

Requirements for premiums and cost sharing for this group are found in the premium and cost sharing sections, as well as in attachment 2.6-A page 12o.

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Ticket to Work Basic

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Individuals between ages 16 and 64 with a disability, who have earned income.

Package Header

Package ID	WA2019MS0004O	SPA ID	WA-20-0030
Submission Type	Official	Initial Submission Date	6/30/2020
Approval Date	02/10/2021	Effective Date	4/1/2020
Superseded SPA ID	WA-20-0006		
	User-Entered		

The state covers the optional Ticket to Work basic eligibility group in accordance with the following provisions:

Ticket to Work Basic

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Package Header

Package ID	WA2019MS0004O	SPA ID	WA-20-0030
Submission Type	Official	Initial Submission Date	6/30/2020
Approval Date	02/10/2021	Effective Date	4/1/2020
Superseded SPA ID	WA-20-0006		
	User-Entered		

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

- 1. Are at least age 16 but less than 65 years of age.
- 2. Have earned income.
- 3. But for earned income, meet the SSI definition of disability.
- 4. Have income and resources that do not exceed the standards established by the state.

Ticket to Work Basic

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Package Header

Package ID	WA2019MS0004O	SPA ID	WA-20-0030
Submission Type	Official	Initial Submission Date	6/30/2020
Approval Date	02/10/2021	Effective Date	4/1/2020
Superseded SPA ID	WA-20-0006		
	User-Entered		

B. Financial Methodologies

1. SSI methodologies are used in calculating household income and resources. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

- ☒ Yes
- ☐ No

The less restrictive income methodologies are:

☒ All income is disregarded. No income test is applied.

3. Less restrictive methodologies are used in calculating countable resources.

- ☒ Yes
- ☐ No

The less restrictive resource methodologies are:

☒ All resources are disregarded. No resource test is applied.

☒ The state uses a less restrictive methodology with respect to the treatment of resources set aside in specified types of accounts.

☒ Resources set aside in Independence/Freedom accounts

Description:

Designated separate account that consists only of earnings resulting from work activity while enrolled in the Ticket and BBA work incentives eligibility groups.

Ticket to Work Basic

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Package Header

Package ID	WA2019MS0004O	SPA ID	WA-20-0030
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Superseded SPA ID	WA-20-0006		
	User-Entered		

C. Income Standard Used

The income standard for this group is:

- ☒ 1. No income standard
- ☐ 2. A percentage of the federal poverty level:
- ☐ 3. A percentage of the SSI Federal Benefit Rate:
- ☐ 4. A dollar amount
- ☐ 5. Other

Ticket to Work Basic

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Package Header

Package ID	WA2019MS0004O	SPA ID	WA-20-0030
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	User-Entered		

D. Resource Standard Used

The resource standard for this group is:

- ☒ 1. No resource standard
- ☐ 2. SSI resource standard
- ☐ 4. A dollar amount higher than the SSI resource standard

Ticket to Work Basic

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Package Header

Package ID	WA2019MS0004O	SPA ID	WA-20-0030
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	User-Entered		

E. Premiums and Cost Sharing

Requirements for premiums and cost sharing for this group are found in the premium and cost sharing sections of the state plan.

Ticket to Work Basic

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Package Header

Package ID	WA2019MS0004O	SPA ID	WA-20-0030
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Superseded SPA ID	WA-20-0006		
	User-Entered		

F. Additional Information (optional)

Requirements for premiums and cost sharing for this group are found in the premium and cost sharing sections, as well as in attachment 2.6-A page 12o.

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Ticket to Work Medical Improvements

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Employed individuals between ages 16 and 64 who are no longer disabled but still have a medical impairment.

Package Header

Package ID	WA2019MS0004O	SPA ID	WA-20-0030
Submission Type	Official	Initial Submission Date	6/30/2020
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	User-Entered		

The state covers the optional Ticket to Work medical improvements eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are at least age 16 but less than 65 years of age.
2. Lost eligibility for the Ticket to Work basic eligibility group because it was determined at a regular disability review that they no longer meet the disability criteria.
3. Continue to have a severe medically determinable impairment.
4. Are employed, using the following definition:

☒ a. Earning at least the minimum wage and working at least 40 hours per month.

☐ b. An alternative definition
5. Have income and resources that do not exceed the standards established by the state.

Ticket to Work Medical Improvements

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Package Header

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	User-Entered		

B. Financial Methodologies

1. SSI methodologies are used in calculating household income and resources. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

- ☒ Yes
- ☐ No

The less restrictive income methodologies are:

☒ All income is disregarded. No income test is applied.

3. Less restrictive methodologies are used in calculating countable resources.

- ☒ Yes
- ☐ No

The less restrictive resource methodologies are:

☒ All resources are disregarded. No resource test is applied.

☒ The state uses a less restrictive methodology with respect to the treatment of resources set aside in specified types of accounts.

☒ Resources set aside in Independence/Freedom accounts

Description:

Designated separate account that consists only of earnings resulting from work activity while enrolled in the Ticket and BBA work incentives eligibility groups.

Ticket to Work Medical Improvements

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Package Header

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	User-Entered		

C. Income Standard Used

The income standard for this group is:

- ☒ 1. No income standard
- ☐ 2. A percentage of the federal poverty level:
- ☐ 3. A percentage of the SSI Federal Benefit Rate:
- ☐ 4. A dollar amount
- ☐ 5. Other

Ticket to Work Medical Improvements

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Package Header

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	User-Entered		

D. Resource Standard Used

The resource standard for this group is:

- ☒ 1. No resource standard
- ☐ 2. SSI resource standard
- ☐ 4. A dollar amount higher than the SSI resource standard

Ticket to Work Medical Improvements

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Package Header

Package ID	WA2019MS0004O	SPA ID	WA-20-0030
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E. Premiums and Cost Sharing

Requirements for premiums and cost sharing for this group are found in the premium and cost sharing sections of the state plan.

Ticket to Work Medical Improvements

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Package Header

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Superseded SPA ID	WA-20-0006		
	User-Entered		

F. Additional Information (optional)

Requirements for premiums and cost sharing for this group are found in the premium and cost sharing sections, as well as in attachment 2.6-A page 12o.

Medicaid State Plan Eligibility

Eligibility Groups - Medically Needy

Medically Needy Populations Based on Age, Blindness or Disability

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Individuals who are age 65 or older or who have blindness or a disability who do not qualify as categorically needy.

Package Header

Package ID	WA2019MS0004O	SPA ID	WA-20-0030
Submission Type	Official	Initial Submission Date	6/30/2020
Approval Date	02/10/2021	Effective Date	4/1/2020
Superseded SPA ID	WA-02-011		
	User-Entered		

The state covers the optional Medically Needy Populations Based on Age, Blindness or Disability eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

- 1.Meet at least one of the following:
 - a. Are age 65 or older;
 - b. Have blindness; or
 - c. Have a disability.
- 2. Are not otherwise eligible for categorically needy coverage under the state plan.
- 3. Have income at or below the medically needy income level and resources at or below the medically needy resource level.

Medically Needy Populations Based on Age, Blindness or Disability

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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Package ID	WA2019MS0004O	SPA ID	WA-20-0030
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Superseded SPA ID	WA-02-011		
	User-Entered		

B. Individuals Covered

The state covers the following populations:

- ☒ 1. Individuals age 65 or older
- ☒ 2. Individuals with blindness
- ☒ 3. Individuals who have a disability

Medically Needy Populations Based on Age, Blindness or Disability

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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	User-Entered		

C. Financial Methodologies

1. The state uses the same financial methodology for all individuals covered.

☒ Yes

☐ No
2. The financial methodology used is:

a. SSI methodologies. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

b. Less restrictive methodologies are used in calculating countable income.

☒ Yes ☐ No

The less restrictive income methodologies are:

☒ Census Bureau wages are disregarded.

Description of disregard:

Wages paid by the Census Bureau for temporary employment related to census activities are excluded.

☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
Income tax obligation	Unearned income withheld, prior receipt by the individual, for income tax purposes, or otherwise withheld beyond the individual's control, is considered exempt when determining eligibility
Maintenance for MN	Income of an individual is exempt in an amount equal to the maintenance allowance of the individual's spouse, living in the same household, who is eligible under clause (VI) of section 1902 (a) (10) (A) (ii) of the Act, less the income of the spouse.
community income	Effective July 1, 1986, if the community income received in the name of the non-applicant or ineligible spouse, living in a separate residence, exceeds the community income received in the name of the applicant/recipient spouse, the applicant/recipient spouse's interest in that excess is considered unavailable to the applicant/recipient.

- c. Less restrictive methodologies are used in calculating countable resources.

☒ Yes ☐ No
- The less restrictive resource methodologies are:

☒ Real property not otherwise excluded is disregarded.

Description of disregard:

Non-cash resources, which cannot be expected to be converted into cash within 20 working days, are not considered available to the extent that an ongoing bona fide effort to convert them into cash is unsuccessful.

☒ The state uses a less restrictive methodology with respect to the treatment of resources set aside in specified types of accounts.

☒ Resources set aside in an Assets for Independence Act (IDA) account

Description:

All funds in IDA accounts funded under the Assets for Independence Act

☒ Resources set aside in Independence/Freedom accounts

Description:

Designated separate account that consists only of earnings resulting from work activity while enrolled in the Ticket and BBA work incentives eligibility groups.

☒ A specified type of resource is disregarded:

Name of resource type:	Description:
Property sales contract	Sales Contract – Effective August 1, 1993, to the extent that it is not transferred, a sales contract on property that was the principal place of residence at the time of institutionalization is an exempt resource. The contract must provide a reasonable rate of return: 1) the interest is consistent with prevailing rates at the time of the sale; and 2) the payment of amount owed is anticipated within the lifetime of the client but does not exceed thirty years. Both interest and principal received in the form of payments are considered unearned income, unless otherwise exempted.

☒ A beneficiary of a "qualified state long-term care insurance partnership" policy (partnership policy), as defined in section 1917(b)(1)(C) of the Social Security Act and 45 CFR 144.200 et seq., is provided a resource disregard, equal to the amount of the insurance benefit payments made to or on behalf of the individual from the partnership policy.

☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
One-half resources	Effective January 1, 1989, it is presumed that one-half of the total resources held jointly by the husband and wife, or held separately by the applicant/recipient, are owned by each spouse (TN 89-2, Approved 8/17/90)
LTC MN excess resources	Non-exempt resources in excess of the Medically Needy resource levels can, at the individuals option, be reduced by allowable incurred expenses as long as such expenses have not been used to reduce excess income.
Holocaust survivor proceeds	When determining the countable resources for a Holocaust survivor, exclude recoveries of insurance proceeds or other assets.

Medically Needy Populations Based on Age, Blindness or Disability

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

Package Header

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D. Income Standard Used

The income standard used for this group is described in the Medically Needy Income Level RU.

Medically Needy Populations Based on Age, Blindness or Disability

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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E. Resource Standard Used

The resource standard used for this group is described in the Medically Needy Resource Level RU.

Medically Needy Populations Based on Age, Blindness or Disability

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F. Spenddown

The state allows individuals to deduct incurred medical and remedial expenses (spend down) to become eligible under this group. Spenddown is defined in the Handling of Excess Income (Spenddown) RU.

Medically Needy Populations Based on Age, Blindness or Disability

MEDICAID | Medicaid State Plan | Eligibility | WA2019MS0004O | WA-20-0030

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G. Additional Information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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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WA - Submission Package - WA2021MS0001O - (WA-21-0002) - Eligibility

Summary Reviewable Units Versions Correspondence Log Approval Letter News Related Actions

CMS-10434 OMB 0938-1188

Medicaid State Plan Eligibility

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2021MS0001O | WA-21-0002

Package Header

Package ID	WA2021MS0001O	SPA ID	WA-21-0002
Submission Type	Official	Initial Submission Date	3/25/2021
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Mandatory Coverage

A. The state provides Medicaid to mandatory groups of individuals. The mandatory groups covered are:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Infants and Children under Age 19		☒	☐	☐	APPROVED
Parents and Other Caretaker Relatives		☒	☐	☐	CONVERTED
Pregnant Women		☒	☐	☐	APPROVED
Deemed Newborns		☒	☐	☐	NEW
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care		☒	☐	☐	APPROVED
Former Foster Care Children		☒	☐	☐	APPROVED
Transitional Medical Assistance		☒	☐	☐	APPROVED
Extended Medicaid due to Spousal Support Collections		☒	☐	☐	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
SSI Beneficiaries		☒	☐	☐	NEW
Closed Eligibility Groups		☒	☐	☐	APPROVED
Individuals Deemed To Be Receiving SSI		☒	☐	☐	NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Working Individuals under 1619(b)		☒	☐	☐	APPROVED
Qualified Medicare Beneficiaries		☒	☒	☐	APPROVED
Qualified Disabled and Working Individuals		☒	☐	☐	NEW
Specified Low Income Medicare Beneficiaries		☒	☒	☐	APPROVED
Qualifying Individuals		☒	☒	☐	APPROVED

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2021MS0001O | WA-21-0002

Package Header

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B. The state elects the Adult Group, described at 42 CFR 435.119.

☒ Yes ☐ No

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Adult Group		☒	☐	☐	CONVERTED

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Qualified Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WA2021MS0001O | WA-21-0002

Individuals with income equal to or less than 100% of the FPL, who are entitled to Medicare Part A, and who qualify for Medicare cost-sharing.

Package Header

Package ID	WA2021MS0001O	SPA ID	WA-21-0002
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	System-Derived		

The state covers the mandatory qualified Medicare beneficiaries group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are entitled to hospital insurance benefits under part A of title XVIII (Medicare Part A), including individuals who have purchased a premium to enroll in Part A.
2. Have income and resources at or below the standard for this group.

Qualified Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WA2021MS0001O | WA-21-0002

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	System-Derived		

B. Financial Methodologies

1. SSI methodologies are used in calculating household income. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

- ☒ Yes
- ☐ No

The less restrictive income methodologies are:

- ☒ Census Bureau wages are disregarded.

Description of disregard:

Wages paid by the Census Bureau for temporary employment related to census activities are excluded.

- ☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
Income tax obligation	Unearned income withheld, prior receipt by the individual, for income tax purposes, or otherwise withheld beyond the individual's control, is considered exempt when determining eligibility
MSP	When determining the available income of an individual for the QMB or SLMB program the agency shall exclude from countable income an amount equal to that expended on medical expenses.

3. Less restrictive methodologies are used in calculating countable resources.

- ☒ Yes
- ☐ No

The less restrictive resource methodologies are:

- ☒ A specified type of resource is disregarded:

Name of resource type:	Description:
Independence Account - earnings while enrolled in MBI	Designated separate account that consists only of earnings resulting from work activity while enrolled in the Ticket and BBA work incentives eligibility groups.
Sales contract resource	Effective August 1, 1993, to the extent that it is not transferred, a sales contract on property that was the principal place of residence at the time of institutionalization is an exempt resource. The contract must provide a reasonable rate of return: 1) the interest is consistent with prevailing rates at the time of the sale; and 2) the payment of amount owed is anticipated within the lifetime of the client but does not exceed thirty years. Both interest and principal received in the form of payments are considered unearned income, unless otherwise exempted.
IDA account	All funds in IDA accounts funded under the Assets for Independence Act
20 days	Non-cash resources, which cannot be expected to be converted into cash within 20 working days, are not considered available to the extent that an ongoing bona fide effort to convert them into cash is unsuccessful.

Name of resource type:	Description:
Holocaust survivor	When determining the countable resources for a Holocaust survivor, exclude recoveries of insurance proceeds or other assets.

☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
FFCRA plus 12	Income that would have otherwise been part of an individual's liability for his or her institutional or home and community-based waiver services based on application of the post-eligibility treatment-of-income (PETI) rules but which became countable resources on or after March 18, 2020. Such resources will be disregarded through the twelve months following the end of the month in which the COVID-19 public health emergency ends.

Qualified Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WA2021MS0001O | WA-21-0002

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C. Income Standard Used

The amount of the income standard for this group is 100% FPL.

D. Resource Standard Used

The resource standard is the same used to determine eligibility for the Medicare Part D full-benefit low-income subsidy (LIS) (but without regard to the life insurance policy exclusion applied in LIS resource eligibility determinations). This standard is three times the SSI resource standard, adjusted annually in accordance with the consumer price index.

E. Medical Assistance Provided

Medical assistance is limited to payment of co-insurance and deductibles for Medicare Parts A, B and C and payment for the premiums for Medicare Parts A and B.

Medical assistance begins the first day of the month following the month in which the individual is determined to qualify for this eligibility group.

Qualified Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WA2021MS0001O | WA-21-0002

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F. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Specified Low Income Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WA2021MS0001O | WA-21-0002

Individuals with income above 100% and below 120% of the FPL who are entitled to Medicare Part A, who qualify for payment of Medicare Part B premiums.

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	System-Derived		

The state covers the mandatory specified low income Medicare beneficiaries group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Would qualify as Qualified Medicare Beneficiaries (described in section 1905(p)(1) of the Act), except that their income exceeds the income level for that eligibility group.
2. Have income below the income standard and resources at or below the resource standard for this group.

Specified Low Income Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WA2021MS0001O | WA-21-0002

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	System-Derived		

B. Financial Methodologies

1. SSI methodologies are used in calculating household income. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

- ☒ Yes
- ☐ No

The less restrictive income methodologies are:

- ☒ Census Bureau wages are disregarded.

Description of disregard:

Wages paid by the Census Bureau for temporary employment related to census activities are excluded.

- ☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
Income tax obligation	Unearned income withheld, prior receipt by the individual, for income tax purposes, or otherwise withheld beyond the individual's control, is considered exempt when determining eligibility
MSP	When determining the available income of an individual for the QMB or SLMB program the agency shall exclude from countable income an amount equal to that expended on medical expenses.

3. Less restrictive methodologies are used in calculating countable resources.

- ☒ Yes
- ☐ No

The less restrictive resource methodologies are:

- ☒ A specified type of resource is disregarded:

Name of resource type:	Description:
Independence Account - earnings while enrolled in MBI	Designated separate account that consists only of earnings resulting from work activity while enrolled in the Ticket and BBA work incentives eligibility groups.
Sales contract resource	Effective August 1, 1993, to the extent that it is not transferred, a sales contract on property that was the principal place of residence at the time of institutionalization is an exempt resource. The contract must provide a reasonable rate of return: 1) the interest is consistent with prevailing rates at the time of the sale; and 2) the payment of amount owed is anticipated within the lifetime of the client but does not exceed thirty years. Both interest and principal received in the form of payments are considered unearned income, unless otherwise exempted.
IDA account	All funds in IDA accounts funded under the Assets for Independence Act
20 days	Non-cash resources, which cannot be expected to be converted into cash within 20 working days, are not considered available to the extent that an ongoing bona fide effort to convert them into cash is unsuccessful.

Name of resource type:	Description:
Holocaust survivor	When determining the countable resources for a Holocaust survivor, exclude recoveries of insurance proceeds or other assets.

☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
FFCRA plus 12	Income that would have otherwise been part of an individual's liability for his or her institutional or home and community-based waiver services based on application of the post-eligibility treatment-of-income (PETI) rules but which became countable resources on or after March 18, 2020. Such resources will be disregarded through the twelve months following the end of the month in which the COVID-19 public health emergency ends.

Specified Low Income Medicare Beneficiaries

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Package Header

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C. Income Standard Used

Family income must be above 100% FPL and below 120% FPL.

D. Resource Standard Used

The resource standard is the same used to determine eligibility for the Medicare Part D full-benefit low-income subsidy (LIS) (but without regard to the life insurance policy exclusion applied in LIS resource eligibility determinations). This standard is three times the SSI resource standard, adjusted annually in accordance with the consumer price index.

E. Medical Assistance Provided

Medical assistance is limited to payment for Medicare Part B premiums.

Specified Low Income Medicare Beneficiaries

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F. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Qualifying Individuals

MEDICAID | Medicaid State Plan | Eligibility | WA2021MS0001O | WA-21-0002

Individuals with income at or above 120% and below 135% of the FPL who are entitled to Medicare Part A, who qualify for payment of Medicare Part B premiums.

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The state covers the mandatory qualifying individuals group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet all of the following criteria:

1. Would qualify as Qualified Medicare Beneficiaries (described in section 1905(p)(1) of the Act), except that their income exceeds the income level for that eligibility group.
2. Are not otherwise eligible for Medicaid under the state plan.
3. Have income below the income standard and resources at or below the resource standard for this group.

Qualifying Individuals

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B. Financial Methodologies

1. SSI methodologies are used in calculating household income. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

- ☒ Yes
- ☐ No

The less restrictive income methodologies are:

- ☒ Census Bureau wages are disregarded.

Description of disregard:

Wages paid by the Census Bureau for temporary employment related to census activities are excluded.

- ☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
Income tax obligation	Unearned income withheld, prior receipt by the individual, for income tax purposes, or otherwise withheld beyond the individual's control, is considered exempt when determining eligibility

3. Less restrictive methodologies are used in calculating countable resources.

- ☒ Yes
- ☐ No

The less restrictive resource methodologies are:

- ☒ A specified type of resource is disregarded:

Name of resource type:	Description:
Independence Account - earnings while enrolled in MBI	Designated separate account that consists only of earnings resulting from work activity while enrolled in the Ticket and BBA work incentives eligibility groups.
Sales contract resource	Effective August 1, 1993, to the extent that it is not transferred, a sales contract on property that was the principal place of residence at the time of institutionalization is an exempt resource. The contract must provide a reasonable rate of return: 1) the interest is consistent with prevailing rates at the time of the sale; and 2) the payment of amount owed is anticipated within the lifetime of the client but does not exceed thirty years. Both interest and principal received in the form of payments are considered unearned income, unless otherwise exempted.
IDA account	All funds in IDA accounts funded under the Assets for Independence Act
20 days	Non-cash resources, which cannot be expected to be converted into cash within 20 working days, are not considered available to the extent that an ongoing bona fide effort to convert them into cash is unsuccessful.
Holocaust survivor	When determining the countable resources for a Holocaust survivor, exclude recoveries of insurance proceeds or other assets.

☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
FFCRA plus 12	Income that would have otherwise been part of an individual's liability for his or her institutional or home and community-based waiver services based on application of the post-eligibility treatment-of-income (PETI) rules but which became countable resources on or after March 18, 2020. Such resources will be disregarded through the twelve months following the end of the month in which the COVID-19 public health emergency ends.

Qualifying Individuals

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C. Income Standard Used

Family income must be at or above 120% FPL and below 135% FPL.

D. Resource Standard Used

The resource standard is the same used to determine eligibility for the Medicare Part D full-benefit low-income subsidy (LIS) (but without regard to the life insurance policy exclusion applied in LIS resource eligibility determinations). This standard is three times the SSI resource standard, adjusted annually in accordance with the consumer price index.

E. Medical Assistance Provided

Medical assistance is limited to payment for Medicare Part B premiums.

Qualifying Individuals

MEDICAID | Medicaid State Plan | Eligibility | WA2021MS0001O | WA-21-0002

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F. Additional Information (optional)

Medicaid State Plan Eligibility

Optional Eligibility Groups

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A. Options for Coverage

The state provides Medicaid to specified optional groups of individuals.

☒ Yes ☐ No

The optional eligibility groups covered in the state plan are (elections made in this screen may not be comprehensive during the transition period from the paper-based state plan to MACPro):

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Optional Coverage of Parents and Other Caretaker Relatives		☐	☐	☐	NEW
Reasonable Classifications of Individuals under Age 21		☒	☐	☐	APPROVED
Children with Non-IV-E Adoption Assistance		☒	☐	☐	APPROVED
Independent Foster Care Adolescents		☐	☐	☐	NEW
Optional Targeted Low Income Children		☐	☐	☐	NEW
Individuals above 133% FPL under Age 65		☐	☐	☐	APPROVED
Individuals Needing Treatment for Breast or Cervical Cancer		☒	☐	☐	APPROVED
Individuals Eligible for Family Planning Services		☐	☐	☐	NEW
Individuals with Tuberculosis		☐	☐	☐	NEW
Individuals Electing COBRA Continuation Coverage		☐	☐	☐	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Individuals Eligible for but Not Receiving Cash Assistance		☒	☒	☐	APPROVED

Eligibility Group Name		Covered In State Plan	Include RU In Package 	Included in Another Submission Package	Source Type 
Individuals Eligible for Cash Except for Institutionalization		☒	☒	☐	APPROVED
Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules		☒	☐	☐	APPROVED
Optional State Supplement Beneficiaries		☐	☐	☐	NEW
Individuals in Institutions Eligible under a Special Income Level		☒	☐	☐	NEW
PACE Participants		☒	☐	☐	NEW
Individuals Receiving Hospice		☒	☐	☐	NEW
Children under Age 19 with a Disability		☐	☐	☐	NEW
Age and Disability-Related Poverty Level		☐	☐	☐	NEW
Work Incentives		☒	☐	☐	APPROVED
Ticket to Work Basic		☒	☐	☐	APPROVED
Ticket to Work Medical Improvements		☒	☐	☐	APPROVED
Family Opportunity Act Children with a Disability		☐	☐	☐	NEW
Individuals Receiving State Plan Home and Community-Based Services		☐	☐	☐	NEW
Individuals Receiving State Plan Home and Community-Based Services Who Are Otherwise Eligible for HCBS Waivers		☐	☐	☐	NEW

Optional Eligibility Groups

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B. Medically Needy Options for Coverage

The state provides Medicaid to specified groups of individuals who are medically needy.

☒ Yes ☐ No

The medically needy eligibility groups covered in the state plan are:

1. Mandatory Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Medically Needy Pregnant Women		☒	☐	☐	NEW
Medically Needy Children under Age 18		☒	☐	☐	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Protected Medically Needy Individuals Who Were Eligible in 1973		☒	☐	☐	NEW

2. Optional Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Medically Needy Reasonable Classifications of Individuals under Age 21		☒	☐	☐	NEW
Medically Needy Parents and Other Caretaker Relatives		☐	☐	☐	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Medically Needy Populations Based on Age, Blindness or Disability		☒	☒	☐	APPROVED

Optional Eligibility Groups

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C. Additional Information (optional)

Effective January 1, 2019, Washington no longer covers the Medicaid eligibility group for individuals who qualify on the basis of receiving optional state supplement payments (1902(a)(10)(A)(ii)(XI) 42 CFR 435.232 and 435.434).

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Individuals Eligible for but Not Receiving Cash Assistance

MEDICAID | Medicaid State Plan | Eligibility | WA2021MS0001O | WA-21-0002

Individuals who are eligible for but not receiving federal cash assistance or an optional state supplement.

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The state covers the optional Individuals Eligible for but Not Receiving Cash Assistance eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Meet the eligibility requirements of at least one of the following cash assistance programs:
 - ☒ a. SSI
 - ☐ b. Optional State Supplement
 - ☐ c. AFDC
2. Do not receive cash assistance under these programs.

Individuals Eligible for but Not Receiving Cash Assistance

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B. Individuals Covered

1. The state covers all individuals who meet the characteristics described in section A.

- ☒ Yes
- ☐ No

Individuals Eligible for but Not Receiving Cash Assistance

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C. Financial Methodologies

1. In calculating household income and resources for individuals who are seeking eligibility on the basis of being age 65 or older or having blindness or disability, SSI methodologies are used. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

3. Less restrictive methodologies are used in calculating countable income.

- ☒ Yes
- ☐ No

The less restrictive income methodologies are:

☒ Census Bureau wages are disregarded.

Description of disregard:

Wages paid by the Census Bureau for temporary employment related to census activities are excluded.

☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
Income tax obligation	Unearned income withheld, prior receipt by the individual, for income tax purposes, or otherwise withheld beyond the individual's control, is considered exempt when determining eligibility

4. Less restrictive methodologies are used in calculating countable resources.

- ☒ Yes
- ☐ No

The less restrictive resource methodologies are:

☒ A specified type of resource is disregarded:

Name of resource type:	Description:
property sales contract	Effective August 1, 1993, to the extent that it is not transferred, a sales contract on property that was the principal place of residence at the time of institutionalization is an exempt resource. The contract must provide a reasonable rate of return: 1) the interest is consistent with prevailing rates at the time of the sale; and 2) the payment of amount owed is anticipated within the lifetime of the client but does not exceed thirty years. Both interest and principal received in the form of payments are considered unearned income, unless otherwise exempted.

☒ A beneficiary of a "qualified state long-term care insurance partnership" policy (partnership policy), as defined in section 1917(b)(1)(C) of the Social Security Act and 45 CFR 144.200 et seq., is provided a resource disregard, equal to the amount of the insurance benefit payments made to or on behalf of the individual from the partnership policy.

☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
One-half resources	Effective January 1, 1989, it is presumed that one-half of the total resources

Name of methodology:	Description:
	held jointly by the husband and wife, or held separately by the applicant/recipient, are owned by each spouse (TN 89-2, Approved 8/17/90)
Independence Account - earnings while enrolled in MBI	Designated separate account that consists only of earnings resulting from work activity while enrolled in the Ticket and BBA work incentives eligibility groups.
IDA account	All funds in IDA accounts funded under the Assets for Independence Act
20 days	Non-cash resources, which cannot be expected to be converted into cash within 20 working days, are not considered available to the extent that an ongoing bona fide effort to convert them into cash is unsuccessful.
Holocaust survivor	When determining the countable resources for a Holocaust survivor, exclude recoveries of insurance proceeds or other assets.
Non-exempt resources	Non-exempt resources in excess of the Medically Needy resource levels can, at the individuals option, be reduced by allowable incurred expenses as long as such expenses have not been used to reduce excess income.
FFCRA plus 12	Income that would have otherwise been part of an individual's liability for his or her institutional or home and community-based waiver services based on application of the post-eligibility treatment-of-income (PETI) rules but which became countable resources on or after March 18, 2020. Such resources will be disregarded through the twelve months following the end of the month in which the COVID-19 public health emergency ends.

Individuals Eligible for but Not Receiving Cash Assistance

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D. Income Standard Used

The income standard used is the standard of the most closely related cash assistance program.

E. Resource Standard Used

The resource standard used is the standard of the most closely related cash assistance program.

Individuals Eligible for but Not Receiving Cash Assistance

MEDICAID | Medicaid State Plan | Eligibility | WA2021MS0001O | WA-21-0002

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F. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Individuals Eligible for Cash Except for Institutionalization

MEDICAID | Medicaid State Plan | Eligibility | WA2021MS0001O | WA-21-0002

Individuals who would be eligible for federal cash assistance or an optional state supplement, except for institutionalization.

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The state covers the optional Individuals Eligible for Cash Except for Institutionalization eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are in a medical institution.
2. Would meet the eligibility requirements for at least one of the following cash assistance programs, but for the lower income standards used to determine eligibility for institutionalized individuals:

☒ a. SSI

☐ b. Optional State Supplement

☒ c. AFDC

Individuals Eligible for Cash Except for Institutionalization

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B. Individuals Covered

1. The state covers all individuals who meet the characteristics described in section A.

- ☒ Yes
- ☐ No

Individuals Eligible for Cash Except for Institutionalization

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C. Financial Methodologies

1. In calculating household income and resources for individuals who are seeking eligibility on the basis of being age 65 or older or having blindness or disability, SSI methodologies are used. Please refer as necessary to Non-MAGI Methodologies, completed by the state.
2. In calculating household income and resources for populations for which AFDC is the most closely related program, the following methodology(ies) are used:
- ☐ a. MAGI-like methodologies. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

☒ b. AFDC methodologies. Please refer as necessary to Non-MAGI Methodologies, completed by the state.
3. Less restrictive methodologies are used in calculating countable income.
- ☒ Yes

☐ No

The less restrictive income methodologies are:

- ☒ The difference between one income standard and another is disregarded.

☐ Between the following percentages of the FPL:

☐ Between the medically needy income limit and a percentage of the FPL:

☐ Between the SSI Federal Benefit Rate and:

☒ Between other income standards:

Between this standard:

TANF payment standard by family size

and this standard:

AFDC payment standard by family size

- ☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
community income	Effective July 1, 1986, if the community income received in the name of the non-applicant or ineligible spouse, living in a separate residence, exceeds the community income received in the name of the applicant/recipient spouse, the applicant/recipient spouse's interest in that excess is considered unavailable to the applicant/recipient.
income tax obligation	Unearned income withheld, prior receipt by the individual, for income tax purposes, or otherwise withheld beyond the individual's control, is considered exempt when determining eligibility
FBR and CN	Disregard income equal to the difference between the Federal Benefit Rate and the Categorically Needy Income Level for individuals and couples as in effect on January 1, 2002

4. Less restrictive methodologies are used in calculating countable resources.
- ☒ Yes

☐ No

The less restrictive resource methodologies are:

- ☒ A specified type of resource is disregarded:

Name of resource type:	Description:
property sales contract	Effective August 1, 1993, to the extent that it is not transferred, a sales contract on property that was the principal place of residence at the time of institutionalization is an exempt resource. The contract must provide a reasonable rate of return: 1) the interest is consistent with prevailing rates at the time of the sale; and 2) the payment of amount owed is anticipated within the lifetime of the client but does not exceed thirty years. Both interest and principal received in the form of payments are considered unearned income, unless otherwise exempted.

☒ A beneficiary of a "qualified state long-term care insurance partnership" policy (partnership policy), as defined in section 1917(b)(1)(C) of the Social Security Act and 45 CFR 144.200 et seq., is provided a resource disregard, equal to the amount of the insurance benefit payments made to or on behalf of the individual from the partnership policy.

☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
One-half resources	Effective January 1, 1989, it is presumed that one-half of the total resources held jointly by the husband and wife, or held separately by the applicant/recipient, are owned by each spouse (TN 89-2, Approved 8/17/90)
Independence Account - earnings while enrolled in MBI	Designated separate account that consists only of earnings resulting from work activity while enrolled in the Ticket and BBA work incentives eligibility groups.
IDA account	All funds in IDA accounts funded under the Assets for Independence Act
20 days	Non-cash resources, which cannot be expected to be converted into cash within 20 working days, are not considered available to the extent that an ongoing bona fide effort to convert them into cash is unsuccessful.
Holocaust survivor	When determining the countable resources for a Holocaust survivor, exclude recoveries of insurance proceeds or other assets.
Non-exempt resources	Non-exempt resources in excess of the Medically Needy resource levels can, at the individuals option, be reduced by allowable incurred expenses as long as such expenses have not been used to reduce excess income.
FFCRA plus 12	Income that would have otherwise been part of an individual's liability for his or her institutional or home and community-based waiver services based on application of the post-eligibility treatment-of-income (PETI) rules but which became countable resources on or after March 18, 2020. Such resources will be disregarded through the twelve months following the end of the month in which the COVID-19 public health emergency ends.

Individuals Eligible for Cash Except for Institutionalization

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D. Income Standard Used

The income standard used is the standard of the most closely related cash assistance program.

E. Resource Standard Used

The resource standard used is the standard of the most closely related cash assistance program.

Individuals Eligible for Cash Except for Institutionalization

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F. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Medically Needy

Medically Needy Populations Based on Age, Blindness or Disability

MEDICAID | Medicaid State Plan | Eligibility | WA2021MS0001O | WA-21-0002

Individuals who are age 65 or older or who have blindness or a disability who do not qualify as categorically needy.

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The state covers the optional Medically Needy Populations Based on Age, Blindness or Disability eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

- 1.Meet at least one of the following:
 - a. Are age 65 or older;
 - b. Have blindness; or
 - c. Have a disability.
- 2. Are not otherwise eligible for categorically needy coverage under the state plan.
- 3. Have income at or below the medically needy income level and resources at or below the medically needy resource level.

Medically Needy Populations Based on Age, Blindness or Disability

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Approval Date	06/14/2021	Effective Date	1/1/2021
Superseded SPA ID	WA-20-0030		
	System-Derived		

B. Individuals Covered

The state covers the following populations:

- ☒ 1. Individuals age 65 or older
- ☒ 2. Individuals with blindness
- ☒ 3. Individuals who have a disability

Medically Needy Populations Based on Age, Blindness or Disability

MEDICAID | Medicaid State Plan | Eligibility | WA2021MS0001O | WA-21-0002

Package Header

Package ID	WA2021MS0001O	SPA ID	WA-21-0002
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	System-Derived		

C. Financial Methodologies

1. The state uses the same financial methodology for all individuals covered.

☒ Yes

☐ No
2. The financial methodology used is:

a. SSI methodologies. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

b. Less restrictive methodologies are used in calculating countable income.

☒ Yes ☐ No

The less restrictive income methodologies are:

☒ Census Bureau wages are disregarded.

Description of disregard:

Wages paid by the Census Bureau for temporary employment related to census activities are excluded.

☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
Income tax obligation	Unearned income withheld, prior receipt by the individual, for income tax purposes, or otherwise withheld beyond the individual's control, is considered exempt when determining eligibility
Maintenance for MN	Income of an individual is exempt in an amount equal to the maintenance allowance of the individual's spouse, living in the same household, who is eligible under clause (VI) of section 1902 (a) (10) (A) (ii) of the Act, less the income of the spouse.
community income	Effective July 1, 1986, if the community income received in the name of the non-applicant or ineligible spouse, living in a separate residence, exceeds the community income received in the name of the applicant/recipient spouse, the applicant/recipient spouse's interest in that excess is considered unavailable to the applicant/recipient.

- c. Less restrictive methodologies are used in calculating countable resources.

☒ Yes ☐ No
- The less restrictive resource methodologies are:

☒ Real property not otherwise excluded is disregarded.

Description of disregard:

Non-cash resources, which cannot be expected to be converted into cash within 20 working days, are not considered available to the extent that an ongoing bona fide effort to convert them into cash is unsuccessful.

☒ The state uses a less restrictive methodology with respect to the treatment of resources set aside in specified types of accounts.

☒ Resources set aside in an Assets for Independence Act (IDA) account

Description:

All funds in IDA accounts funded under the Assets for Independence Act

☒ Resources set aside in Independence/Freedom accounts

Description:

Designated separate account that consists only of earnings resulting from work activity while enrolled in the Ticket and BBA work incentives eligibility groups.

- ☒ A beneficiary of a "qualified state long-term care insurance partnership" policy (partnership policy), as defined in section 1917(b)(1)(C) of the Social Security Act and 45 CFR 144.200 et seq., is provided a resource disregard, equal to the amount of the insurance benefit payments made to or on behalf of the individual from the partnership policy.
- ☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
FFCRA plus 12	Income that would have otherwise been part of an individual's liability for his or her institutional or home and community-based waiver services based on application of the post-eligibility treatment-of-income (PETI) rules but which became countable resources on or after March 18, 2020. Such resources will be disregarded through the twelve months following the end of the month in which the COVID-19 public health emergency ends.
sales contract	Effective August 1, 1993, to the extent that it is not transferred, a sales contract on property that was the principal place of residence at the time of institutionalization is an exempt resource. The contract must provide a reasonable rate of return: 1) the interest is consistent with prevailing rates at the time of the sale; and 2) the payment of amount owed is anticipated within the lifetime of the client but does not exceed thirty years. Both interest and principal received in the form of payments are considered unearned income, unless otherwise exempted.
LTC MN excess resources	Non-exempt resources in excess of the Medically Needy resource levels can, at the individuals option, be reduced by allowable incurred expenses as long as such expenses have not been used to reduce excess income.
Holocaust survivor proceeds	When determining the countable resources for a Holocaust survivor, exclude recoveries of insurance proceeds or other assets.
One-half resources	Effective January 1, 1989, it is presumed that one-half of the total resources held jointly by the husband and wife, or held separately by the applicant/recipient, are owned by each spouse (TN 89-2, Approved 8/17/90)

Medically Needy Populations Based on Age, Blindness or Disability

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D. Income Standard Used

The income standard used for this group is described in the Medically Needy Income Level RU.

Medically Needy Populations Based on Age, Blindness or Disability

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E. Resource Standard Used

The resource standard used for this group is described in the Medically Needy Resource Level RU.

Medically Needy Populations Based on Age, Blindness or Disability

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F. Spenddown

The state allows individuals to deduct incurred medical and remedial expenses (spend down) to become eligible under this group. Spenddown is defined in the Handling of Excess Income (Spenddown) RU.

Medically Needy Populations Based on Age, Blindness or Disability

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G. Additional Information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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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WA - Submission Package - WA2021MS0002O - (WA-21-0022) - Eligibility

Summary Reviewable Units Versions Correspondence Log Approval Letter News Related Actions

CMS-10434 OMB 0938-1188

Medicaid State Plan Eligibility

Non-Financial Eligibility

Citizenship and Non-Citizen Eligibility

MEDICAID | Medicaid State Plan | Eligibility | WA2021MS0002O | WA-21-0022

Package Header

Package ID	WA2021MS0002O	SPA ID	WA-21-0022
Submission Type	Official	Initial Submission Date	8/12/2021
Approval Date	10/29/2021	Effective Date	7/1/2021
Superseded SPA ID	WA-18-0031		
	User-Entered		

☒ The state provides Medicaid to citizens and nationals of the United States and certain non-citizens who meet all other Medicaid eligibility requirements under the state plan, consistent with requirements of 42 CFR 435.406, including during a reasonable opportunity period pending verification of their citizenship, national status or satisfactory immigration status.

A. Citizens, Nationals and Eligible Non-Citizens

The state provides Medicaid eligibility to otherwise eligible individuals:

- Who are citizens or nationals of the United States; or
- Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641) or who are non-citizens treated as refugees under other federal statutes for purposes of Medicaid eligibility, subject to the requirements at 8 U.S.C. §1612(b)(2), and are not restricted by section 403 of PRWORA (8 U.S.C. §1613); or who are non-citizens whose eligibility is required by 8 U.S.C. 1612(b)(2)(E) and (F); and
- Who have declared themselves to be citizens or nationals of the United States, or non-citizens having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), 1902(ee) of the SSA and 42 CFR 435.406, 911, and 956.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

a. The agency provides for an extension of the reasonable opportunity period for non-citizens if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process.

- ☒ Yes
- ☐ No

☒ b. When a reasonable opportunity period is provided, the agency furnishes benefits to otherwise eligible individuals on the following date:

The date benefits are furnished is:

- ☐ i. The date of the application containing the declaration of citizenship or immigration status.
- ☒ ii. The first day of the month of application.

Citizenship and Non-Citizen Eligibility

MEDICAID | Medicaid State Plan | Eligibility | WA2021MS0002O | WA-21-0022

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B. Optional Coverage of Qualified Non-Citizens

The state provides Medicaid coverage to all otherwise-eligible Qualified Non-Citizens whose eligibility is not restricted by section 403 of PRWORA (8 U.S.C. §1613).

- ☒ Yes
- ☐ No

Citizenship and Non-Citizen Eligibility

MEDICAID | Medicaid State Plan | Eligibility | WA2021MS0002O | WA-21-0022

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C. Coverage of Lawfully Residing Individuals

The state elects the option to provide Medicaid coverage to otherwise eligible individuals, lawfully residing in the United States, as provided in section 1903(v)(4) of the Act.

☒ Yes

☐ No

☒ 1. Pregnant women

☒ 2. Individuals under a specified age:

☒ a. Individuals under age 21

☐ b. Individuals under age 20

☐ c. Individuals under age 19

3. An individual is considered to be lawfully residing in the United States if he or she is lawfully present and otherwise meets the eligibility requirements in the state plan.

4. An individual is considered to be lawfully present in the United States if he or she is:

a. A qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);

b. A non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));

c. A non-citizen who has been paroled into the United States in accordance with 8 U.S.C.1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

d. A non-citizen who belongs to one of the following classes:

i. Granted temporary resident status in accordance with 8 U.S.C.1160 or 1255a, respectively;

ii. Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;

iii. Granted employment authorization under 8 CFR 274a.12(c);

iv. Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;

v. Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

vi. Granted Deferred Action status;

vii. Granted an administrative stay of removal under 8 CFR 241;

viii. Beneficiary of approved visa petition who has a pending application for adjustment of status;

e. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C.1231,or under the Convention Against Torture who:

i. Has been granted employment authorization; or

ii. Is under the age of 14 and has had an application pending for at least 180 days;

f. Has been granted withholding of removal under the Convention Against Torture;

g. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C.1101(a)(27)(J);

h. Is lawfully present in American Samoa under the immigration laws of American Samoa; or

i. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b)).

j. Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (a) through (i) of this definition.

☒ k. Other

Description:

- Individuals granted an administrative stay of removal under 8 CFR 241, described under C.4.d.vii., above, are not considered to be lawfully present;
- Individuals granted employment authorization under 8 CFR 274a.12(c)(35) and (c)(36), described under paragraph C.4.d.iii, are not considered to be lawfully present unless they have an immigration status considered lawfully present under paragraph 4.a. through i.

Citizenship and Non-Citizen Eligibility

MEDICAID | Medicaid State Plan | Eligibility | WA2021MS0002O | WA-21-0022

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D. Emergency Coverage

☒ The state assures that it provides limited Medicaid services for treatment of an emergency medical condition, not related to an organ transplant procedure, as defined in 1903(v)(3) of the Social Security Act and implemented at 42 CFR 440.255, to the following individuals who meet all Medicaid eligibility requirements, except documentation of citizenship or satisfactory immigration status and/or present an SSN:

- 1. Qualified non-citizens subject to the 5 year waiting period described in 8 U.S.C. 1613(a)
- 2. Non-qualified non-citizens, unless covered as a lawfully residing child or pregnant woman by the state under the option in accordance with 1903(v)(4) and implemented at 435.406(b).

E. Additional Information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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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WA - Submission Package - WA2022MS0002O - (WA-22-0012) - Eligibility

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CMS-10434 OMB 0938-1188

Medicaid State Plan Eligibility

Eligibility and Enrollment Processes

Continuous Eligibility for Pregnant Women and Extended Postpartum Coverage

MEDICAID | Medicaid State Plan | Eligibility | WA2022MS0002O | WA-22-0012

Package Header

Package ID	WA2022MS0002O	SPA ID	WA-22-0012
Submission Type	Official	Initial Submission Date	5/3/2022
Approval Date	06/30/2022	Effective Date	4/1/2022
Superseded SPA ID	NEW		
	User-Entered		

The state provides continuous eligibility for pregnant individuals and extended postpartum coverage in accordance with the following provisions:

A. Mandatory Continuous Eligibility for Pregnant Women

The state provides continuous eligibility to pregnant individuals who were eligible and enrolled under the state plan, without regard to any changes in income that otherwise would result in ineligibility, through the last day of the month in which a 60-day postpartum period (beginning on the last day of the pregnancy) ends. This extension does not apply to pregnant individuals eligible only during a period of presumptive eligibility.

B. Optional 12-Month Postpartum Continuous Eligibility for Pregnant Women

The state provides continuous eligibility to pregnant individuals who were eligible and enrolled under the state plan while pregnant (including during a period of retroactive eligibility) through the last day of the month in which a 12-month postpartum period (beginning on the last day of the pregnancy) ends. The 12-month postpartum continuous eligibility option applies for the period beginning on the effective date of this reviewable unit and is available through March 31, 2027 (or other date as specified by law).

- ☒ Yes
- ☐ No

1. This extension does not apply to pregnant individuals eligible only during a period of presumptive eligibility.
2. Full benefits are provided for a pregnant or postpartum individual under this option. This includes all items and services covered under the state plan (or waiver) that are not less in amount, duration, or scope than, or are determined by the Secretary to be substantially equivalent to, the medical assistance available for an individual described in subsection 1902 (a)(10)(A)(i) of the Act.
3. Continuous eligibility is provided to pregnant individuals eligible and enrolled under the state plan through the end of the 12-month postpartum period who would otherwise lose eligibility because of a change in circumstances, unless:

a. The individual requests voluntary termination of eligibility;

b. The individual ceases to be a resident of the state;

c. The Medicaid agency determines that eligibility was determined incorrectly at the most recent determination or redetermination of eligibility because of agency error or fraud, abuse or perjury attributed to the individual; or

d. The individual dies.

C. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility and Enrollment Processes

Continuous Eligibility for Children

MEDICAID | Medicaid State Plan | Eligibility | WA2022MS0002O | WA-22-0012

Package Header

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Submission Type	Official	Initial Submission Date	5/3/2022

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 User-Entered

Effective Date 4/1/2022

The state provides continuous eligibility for children in accordance with the following provisions:

A. Mandatory Continuous Eligibility for Hospitalized Children

The state provides Medicaid to a child eligible for and enrolled under the Infants and Children under Age 19 (42 CFR 435.118) eligibility group until the end of an inpatient stay for which inpatient services are covered, if the child:

1. Was receiving inpatient services covered by Medicaid on the date the child becomes ineligible under the eligibility group based on the child's age; and
2. Would remain eligible but for attaining such age.

B. Options for Continuous Eligibility for Children

The state provides continuous eligibility to children.

- ☒ Yes
☐ No

1. Continuous eligibility is provided to all children of the following age:

- ☒ a. Under age 19
☐ b. Under other age

2. The continuous eligibility period begins on the effective date of the child's most recent determination or redetermination of eligibility, and ends the last day of the earlier of the following periods:

- a. The month that the child's age exceeds the age limit to which this provision applies
- b. The end of the continuous eligibility period, which is:
 - ☒ i. 12 months
 - ☐ ii. Another period of continuous eligibility, not to exceed 12 months

3. Continuous eligibility is provided to children eligible under all mandatory and optional eligibility groups (excluding Medically Needy) who would otherwise lose eligibility because of any change in circumstances, unless:

- a. The child dies;
- b. The child or the child's representative voluntarily requests a termination of the child's eligibility;
- c. The child ceases to be a resident of the state;
- d. The Medicaid agency determines that eligibility was determined incorrectly at the most recent determination or redetermination of eligibility because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or
- e. The child attains the maximum age specified in B.

C. Additional Information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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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Medicaid State Plan Eligibility

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2023MS0001O | WA-22-0034

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Approval Date	02/02/2023	Effective Date	1/1/2023
Superseded SPA ID	WA-21-0002		
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Mandatory Coverage

A. The state provides Medicaid to mandatory groups of individuals. The mandatory groups covered are:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package?	Included in Another Submission Package	Source Type?
Infants and Children under Age 19		☒	☐	☐	APPROVED
Parents and Other Caretaker Relatives		☒	☐	☐	CONVERTED
Pregnant Women		☒	☐	☐	APPROVED
Deemed Newborns		☒	☐	☐	NEW
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care		☒	☐	☐	APPROVED
Former Foster Care Children		☒	☐	☐	APPROVED
Transitional Medical Assistance		☒	☐	☐	APPROVED
Extended Medicaid due to Spousal Support Collections		☒	☐	☐	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package?	Included in Another Submission Package	Source Type?
SSI Beneficiaries		☒	☐	☐	NEW
Closed Eligibility Groups		☒	☐	☐	APPROVED
Individuals Deemed To Be Receiving SSI		☒	☐	☐	NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Working Individuals under 1619(b)		☒	☐	☐	APPROVED
Qualified Medicare Beneficiaries		☒	☒	☐	APPROVED
Qualified Disabled and Working Individuals		☒	☐	☐	NEW
Specified Low Income Medicare Beneficiaries		☒	☒	☐	APPROVED
Qualifying Individuals		☒	☒	☐	APPROVED

Mandatory Eligibility Groups

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B. The state elects the Adult Group, described at 42 CFR 435.119.

☒ Yes ☐ No

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Adult Group		☒	☐	☐	CONVERTED

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Qualified Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WA2023MS0001O | WA-22-0034

Individuals with income equal to or less than 100% of the FPL, who are entitled to Medicare Part A, and who qualify for Medicare cost-sharing.

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The state covers the mandatory qualified Medicare beneficiaries group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are entitled to hospital insurance benefits under part A of title XVIII (Medicare Part A), including individuals who have purchased a premium to enroll in Part A.
2. Have income and resources at or below the standard for this group.

Qualified Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WA2023MS0001O | WA-22-0034

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B. Financial Methodologies

1. SSI methodologies are used in calculating household income. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

- ☒ Yes
- ☐ No

The less restrictive income methodologies are:

- ☒ Census Bureau wages are disregarded.

Description of disregard:

Wages paid by the Census Bureau for temporary employment related to census activities are excluded.

- ☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
Income tax obligation	Unearned income withheld, prior receipt by the individual, for income tax purposes, or otherwise withheld beyond the individual's control, is considered exempt when determining eligibility
MSP	When determining the available income of an individual for the QMB or SLMB program the agency shall exclude from countable income an amount equal to that expended on medical expenses.

3. Less restrictive methodologies are used in calculating countable resources.

- ☒ Yes
- ☐ No

The less restrictive resource methodologies are:

- ☒ All resources are disregarded. No resource test is applied.

Qualified Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WA2023MS0001O | WA-22-0034

Package Header

Package ID	WA2023MS0001O	SPA ID	WA-22-0034
Submission Type	Official	Initial Submission Date	1/12/2023
Approval Date	02/02/2023	Effective Date	1/1/2023
Superseded SPA ID	WA-21-0002		
	System-Derived		

C. Income Standard Used

The amount of the income standard for this group is 100% FPL.

D. Resource Standard Used

The resource standard is the same used to determine eligibility for the Medicare Part D full-benefit low-income subsidy (LIS) (but without regard to the life insurance policy exclusion applied in LIS resource eligibility determinations). This standard is three times the SSI resource standard, adjusted annually in accordance with the consumer price index.

E. Medical Assistance Provided

Medical assistance is limited to payment of co-insurance and deductibles for Medicare Parts A, B and C and payment for the premiums for Medicare Parts A and B.

Medical assistance begins the first day of the month following the month in which the individual is determined to qualify for this eligibility group.

Qualified Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WA2023MS0001O | WA-22-0034

Package Header

Package ID	WA2023MS0001O	SPA ID	WA-22-0034
Submission Type	Official	Initial Submission Date	1/12/2023
Approval Date	02/02/2023	Effective Date	1/1/2023
Superseded SPA ID	WA-21-0002		
	System-Derived		

F. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Specified Low Income Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WA2023MS0001O | WA-22-0034

Individuals with income above 100% and below 120% of the FPL who are entitled to Medicare Part A, who qualify for payment of Medicare Part B premiums.

Package Header

Package ID	WA2023MS0001O	SPA ID	WA-22-0034
Submission Type	Official	Initial Submission Date	1/12/2023
Approval Date	02/02/2023	Effective Date	1/1/2023
Superseded SPA ID	WA-21-0002		
	System-Derived		

The state covers the mandatory specified low income Medicare beneficiaries group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Would qualify as Qualified Medicare Beneficiaries (described in section 1905(p)(1) of the Act), except that their income exceeds the income level for that eligibility group.
2. Have income below the income standard and resources at or below the resource standard for this group.

Specified Low Income Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WA2023MS0001O | WA-22-0034

Package Header

Package ID	WA2023MS0001O	SPA ID	WA-22-0034
Submission Type	Official	Initial Submission Date	1/12/2023
Approval Date	02/02/2023	Effective Date	1/1/2023
Superseded SPA ID	WA-21-0002		
	System-Derived		

B. Financial Methodologies

1. SSI methodologies are used in calculating household income. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

- ☒ Yes
- ☐ No

The less restrictive income methodologies are:

- ☒ Census Bureau wages are disregarded.

Description of disregard:

Wages paid by the Census Bureau for temporary employment related to census activities are excluded.

- ☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
Income tax obligation	Unearned income withheld, prior receipt by the individual, for income tax purposes, or otherwise withheld beyond the individual's control, is considered exempt when determining eligibility
MSP	When determining the available income of an individual for the QMB or SLMB program the agency shall exclude from countable income an amount equal to that expended on medical expenses.

3. Less restrictive methodologies are used in calculating countable resources.

- ☒ Yes
- ☐ No

The less restrictive resource methodologies are:

- ☒ All resources are disregarded. No resource test is applied.

Specified Low Income Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WA2023MS0001O | WA-22-0034

Package Header

Package ID	WA2023MS0001O	SPA ID	WA-22-0034
Submission Type	Official	Initial Submission Date	1/12/2023
Approval Date	02/02/2023	Effective Date	1/1/2023
Superseded SPA ID	WA-21-0002		
	System-Derived		

C. Income Standard Used

Family income must be above 100% FPL and below 120% FPL.

D. Resource Standard Used

The resource standard is the same used to determine eligibility for the Medicare Part D full-benefit low-income subsidy (LIS) (but without regard to the life insurance policy exclusion applied in LIS resource eligibility determinations). This standard is three times the SSI resource standard, adjusted annually in accordance with the consumer price index.

E. Medical Assistance Provided

Medical assistance is limited to payment for Medicare Part B premiums.

Specified Low Income Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WA2023MS0001O | WA-22-0034

Package Header

Package ID	WA2023MS0001O	SPA ID	WA-22-0034
Submission Type	Official	Initial Submission Date	1/12/2023
Approval Date	02/02/2023	Effective Date	1/1/2023
Superseded SPA ID	WA-21-0002		
	System-Derived		

F. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Qualifying Individuals

MEDICAID | Medicaid State Plan | Eligibility | WA2023MS0001O | WA-22-0034

Individuals with income at or above 120% and below 135% of the FPL who are entitled to Medicare Part A, who qualify for payment of Medicare Part B premiums.

Package Header

Package ID	WA2023MS0001O	SPA ID	WA-22-0034
Submission Type	Official	Initial Submission Date	1/12/2023
Approval Date	02/02/2023	Effective Date	1/1/2023
Superseded SPA ID	WA-21-0002		
	System-Derived		

The state covers the mandatory qualifying individuals group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet all of the following criteria:

1. Would qualify as Qualified Medicare Beneficiaries (described in section 1905(p)(1) of the Act), except that their income exceeds the income level for that eligibility group.
2. Are not otherwise eligible for Medicaid under the state plan.
3. Have income below the income standard and resources at or below the resource standard for this group.

Qualifying Individuals

MEDICAID | Medicaid State Plan | Eligibility | WA2023MS0001O | WA-22-0034

Package Header

Package ID	WA2023MS0001O	SPA ID	WA-22-0034
Submission Type	Official	Initial Submission Date	1/12/2023
Approval Date	02/02/2023	Effective Date	1/1/2023
Superseded SPA ID	WA-21-0002		
	System-Derived		

B. Financial Methodologies

1. SSI methodologies are used in calculating household income. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

- ☒ Yes
- ☐ No

The less restrictive income methodologies are:

☒ Census Bureau wages are disregarded.

Description of disregard:

Wages paid by the Census Bureau for temporary employment related to census activities are excluded.

☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
Income tax obligation	Unearned income withheld, prior receipt by the individual, for income tax purposes, or otherwise withheld beyond the individual's control, is considered exempt when determining eligibility

3. Less restrictive methodologies are used in calculating countable resources.

- ☒ Yes
- ☐ No

The less restrictive resource methodologies are:

☒ All resources are disregarded. No resource test is applied.

Qualifying Individuals

MEDICAID | Medicaid State Plan | Eligibility | WA2023MS0001O | WA-22-0034

Package Header

Package ID	WA2023MS0001O	SPA ID	WA-22-0034
Submission Type	Official	Initial Submission Date	1/12/2023
Approval Date	02/02/2023	Effective Date	1/1/2023
Superseded SPA ID	WA-21-0002		
	System-Derived		

C. Income Standard Used

Family income must be at or above 120% FPL and below 135% FPL.

D. Resource Standard Used

The resource standard is the same used to determine eligibility for the Medicare Part D full-benefit low-income subsidy (LIS) (but without regard to the life insurance policy exclusion applied in LIS resource eligibility determinations). This standard is three times the SSI resource standard, adjusted annually in accordance with the consumer price index.

E. Medical Assistance Provided

Medical assistance is limited to payment for Medicare Part B premiums.

Qualifying Individuals

MEDICAID | Medicaid State Plan | Eligibility | WA2023MS0001O | WA-22-0034

Package Header

Package ID	WA2023MS0001O	SPA ID	WA-22-0034
Submission Type	Official	Initial Submission Date	1/12/2023
Approval Date	02/02/2023	Effective Date	1/1/2023
Superseded SPA ID	WA-21-0002		
	System-Derived		

F. Additional Information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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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WA - Submission Package - WA2023MS0002O - (WA-23-0008) - Eligibility

Summary Reviewable Units Versions Correspondence Log Approval Letter News Related Actions

CMS-10434 OMB 0938-1188

Medicaid State Plan Eligibility

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2023MS0002O | WA-23-0008

Package Header

Package ID	WA2023MS0002O	SPA ID	WA-23-0008
Submission Type	Official	Initial Submission Date	3/8/2023
Approval Date	05/25/2023	Effective Date	1/1/2023
Superseded SPA ID	WA-22-0034		
	User-Entered		

Mandatory Coverage

A. The state provides Medicaid to mandatory groups of individuals. The mandatory groups covered are:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Infants and Children under Age 19		☒	☐	☐	APPROVED
Parents and Other Caretaker Relatives		☒	☐	☐	CONVERTED
Pregnant Women		☒	☐	☐	APPROVED
Deemed Newborns		☒	☐	☐	NEW
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care		☒	☐	☐	APPROVED
Former Foster Care Children		☒	☒	☐	APPROVED
Transitional Medical Assistance		☒	☐	☐	APPROVED
Extended Medicaid due to Spousal Support Collections		☒	☐	☐	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
SSI Beneficiaries		☒	☐	☐	NEW
Closed Eligibility Groups		☒	☐	☐	APPROVED
Individuals Deemed To Be Receiving SSI		☒	☐	☐	NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Working Individuals under 1619(b)		☒	☐	☐	APPROVED
Qualified Medicare Beneficiaries		☒	☐	☐	APPROVED
Qualified Disabled and Working Individuals		☒	☐	☐	NEW
Specified Low Income Medicare Beneficiaries		☒	☐	☐	APPROVED
Qualifying Individuals		☒	☐	☐	APPROVED

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2023MS0002O | WA-23-0008

Package Header

Package ID	WA2023MS0002O	SPA ID	WA-23-0008
Submission Type	Official	Initial Submission Date	3/8/2023
Approval Date	05/25/2023	Effective Date	1/1/2023
Superseded SPA ID	WA-22-0034		
	User-Entered		

B. The state elects the Adult Group, described at 42 CFR 435.119.

☒ Yes ☐ No

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Adult Group		☒	☐	☐	CONVERTED

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Former Foster Care Children

MEDICAID | Medicaid State Plan | Eligibility | WA2023MS0002O | WA-23-0008

Individuals under the age of 26, who were in foster care and on Medicaid when they turned age 18 or aged out of foster care.

Package Header

Package ID	WA2023MS0002O	SPA ID	WA-23-0008
Submission Type	Official	Initial Submission Date	3/8/2023
Approval Date	05/25/2023	Effective Date	1/1/2023
Superseded SPA ID	WA-13-0030		
	User-Entered		

The state covers the mandatory former foster care children group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

- 1. Are under age 26
- 2. Were in foster care upon attaining age 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act (up to age 21).
- 3. Are described under either Section B. or C.

B. Individuals Covered

For individuals who turn 18 before January 1, 2023:

1. The state covers individuals who:

- a. Upon attaining age 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act (up to age 21) were:
 - i. In foster care under the responsibility of the state or a Tribe within the state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program); and
 - ii. Enrolled in Medicaid under the state's Medicaid state plan or 1115 demonstration; and
- b. Are not otherwise eligible for and enrolled for mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

2. In addition to B.1., the state elects to cover individuals who were in foster care under the responsibility of the state or a Tribe within the state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program) when they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act, and meet the following criteria:
- ☐ a. They were enrolled in Medicaid under the state's Medicaid state plan or 1115 demonstration at any time during the foster care period in which they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.
 - ☒ b. They were placed by the state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project when they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.
 - ☐ c. They were placed by the state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project at any time during the foster care period in which they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.

C. Individuals Covered

For individuals who turn 18 on or after January 1, 2023:

1. The state covers individuals who:

- a. Upon attaining age 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act (up to age 21) were:
 - i. In foster care under the responsibility of any state or a Tribe within any state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program); and
 - ii. Enrolled in Medicaid under a state's Medicaid state plan or 1115 demonstration; and
- b. Are not enrolled in mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

2. In addition to C.1., the state elects to cover individuals who were in foster care under the responsibility of any state or a Tribe within any state (including children who were cared for through a grant to a state under the unaccompanied refugee minor program) when they turned 18 or a higher age at which that state's or Tribe's foster care assistance ends under title IV-E of the Act, and meet the following criteria:
- ☐ a. They were enrolled in Medicaid under a state's Medicaid state plan or 1115 demonstration at any time during the foster care period in which they turned 18 or a higher age at which a state's or Tribe's foster care assistance ends.
 - ☒ b. They were placed by a state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project when they turned 18 or a higher age at which a state's or Tribe's foster care assistance ends.
 - ☐ c. They were placed by a state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project at any time during the foster care period in which they turned 18 or a higher age at which a state's or Tribe's foster care assistance ends.

Former Foster Care Children

MEDICAID | Medicaid State Plan | Eligibility | WA2023MS0002O | WA-23-0008

Package Header

Package ID	WA2023MS0002O	SPA ID	WA-23-0008
Submission Type	Official	Initial Submission Date	3/8/2023
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Superseded SPA ID	WA-13-0030		
	User-Entered		

D. Additional Information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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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WA - Submission Package - WA2024MS0001O - (WA-24-0003) - Eligibility

Summary Reviewable Units Versions Correspondence Log Approval Letter News Related Actions

CMS-10434 OMB 0938-1188

Medicaid State Plan Eligibility

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Package Header

Package ID	WA2024MS0001O	SPA ID	WA-24-0003
Submission Type	Official	Initial Submission Date	1/10/2024
Approval Date	04/03/2024	Effective Date	7/1/2024
Superseded SPA ID	WA-22-0034		
	System-Derived		

Mandatory Coverage

A. The state provides Medicaid to mandatory groups of individuals. The mandatory groups covered are:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Infants and Children under Age 19		☒	☒	☐	APPROVED
Parents and Other Caretaker Relatives		☒	☐	☐	CONVERTED
Pregnant Women		☒	☒	☐	APPROVED
Deemed Newborns		☒	☐	☐	NEW
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care		☒	☒	☐	APPROVED
Former Foster Care Children		☒	☒	☐	APPROVED
Transitional Medical Assistance		☒	☒	☐	APPROVED
Extended Medicaid due to Spousal Support Collections		☒	☐	☐	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
SSI Beneficiaries		☒	☐	☐	NEW
Closed Eligibility Groups		☒	☒	☐	APPROVED
Individuals Deemed To Be Receiving SSI		☒	☐	☐	NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Working Individuals under 1619(b)		☒	☒	☐	APPROVED
Qualified Medicare Beneficiaries		☒	☐	☐	APPROVED
Qualified Disabled and Working Individuals		☒	☐	☐	NEW
Specified Low Income Medicare Beneficiaries		☒	☐	☐	APPROVED
Qualifying Individuals		☒	☐	☐	APPROVED

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Package Header

Package ID	WA2024MS0001O	SPA ID	WA-24-0003
Submission Type	Official	Initial Submission Date	1/10/2024
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Superseded SPA ID	WA-22-0034		
	System-Derived		

B. The state elects the Adult Group, described at 42 CFR 435.119.

☒ Yes ☐ No

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Adult Group		☒	☐	☐	CONVERTED

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Infants and Children under Age 19

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Infants and children under age 19 with household income at or below standards established by the state based on age group.

Package Header

Package ID	WA2024MS0001O	SPA ID	WA-24-0003
Submission Type	Official	Initial Submission Date	1/10/2024
Approval Date	04/03/2024	Effective Date	7/1/2024
Superseded SPA ID	WA-13-0030		
	System-Derived		

The state covers the mandatory infants and children under age 19 group in accordance with the following provisions:

A. Characteristics

Children qualifying under this eligibility group must meet the following criteria:

- 1. Are under age 19
- 2. Have household income at or below the standard established by the state.

B. Financial Methodologies

MAGI-based methodologies are used in calculating household income. Please refer as necessary to MAGI-Based Methodologies, completed by the state.

C. Income Standards Used

1. The amount of the income standard for infants under age one is:	FPL 210.00%
2. The amount of the income standard for children age one through five is:	FPL 210.00%
3. The amount of the income standard for children age six through eighteen is:	FPL 210.00%

Infants and Children under Age 19

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Package Header

Package ID	WA2024MS0001O	SPA ID	WA-24-0003
Submission Type	Official	Initial Submission Date	1/10/2024
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Superseded SPA ID	WA-13-0030		
	System-Derived		

D. Basis for the Income Standard for Infants under Age 1

1. Minimum income standard

a. The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for infants under age one, or as of July 1, 1989, had authorizing legislation to do so.

☒ Yes ☐ No

b. Enter the amount of the minimum income standard (no higher than 185% FPL): **FPL 185.00%**

2. Maximum income standard

☒ a. The state certifies that it has submitted and received approval for its converted income standard(s) for infants under age one to MAGI-equivalent standards and the determination of the maximum income standard to be used for infants under age one.

b. The state's maximum income standard for this age group is:

- ☒ i. The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- ☐ ii. The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- ☐ iii. The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- ☐ iv. The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- ☐ v. 185% FPL

c. The amount of the maximum income standard is: **FPL 210.00%**

Infants and Children under Age 19

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Package Header

Package ID	WA2024MS0001O	SPA ID	WA-24-0003
Submission Type	Official	Initial Submission Date	1/10/2024
Approval Date	04/03/2024	Effective Date	7/1/2024
Superseded SPA ID	WA-13-0030		
	System-Derived		

E. Basis for the Income Standard for Children Age One through Age Five

1. Minimum income standard

The minimum income standard used for this age group is 133% FPL.

2. Maximum income standard

- ☒ a. The state certifies that it has submitted and received approval for its converted income standard(s) for children age one through five to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age one through five.
- b. The state's maximum income standard for this age group is:**

☒ i. The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

☐ ii. The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

☐ iii. The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

☐ iv. The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

☐ v. 133% FPL
- c. The amount of the maximum income standard is:**

FPL 210.00%

F. Basis for the Income Standard for Children Age Six through Age Eighteen

1. Minimum income standard

The minimum income standard used for this age group is 133% FPL.

2. Maximum income standard

- ☒ a. The state certifies that it has submitted and received approval for its converted income standard(s) for children age six through eighteen to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age six through age eighteen.
- b. The state's maximum income standard for this age group is:**

☒ i. The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

☐ ii. The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

☐ iii. The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

☐ iv. The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

☐ v. 133% FPL
- c. The amount of the maximum income standard is:**

FPL 210.00%

Infants and Children under Age 19

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Package Header

Package ID	WA2024MS0001O	SPA ID	WA-24-0003
Submission Type	Official	Initial Submission Date	1/10/2024
Approval Date	04/03/2024	Effective Date	7/1/2024
Superseded SPA ID	WA-13-0030		
	System-Derived		

G. Additional Information (optional)

Consistent with section 1902(e)(14)(D)(iv) of the Act, in determining eligibility for medical assistance for the Supportive Supervision and Oversight benefit approved under the authority of section 1915(i) of the Act, individuals who meet the needs-based and targeting criteria for Community Behavioral Health Support (CBHS) shall have MAGI-like methodologies used to determine income, except that income above 150 percent of the federal poverty level is disregarded.

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Pregnant Women

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Women who are pregnant or post-partum, with household income at or below a standard established by the state.

Package Header

Package ID	WA2024MS0001O	SPA ID	WA-24-0003
Submission Type	Official	Initial Submission Date	1/10/2024
Approval Date	04/03/2024	Effective Date	7/1/2024
Superseded SPA ID	WA-13-0030		
	System-Derived		

The state covers the mandatory pregnant women group in accordance with the following provisions:

A. Characteristics

- 1. Individuals qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.
- 2. Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan Parents and Other Caretaker Relatives at 42 C.F.R. 435.110.

☒ Yes

☐ No

B. Financial Methodologies

MAGI-based methodologies are used in calculating household income. Please refer as necessary to MAGI-Based Methodologies, completed by the state.

C. Income Standard Used

The state uses the following income standard for this group:

FPL 193.00%

Pregnant Women

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Package Header

Package ID	WA2024MS0001O	SPA ID	WA-24-0003
Submission Type	Official	Initial Submission Date	1/10/2024
Approval Date	04/03/2024	Effective Date	7/1/2024
Superseded SPA ID	WA-13-0030		
	System-Derived		

D. Benefits for Pregnant Women

Benefits for individuals in this eligibility group consist of the following:

- ☒ 1. All pregnant women eligible under this group receive full Medicaid coverage under this state plan.
- ☐ 2. Pregnant women whose income exceeds the income limit specified for full coverage of pregnant women receive only pregnancy-related services.

Pregnant Women

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Package Header

Package ID	WA2024MS0001O	SPA ID	WA-24-0003
Submission Type	Official	Initial Submission Date	1/10/2024
Approval Date	04/03/2024	Effective Date	7/1/2024
Superseded SPA ID	WA-13-0030		
System-Derived			

E. Basis for Pregnant Women Income Standard

1. Minimum income standard

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women, or as of July 1, 1989, had authorizing legislation to do so.

- ☒ Yes
- ☐ No

a. The amount of the minimum income standard (no higher than 185% FPL) is:

FPL 185.00%

2. Maximum income standard

☒ a. The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for pregnant women under this eligibility group.

b. The state's maximum income standard for this eligibility group is:

- ☒ i. The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- ☐ ii. The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- ☐ iii. The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- ☐ iv. The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- ☐ v. 185% FPL

c. The amount of the maximum income standard is: FPL 193.00%

G. Additional Information (optional)

Consistent with section 1902(e)(14)(D)(iv) of the Act, in determining eligibility for medical assistance for the Supportive Supervision and Oversight benefit approved under the authority of section 1915(i) of the Act, individuals who meet the needs-based and targeting criteria for Community Behavioral Health Support (CBHS) shall have MAGI-like methodologies used to determine income, except that income above 150 percent of the federal poverty level is disregarded.

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Individuals for whom an adoption assistance agreement is in effect or foster care or kinship guardianship assistance maintenance payments are made under Title IV-E of the Act.

Package Header

Package ID	WA2024MS0001O	SPA ID	WA-24-0003
Submission Type	Official	Initial Submission Date	1/10/2024
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Superseded SPA ID	WA-91-22		
	User-Entered		

The state covers the mandatory children with Title IV-E adoption assistance, foster care or guardianship care group in accordance with the following provisions:

A. Characteristics

- Individuals qualifying under this eligibility group must meet one of the following criteria:
 - An adoption assistance agreement is in effect for the individual with any state or Tribe under title IV-E of the Act, regardless of whether adoption assistance is being provided or an interlocutory or other judicial decree of adoption has been issued; or
 - Foster care or kinship guardian assistance maintenance payments are being made by a state or Tribe under Title IV-E of the Act.
- The upper age limit for eligibility under this group is determined by the terms of the adoption assistance agreement or the terms of the foster care or kinship guardianship assistance maintenance payments, as established by the IV-E plan of the state or Tribe that established the agreement or is making the payments.
- Individuals may not be required to file an application for this group.

Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

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Package ID	WA2024MS0001O	SPA ID	WA-24-0003
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Superseded SPA ID	WA-91-22		
	User-Entered		

B. Additional Information (optional)

The methodology used to determine income eligibility for the Community Behavioral Health Support (CBHS) in the Supportive Supervision and Oversight benefit approved under the authority of section 1915(i) of the Act excludes all income.

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Former Foster Care Children

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Individuals under the age of 26, who were in foster care and on Medicaid when they turned age 18 or aged out of foster care.

Package Header

Package ID	WA2024MS0001O	SPA ID	WA-24-0003
Submission Type	Official	Initial Submission Date	1/10/2024
Approval Date	04/03/2024	Effective Date	7/1/2024
Superseded SPA ID	WA-23-0008		
	User-Entered		

The state covers the mandatory former foster care children group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

- 1. Are under age 26
- 2. Were in foster care upon attaining age 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act (up to age 21).
- 3. Are described under either Section B. or C.

B. Individuals Covered

For individuals who turn 18 before January 1, 2023:

1. The state covers individuals who:

- a. Upon attaining age 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act (up to age 21) were:
 - i. In foster care under the responsibility of the state or a Tribe within the state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program); and
 - ii. Enrolled in Medicaid under the state's Medicaid state plan or 1115 demonstration; and
- b. Are not otherwise eligible for and enrolled for mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

2. In addition to B.1., the state elects to cover individuals who were in foster care under the responsibility of the state or a Tribe within the state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program) when they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act, and meet the following criteria:
- ☐ a. They were enrolled in Medicaid under the state's Medicaid state plan or 1115 demonstration at any time during the foster care period in which they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.
 - ☒ b. They were placed by the state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project when they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.
 - ☐ c. They were placed by the state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project at any time during the foster care period in which they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.

C. Individuals Covered

For individuals who turn 18 on or after January 1, 2023:

1. The state covers individuals who:

- a. Upon attaining age 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act (up to age 21) were:
 - i. In foster care under the responsibility of any state or a Tribe within any state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program); and
 - ii. Enrolled in Medicaid under a state's Medicaid state plan or 1115 demonstration; and
- b. Are not enrolled in mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

2. In addition to C.1., the state elects to cover individuals who were in foster care under the responsibility of any state or a Tribe within any state (including children who were cared for through a grant to a state under the unaccompanied refugee minor program) when they turned 18 or a higher age at which that state's or Tribe's foster care assistance ends under title IV-E of the Act, and meet the following criteria:
- ☐ a. They were enrolled in Medicaid under a state's Medicaid state plan or 1115 demonstration at any time during the foster care period in which they turned 18 or a higher age at which a state's or Tribe's foster care assistance ends.
 - ☒ b. They were placed by a state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project when they turned 18 or a higher age at which a state's or Tribe's foster care assistance ends.
 - ☐ c. They were placed by a state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project at any time during the foster care period in which they turned 18 or a higher age at which a state's or Tribe's foster care assistance ends.

Former Foster Care Children

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Package Header

Package ID	WA2024MS0001O	SPA ID	WA-24-0003
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	User-Entered		

D. Additional Information (optional)

The methodology used to determine income eligibility for the Community Behavioral Health Support (CBHS) in the Supportive Supervision and Oversight benefit approved under the authority of section 1915(i) of the Act excludes all income.

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Transitional Medical Assistance

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Families with Medicaid eligibility extended for up to 12 months because of earnings.

Package Header

Package ID	WA2024MS0001O	SPA ID	WA-24-0003
Submission Type	Official	Initial Submission Date	1/10/2024
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Superseded SPA ID	WA-91-22		
	User-Entered		

The state covers the mandatory transitional medical assistance group in accordance with the following provisions:

A. Characteristics

1. An individual qualifying under this eligibility group must meet one of the following criteria:

a. Lost coverage under the parents and other caretaker relatives group (42 CFR 435.110) due to work hours or income from employment, or

b. Is the child of a parent or caretaker relative described in A.1.a.
2. In accordance with the requirements described in section 1925 of the Act, and in this reviewable unit, the state provides extended Medicaid eligibility, as follows:

☐ a. The initial extended eligibility period is for 6 months, followed by a second extended eligibility period of 6 months.

☒ b. The initial extended eligibility period is for 12 months, with no second extended eligibility period.

Transitional Medical Assistance

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Package Header

Package ID	WA2024MS0001O	SPA ID	WA-24-0003
Submission Type	Official	Initial Submission Date	1/10/2024
Approval Date	04/03/2024	Effective Date	7/1/2024
Superseded SPA ID	WA-91-22		
	User-Entered		

B. Individuals Covered

1. Parents or other caretaker relatives
- a. A parent or other caretaker relative must meet the following criteria to qualify for an initial extended eligibility period:

i. Was eligible and enrolled in the parents and other caretaker relatives eligibility group, during the six months immediately preceding the month that eligibility was lost, for at least:

☐ (1) 1 month

☐ (2) 2 months

☒ (3) 3 months

ii. Lost eligibility under the parents and other caretaker relatives eligibility group because:

(1) The earnings of a parent or caretaker relative caused household income to exceed the income standard of that group; or

(2) The hours of employment of a parent or caretaker relative resulted in the individual no longer being considered to have a dependent child (as described in 42 CFR 435.4 and the Parents and Other Caretaker Relatives RU).

iii. Continues to live with a child.
2. A child qualifying under this eligibility group must meet all of the following requirements:
- a. Lives with a parent or other caretaker relative who is eligible under this eligibility group.

b. Is not eligible for the infants and children under age 19 eligibility group (42 CFR 435.118).

Transitional Medical Assistance

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Package Header

Package ID	WA2024MS0001O	SPA ID	WA-24-0003
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	User-Entered		

C. Initial Extended Eligibility Period

1. Income/Resource Standard Used

There is no income or resource standard.

2. Medical Assistance Provided

- a. The amount, duration, and scope of coverage provided is the same as that provided to parents and caretaker relatives enrolled in the parents and other caretaker relatives eligibility group and to children enrolled in the eligibility group for infants and children under age 19.
- b. The state's election to provide premium assistance for employer sponsored coverage is described in the benefits section of the state plan.

3. Termination of Extension

- a. If the family ceases to include a child, the initial extension of eligibility will end prior to the scheduled end date. In such cases, eligibility is terminated at the close of the first month in which the family no longer includes a child.
- b. Termination of eligibility will occur in accordance with all requirements described in the Eligibility Process RU.

Transitional Medical Assistance

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

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F. Additional Information (optional)

The methodology used to determine income eligibility for the Community Behavioral Health Support (CBHS) in the Supportive Supervision and Oversight benefit approved under the authority of section 1915(i) of the Act excludes all income.

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Closed Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Certain individuals who were eligible in the 1970s and 1980s and continue to qualify under specified requirements.

Package Header

Package ID	WA2024MS0001O	SPA ID	WA-24-0003
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The state covers mandatory individuals who were previously eligible for Medicaid in the 1970s or 1980s and continue to meet the eligibility requirements. These individuals are described in one or more of the following sections A through F.

A. Individuals Receiving Mandatory State Supplements

Individuals qualifying under this eligibility group must be receiving mandatory state supplements.

Closed Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

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User-Entered			

B. Individuals Who Are Essential Spouses

Individuals qualifying under this eligibility group must meet all of the following criteria:

1. In December, 1973 were eligible for Medicaid as essential spouses;
2. Have continued to live with and be essential to the well-being of an individual who continues to meet the eligibility requirements for one of the cash assistance programs under OAA, AB, APTD, or AABD; and
3. Continue to meet the December, 1973 criteria that applied in determining the amount of the cash payment.

Closed Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

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Superseded SPA ID	WA-91-22		
User-Entered			

C. Institutionalized Individuals Continuously Eligible Since 1973

Individuals qualifying under this eligibility group must meet all of the following criteria:

- 1. Were eligible for Medicaid in December, 1973 as inpatients of medical institutions or residents of intermediate care facilities participating in Medicaid;
- 2. For each consecutive month after December, 1973, continue to meet the requirements for Medicaid eligibility in effect under the state plan in December, 1973 for institutionalized individuals, and remain institutionalized; and
- 3. Are determined by the state or a professional standards review organization to continue to need institutional care.

Closed Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

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User-Entered			

D. Individuals Eligible in 1973 Who Have Blindness or a Disability

Individuals qualifying under this eligibility group must meet all of the following criteria:

- 1. Meet all the current Medicaid eligibility requirements, except for blindness and disability;
- 2. Were eligible for Medicaid in December, 1973 as blind or disabled; and
- 3. Continue to meet the December, 1973 criteria for Medicaid.

Closed Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

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User-Entered			

E. Individuals Who Lost Eligibility for SSI/SSP Due to an Increase in OASDI Benefits in 1972

Individuals qualifying under this eligibility group must meet the following criteria:

- 1. Were entitled to and receiving cash assistance in August, 1972, or would have been eligible had they applied or not been institutionalized (and the state covered these optional groups); and
- 2. Would currently be eligible for SSI or state supplement, except for the increase in OASDI under Public Law No. 92-336.

Closed Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

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Superseded SPA ID	WA-91-22		
	User-Entered		

F. Disabled Widows and Widowers Ineligible for SSI due to Increase in OASDI

1. Individuals qualifying under this eligibility group must meet all of the following criteria:
- a. Are disabled widows or widowers who are deemed to be SSI or state supplement beneficiaries.

b. Became ineligible for SSI or state supplement as a result of the elimination of the reduction factor required by section 134 of Public. Law No. 98-21.

c. Would be eligible for SSI or state supplement, except for the increase under Public Law No. 98-21 and subsequent cost-of-living increases in widow's or widower's benefits under section 215(i) of the Act.

d. Filed a written application for Medicaid on or before June 30,1988.

2. Individuals receiving only state supplement qualify for this group.

- ☒ Yes
- ☐ No

3. SSI Methodologies are used in calculating household income.

Closed Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

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Superseded SPA ID	WA-91-22		
	User-Entered		

G. Additional Information (optional)

The methodology used to determine income eligibility for the Community Behavioral Health Support (CBHS) in the Supportive Supervision and Oversight benefit approved under the authority of section 1915(i) of the Act excludes all income.

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Working Individuals under 1619(b)

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Individuals who have blindness or a disability who participated in Medicaid as SSI beneficiaries or who were considered to be receiving SSI, who would still qualify for SSI except for earnings.

Package Header

Package ID	WA2024MS0001O	SPA ID	WA-24-0003
Submission Type	Official	Initial Submission Date	1/10/2024
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Superseded SPA ID	WA-91-22		
User-Entered			

The state covers the working individuals under 1619(b) mandatory eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

- In the month preceding the month of qualification under this group:
 - Received SSI or state supplement; and
 - Were eligible for Medicaid under the state plan.
- Continue to have blindness or a disability.
- Continue to meet all non-disability-related requirements for eligibility for SSI or state supplement.
- Would qualify for SSI or State Supplement, except for earned income.
- For whom the loss of eligibility for Medicaid would seriously inhibit the individual's ability to continue or obtain employment.
- For whom the individual's earnings are not sufficient to provide a reasonable equivalent of SSI (including state supplement), Medicaid, and publicly funded attendant care services.

Working Individuals under 1619(b)

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

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Superseded SPA ID	WA-91-22		
	User-Entered		

B. Additional Information (optional)

The methodology used to determine income eligibility for the Community Behavioral Health Support (CBHS) in the Supportive Supervision and Oversight benefit approved under the authority of section 1915(i) of the Act excludes all income.

Medicaid State Plan Eligibility

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

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Submission Type	Official	Initial Submission Date	1/10/2024
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System-Derived			

A. Options for Coverage

The state provides Medicaid to specified optional groups of individuals.

☒ Yes ☐ No

The optional eligibility groups covered in the state plan are (elections made in this screen may not be comprehensive during the transition period from the paper-based state plan to MACPro):

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Optional Coverage of Parents and Other Caretaker Relatives		☐	☐	☐	NEW
Reasonable Classifications of Individuals under Age 21		☒	☒	☐	APPROVED
Children with Non-IV-E Adoption Assistance		☒	☒	☐	APPROVED
Independent Foster Care Adolescents		☐	☐	☐	NEW
Optional Targeted Low Income Children		☐	☐	☐	NEW
Individuals above 133% FPL under Age 65		☐	☐	☐	APPROVED
Individuals Needing Treatment for Breast or Cervical Cancer		☒	☒	☐	APPROVED
Individuals Eligible for Family Planning Services		☐	☐	☐	NEW
Individuals with Tuberculosis		☐	☐	☐	NEW
Individuals Electing COBRA Continuation Coverage		☐	☐	☐	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Individuals Eligible for but Not Receiving Cash Assistance		☒	☐	☐	APPROVED

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Individuals Eligible for Cash Except for Institutionalization		☒	☐	☐	APPROVED
Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules		☒	☐	☐	APPROVED
Optional State Supplement Beneficiaries		☐	☐	☐	NEW
Individuals in Institutions Eligible under a Special Income Level		☒	☐	☐	NEW
PACE Participants		☒	☐	☐	NEW
Individuals Receiving Hospice		☒	☐	☐	NEW
Children under Age 19 with a Disability		☐	☐	☐	NEW
Age and Disability-Related Poverty Level		☐	☐	☐	NEW
Work Incentives		☒	☒	☐	APPROVED
Ticket to Work Basic		☒	☒	☐	APPROVED
Ticket to Work Medical Improvements		☒	☒	☐	APPROVED
Family Opportunity Act Children with a Disability		☐	☐	☐	NEW
Individuals Receiving State Plan Home and Community-Based Services		☐	☐	☐	NEW
Individuals Receiving State Plan Home and Community-Based Services Who Are Otherwise Eligible for HCBS Waivers		☐	☐	☐	NEW

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Package Header

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Superseded SPA ID	WA-21-0002		
	System-Derived		

B. Medically Needy Options for Coverage

The state provides Medicaid to specified groups of individuals who are medically needy.

☒ Yes ☐ No

The medically needy eligibility groups covered in the state plan are:

1. Mandatory Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Medically Needy Pregnant Women		☒	☐	☐	NEW
Medically Needy Children under Age 18		☒	☐	☐	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Protected Medically Needy Individuals Who Were Eligible in 1973		☒	☐	☐	NEW

2. Optional Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Medically Needy Reasonable Classifications of Individuals under Age 21		☒	☐	☐	NEW
Medically Needy Parents and Other Caretaker Relatives		☐	☐	☐	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Medically Needy Populations Based on Age, Blindness or Disability		☒	☐	☐	APPROVED

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Package Header

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Superseded SPA ID	WA-21-0002		
	System-Derived		

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Reasonable Classification of Individuals under Age 21

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

One or more reasonable classifications of individuals under age 21 who are not mandatorily eligible and who have income at or below a standard established by the state.

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Superseded SPA ID	WA-13-0030		
	System-Derived		

The state covers the reasonable classifications of individuals under age 21 group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

- 1. Are under age 21, or a lower age, as specified in C.
- 2. Have household income at or below the standard established by the state, if the state has an income standard.
- 3. Are not otherwise eligible for and enrolled in mandatory coverage under the state plan.

B. Financial Methodologies

MAGI-based methodologies are used in calculating household income. Please refer as necessary to MAGI-Based Methodologies, completed by the state.

Reasonable Classification of Individuals under Age 21

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

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	System-Derived		

C. Individuals Covered

1.The state covered all children under a specified age or at least one reasonable classification under this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013, with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age.

- ☒ Yes
- ☐ No

2. The state covers at least one age group or reasonable classification of children who were not covered prior to January 1, 2014.

- ☐ Yes
- ☒ No

3. The state covers at least one age group or reasonable classification of children who were covered prior to January 1, 2014.

- ☒ Yes
- ☐ No

a. The state covers all children under a specified age limit who were covered prior to January 1, 2014.

- ☐ Yes
- ☒ No

b. Reasonable classifications of children who were covered prior to January 1, 2014, and are still covered:

Name of classification	Age Range
Pregnant teens	Under age 19

Name: Pregnant teens

Description: Pregnant teens

Age Covered: Under age 19

Reasonable Classification of Individuals under Age 21

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

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Superseded SPA ID	WA-13-0030		
	System-Derived		

D. Income Standard Used

- Pregnant teens

The income standard for this age group or classification that was covered prior to January 1, 2014 and is still covered is:

- ☐ 1. No income test
- ☒ 2. The maximum standard
- ☐ 3. Another income standard

Reasonable Classification of Individuals under Age 21

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

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	System-Derived		

E. Basis for Income Standard

- Pregnant teens

1. Minimum income standard

The minimum income standard for this age group or classification is an FPL percent greater than lowest income standard chosen for children under this age under the Infants and Children under Age 19 eligibility group.

2. Maximum Income Standard

- ☒ a. The state certifies that it has submitted and received approval for its converted income standards for this age group or classification to MAGI-equivalent standards and the determination of the maximum income standard to be used for this classification of children under this eligibility group.
- b. The state's maximum income standard for this age group or classification is:

☐ i. The state's effective income level for this age group or classification under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

☒ ii. The state's effective income level for this age group or classification under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

☐ iii. The state's effective income level for this age group or classification under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

☐ iv. The state's effective income level for this age group or classification under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- c. The amount of the maximum income standard is:

☐ i. A percentage of the federal poverty level:

☒ ii. No income test

☐ iii. The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in AFDC Income Standards.

☐ iv. The maximum income standard for Parents and Other Caretaker relatives.

☐ v. Other dollar amount

Reasonable Classification of Individuals under Age 21

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Package Header

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	System-Derived		

F. Additional Information (Optional)

The methodology used to determine income eligibility for the Community Behavioral Health Support (CBHS) in the Supportive Supervision and Oversight benefit approved under the authority of section 1915(i) of the Act excludes all income.

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Children with Non IV-E Adoption Assistance

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Children with special needs for medical or rehabilitative care for whom there is a non IV-E adoption assistance agreement in effect with a state, who were eligible for Medicaid immediately before the adoption agreement was executed, or who had income at that point in time at or below a standard established by the state .

Package Header

Package ID	WA2024MS0001O	SPA ID	WA-24-0003
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Superseded SPA ID	WA-13-0030		
	System-Derived		

The state covers the children with non IV-E adoption assistance group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are under age 21 or a lower age, as specified in C.
2. Have a state adoption assistance agreement in effect between the adoptive parent(s) and a state.
3. The state adoption agency has determined that they cannot be placed for adoption without Medicaid coverage because of special needs for medical or rehabilitative care.
4. Immediately prior to execution of the adoption agreement, were eligible under the Medicaid state plan of the state with the adoption assistance agreement or, at the state's option, immediately prior to execution of the adoption agreement had income no more than the income standard (which could be no income test) specified in Section D.
5. Are not otherwise eligible for and enrolled in mandatory coverage under the state plan.

B. Financial Methodologies

When income is considered, MAGI-based methodologies are used in calculating household income. Please refer as necessary to MAGI-Based Methodologies, completed by the state.

Children with Non IV-E Adoption Assistance

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

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Superseded SPA ID	WA-13-0030		
	System-Derived		

C. Individuals Covered

1. The state covers all children under a specified age limit for whom there is an adoption assistance agreement in place from any state.

- ☒ Yes
- ☐ No

- a. The age of children covered under this eligibility group is.

☒ i. Under age 21

☐ ii. Under age 20

☐ iii. Under age 19

☐ iv. Under age 18
- b. In addition, the state covers reasonable classifications of children.

☐ Yes

☒ No

Children with Non IV-E Adoption Assistance

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

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	System-Derived		

D. Income Standard Used

1. The state covered this eligibility group in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

- ☒ Yes
- ☐ No

2. The state used an income standard or disregarded all income for this group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

- ☒ Yes
- ☐ No

Age Group or Classification : All children Under age 21

3. For individuals who were not eligible under the Medicaid state plan immediately prior to execution of the adoption agreement, the state additionally elects to establish an income standard for this age group or classification.

- ☒ Yes
- ☐ No

4. The income standard used for this age group or classification to determine if the child is eligible now, using the child's household income immediately before the execution of the adoption assistance agreement, is:

- ☐ a. No income test
- ☒ b. An income standard

i. The income standard for this age group or classification is based on a percentage of the federal poverty level.

- ☒ Yes
- ☐ No

ii. The state uses the following income standard for this age group or classification:

210.00% FPL

Children with Non IV-E Adoption Assistance

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

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System-Derived			

E. Basis for Income Standard - Maximum Income Standard

- ☒ 1. The state certifies that it has submitted and received approval for its converted income standards for this group to MAGI-equivalent standards and the determination of the maximum income standard to be used for this eligibility group.
2. The state's maximum income standard for this eligibility group is:

☒ a. The state's effective income level for this eligibility group under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

☐ b. The state's effective income level for this eligibility group under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

☐ c. The state's effective income level for this eligibility group under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

☐ d. The state's effective income level for this eligibility group under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.
3. The amount of the maximum income standard is:

☒ a. A percentage of the federal poverty level

FPL 210.00%

☐ b. No income test

☐ c. The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in AFDC Income Standards.

☐ d. The maximum income standard for Parents and Other Caretaker relatives.

☐ e. Other dollar amount

Children with Non IV-E Adoption Assistance

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

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	System-Derived		

F. Additional Information (optional)

The methodology used to determine income eligibility for the Community Behavioral Health Support (CBHS) in the Supportive Supervision and Oversight benefit approved under the authority of section 1915(i) of the Act excludes all income.

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Individuals Needing Treatment for Breast or Cervical Cancer

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Individuals under the age of 65 who have been screened for breast or cervical cancer and need treatment.

Package Header

Package ID	WA2024MS0001O	SPA ID	WA-24-0003
Submission Type	Official	Initial Submission Date	1/10/2024
Approval Date	04/03/2024	Effective Date	7/1/2024
Superseded SPA ID	WA-14-0020		
	User-Entered		

The state operates the optional Individuals Needing Treatment for Breast or Cervical Cancer eligibility group in accordance with the following provisions:

A. Characteristics

Individuals (including women and men) qualifying under this eligibility group must meet the following criteria:

1. Are under the age of 65.
2. Are not otherwise eligible for and enrolled in mandatory coverage under the state plan.
3. Have been screened under the Centers for Disease Control and Prevention (CDC) Breast and Cervical Cancer Early Detection Program.
4. As a result of the screening, a determination has been made that the individual needs treatment for breast or cervical cancer, as defined at 42 CFR 435.213(c).
5. Do not otherwise have creditable coverage for treatment of breast or cervical cancer.

Individuals Needing Treatment for Breast or Cervical Cancer

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

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Superseded SPA ID	WA-14-0020		
	User-Entered		

B. Financial Methodologies

This eligibility group has no income or resource test.

Individuals Needing Treatment for Breast or Cervical Cancer

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Package Header

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Superseded SPA ID	WA-14-0020		
	User-Entered		

C. Additional Information (optional)

The methodology used to determine income eligibility for the Community Behavioral Health Support (CBHS) in the Supportive Supervision and Oversight benefit approved under the authority of section 1915(i) of the Act excludes all income.

Eligibility Groups - Options for Coverage

Work Incentives

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Individuals with a disability with income below 250% of the FPL, who would qualify for SSI except for earned income.

Package Header

Package ID	WA2024MS0001O	SPA ID	WA-24-0003
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Superseded SPA ID	WA-20-0030		
	System-Derived		

The state covers the optional Work Incentives eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

- 1. Have earned income.
- 2. Meet the SSI definition of disability, but for earned income.
- 3. Meet income and resource standards following a two-step process, which includes:
 - a. Step One - A comparison of family net income to 250% FPL; and
 - b. Step Two - A comparison of individual net income and resources to the SSI standards, excluding earned income.

Work Incentives

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

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	System-Derived		

B. Step One Financial Methodologies and Income Test

1. Financial methodologies

a. SSI methodologies are used in calculating family income. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

b. Less restrictive methodologies are used in calculating countable income.

- ☒ Yes
- ☐ No

The less restrictive income methodologies are:

- ☒ All income is disregarded. No income test is applied.
- ☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
Financial Disregard for 1915i	Income above 150 percent of the FPL is disregarded for individuals who meet the needs-based and targeting criteria for Community Behavioral Health Support (CBHS) in the Supportive Supervision and Oversight benefit approved under the authority of section 1915(i) of the Act.

2. Income Test

Family net income must be less than 250% FPL. Please refer as necessary to Non-MAGI Methodologies for the definition of family size.

Work Incentives

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Package Header

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C. Step Two Financial Methodologies and Income/Resource Test

1. Financial methodologies

- a. SSI methodologies are used in calculating income and resources, except that earned income is not counted. Please refer as necessary to Non-MAGI Methodologies, completed by the state.
- b. Less restrictive methodologies are used in calculating countable income.

☒ Yes

☐ No

The less restrictive income methodologies are:

- ☒ All income is disregarded. No income test is applied.

c. Less restrictive methodologies are used in calculating countable resources.

☒ Yes

☐ No

The less restrictive resource methodologies are:

- ☒ All resources are disregarded. No resource test is applied.
- ☒ The state uses a less restrictive methodology with respect to the treatment of resources set aside in specified types of accounts.

☒ Resources set aside in Independence/Freedom accounts

Description:

Designated separate account that consists only of earnings resulting from work activity while enrolled in the Ticket and BBA work incentives eligibility groups.

2. Income Test

- For individuals who pass Step One, in Step Two, the individual's unearned income (plus deemed income, if appropriate) must be less than one of the following income standards:
- ☐ a. The SSI income standard.

☒ b. The income standard of the state supplement program.

3. Resource Test

The individual's resources must be less than the SSI resource standard.

Work Incentives

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

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	System-Derived		

D. Premiums and Cost Sharing

Requirements for premiums and cost sharing for this group are found in the premium and cost sharing sections of the state plan.

Work Incentives

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

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E. Additional Information (optional)

Requirements for premiums and cost sharing for this group are found in the premium and cost sharing sections, as well as in attachment 2.6-A page 12o.

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Ticket to Work Basic

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Individuals between ages 16 and 64 with a disability, who have earned income.

Package Header

Package ID	WA2024MS0001O	SPA ID	WA-24-0003
Submission Type	Official	Initial Submission Date	1/10/2024
Approval Date	04/03/2024	Effective Date	7/1/2024
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The state covers the optional Ticket to Work basic eligibility group in accordance with the following provisions:

Ticket to Work Basic

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	System-Derived		

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

- 1. Are at least age 16 but less than 65 years of age.
- 2. Have earned income.
- 3. But for earned income, meet the SSI definition of disability.
- 4. Have income and resources that do not exceed the standards established by the state.

Ticket to Work Basic

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

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	System-Derived		

B. Financial Methodologies

1. SSI methodologies are used in calculating household income and resources. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

- ☒ Yes
- ☐ No

The less restrictive income methodologies are:

- ☒ All income is disregarded. No income test is applied.
- ☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
Financial Disregard for 1915i	Income above 150 percent of the FPL is disregarded for individuals who meet the needs-based and targeting criteria for Community Behavioral Health Support (CBHS) in the Supportive Supervision and Oversight benefit approved under the authority of section 1915(i) of the Act.

3. Less restrictive methodologies are used in calculating countable resources.

- ☒ Yes
- ☐ No

The less restrictive resource methodologies are:

- ☒ All resources are disregarded. No resource test is applied.
- ☒ The state uses a less restrictive methodology with respect to the treatment of resources set aside in specified types of accounts.
- ☒ Resources set aside in Independence/Freedom accounts

Description:

Designated separate account that consists only of earnings resulting from work activity while enrolled in the Ticket and BBA work incentives eligibility groups.

Ticket to Work Basic

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Package Header

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	System-Derived		

C. Income Standard Used

The income standard for this group is:

- ☒ 1. No income standard
- ☐ 2. A percentage of the federal poverty level:
- ☐ 3. A percentage of the SSI Federal Benefit Rate:
- ☐ 4. A dollar amount
- ☐ 5. Other

Ticket to Work Basic

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

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	System-Derived		

D. Resource Standard Used

The resource standard for this group is:

- ☒ 1. No resource standard
- ☐ 2. SSI resource standard
- ☐ 4. A dollar amount higher than the SSI resource standard

Ticket to Work Basic

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

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E. Premiums and Cost Sharing

Requirements for premiums and cost sharing for this group are found in the premium and cost sharing sections of the state plan.

Ticket to Work Basic

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Package Header

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	System-Derived		

F. Additional Information (optional)

Requirements for premiums and cost sharing for this group are found in the premium and cost sharing sections, as well as in attachment 2.6-A page 12o.

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Ticket to Work Medical Improvements

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Employed individuals between ages 16 and 64 who are no longer disabled but still have a medical impairment.

Package Header

Package ID	WA2024MS0001O	SPA ID	WA-24-0003
Submission Type	Official	Initial Submission Date	1/10/2024
Approval Date	04/03/2024	Effective Date	7/1/2024
Superseded SPA ID	WA-20-0030		
	System-Derived		

The state covers the optional Ticket to Work medical improvements eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are at least age 16 but less than 65 years of age.
2. Lost eligibility for the Ticket to Work basic eligibility group because it was determined at a regular disability review that they no longer meet the disability criteria.
3. Continue to have a severe medically determinable impairment.
4. Are employed, using the following definition:

☒ a. Earning at least the minimum wage and working at least 40 hours per month.

☐ b. An alternative definition
5. Have income and resources that do not exceed the standards established by the state.

Ticket to Work Medical Improvements

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Package Header

Package ID	WA2024MS0001O	SPA ID	WA-24-0003
Submission Type	Official	Initial Submission Date	1/10/2024
Approval Date	04/03/2024	Effective Date	7/1/2024
Superseded SPA ID	WA-20-0030		
	System-Derived		

B. Financial Methodologies

1. SSI methodologies are used in calculating household income and resources. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

- ☒ Yes
- ☐ No

The less restrictive income methodologies are:

- ☒ All income is disregarded. No income test is applied.
- ☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
Financial Disregard for 1915i	Income above 150 percent of the FPL is disregarded for individuals who meet the needs-based and targeting criteria for Community Behavioral Health Support (CBHS) in the Supportive Supervision and Oversight benefit approved under the authority of section 1915(i) of the Act.

3. Less restrictive methodologies are used in calculating countable resources.

- ☒ Yes
- ☐ No

The less restrictive resource methodologies are:

- ☒ All resources are disregarded. No resource test is applied.
- ☒ The state uses a less restrictive methodology with respect to the treatment of resources set aside in specified types of accounts.
- ☒ Resources set aside in Independence/Freedom accounts

Description:

Designated separate account that consists only of earnings resulting from work activity while enrolled in the Ticket and BBA work incentives eligibility groups.

Ticket to Work Medical Improvements

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Package Header

Package ID	WA2024MS0001O	SPA ID	WA-24-0003
Submission Type	Official	Initial Submission Date	1/10/2024
Approval Date	04/03/2024	Effective Date	7/1/2024
Superseded SPA ID	WA-20-0030		
	System-Derived		

C. Income Standard Used

The income standard for this group is:

- ☒ 1. No income standard
- ☐ 2. A percentage of the federal poverty level:
- ☐ 3. A percentage of the SSI Federal Benefit Rate:
- ☐ 4. A dollar amount
- ☐ 5. Other

Ticket to Work Medical Improvements

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Package Header

Package ID	WA2024MS0001O	SPA ID	WA-24-0003
Submission Type	Official	Initial Submission Date	1/10/2024
Approval Date	04/03/2024	Effective Date	7/1/2024
Superseded SPA ID	WA-20-0030		
	System-Derived		

D. Resource Standard Used

The resource standard for this group is:

- ☒ 1. No resource standard
- ☐ 2. SSI resource standard
- ☐ 4. A dollar amount higher than the SSI resource standard

Ticket to Work Medical Improvements

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Package Header

Package ID	WA2024MS0001O	SPA ID	WA-24-0003
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Superseded SPA ID	WA-20-0030		
	System-Derived		

E. Premiums and Cost Sharing

Requirements for premiums and cost sharing for this group are found in the premium and cost sharing sections of the state plan.

Ticket to Work Medical Improvements

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0001O | WA-24-0003

Package Header

Package ID	WA2024MS0001O	SPA ID	WA-24-0003
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Superseded SPA ID	WA-20-0030		
	System-Derived		

F. Additional Information (optional)

Requirements for premiums and cost sharing for this group are found in the premium and cost sharing sections, as well as in attachment 2.6-A page 12o.

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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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WA - Submission Package - WA2024MS0007O - (WA-24-0018-2) - Eligibility

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CMS-10434 OMB 0938-1188

Medicaid State Plan Eligibility

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0007O | WA-24-0018-2

Package Header

Package ID	WA2024MS0007O	SPA ID	WA-24-0018-2
Submission Type	Official	Initial Submission Date	4/3/2024
Approval Date	05/03/2024	Effective Date	4/1/2024
Superseded SPA ID	WA-23-0008		
	System-Derived		

Mandatory Coverage

A. The state provides Medicaid to mandatory groups of individuals. The mandatory groups covered are:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Infants and Children under Age 19		☒	☐	☐	APPROVED
Parents and Other Caretaker Relatives		☒	☐	☐	CONVERTED
Pregnant Women		☒	☐	☐	APPROVED
Deemed Newborns		☒	☐	☐	NEW
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care		☒	☐	☐	APPROVED
Former Foster Care Children		☒	☐	☐	APPROVED
Transitional Medical Assistance		☒	☐	☐	APPROVED
Extended Medicaid due to Spousal Support Collections		☒	☐	☐	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
SSI Beneficiaries		☒	☐	☐	NEW
Closed Eligibility Groups		☒	☐	☐	APPROVED
Individuals Deemed To Be Receiving SSI		☒	☐	☐	NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Working Individuals under 1619(b)		☒	☐	☐	APPROVED
Qualified Medicare Beneficiaries		☒	☒	☐	APPROVED
Qualified Disabled and Working Individuals		☒	☐	☐	NEW
Specified Low Income Medicare Beneficiaries		☒	☒	☐	APPROVED
Qualifying Individuals		☒	☒	☐	APPROVED

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0007O | WA-24-0018-2

Package Header

Package ID	WA2024MS0007O	SPA ID	WA-24-0018-2
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	System-Derived		

B. The state elects the Adult Group, described at 42 CFR 435.119.

☒ Yes ☐ No

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Adult Group		☒	☐	☐	CONVERTED

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Qualified Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0007O | WA-24-0018-2

Individuals with income equal to or less than 100% of the FPL, who are entitled to Medicare Part A, and who qualify for Medicare cost-sharing.

Package Header

Package ID	WA2024MS0007O	SPA ID	WA-24-0018-2
Submission Type	Official	Initial Submission Date	4/3/2024
Approval Date	05/03/2024	Effective Date	4/1/2024
Superseded SPA ID	WA-22-0034		
	System-Derived		

The state covers the mandatory qualified Medicare beneficiaries group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are entitled to hospital insurance benefits under part A of title XVIII (Medicare Part A), including individuals who have purchased a premium to enroll in Part A.
2. Have income and resources at or below the standard for this group.

Qualified Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0007O | WA-24-0018-2

Package Header

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Superseded SPA ID	WA-22-0034		
	System-Derived		

B. Financial Methodologies

1. SSI methodologies are used in calculating household income. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

- ☒ Yes
- ☐ No

The less restrictive income methodologies are:

☒ The difference between one income standard and another is disregarded.

☒ Between the following percentages of the FPL:

FPL 100.00%

and

FPL 110.00%

- ☐ Between the medically needy income limit and a percentage of the FPL:
- ☐ Between the SSI Federal Benefit Rate and:
- ☐ Between other income standards:

☒ Census Bureau wages are disregarded.

Description of disregard:

Wages paid by the Census Bureau for temporary employment related to census activities are excluded.

☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
Income tax obligation	Unearned income withheld, prior receipt by the individual, for income tax purposes, or otherwise withheld beyond the individual's control, is considered exempt when determining eligibility.
MSP	When determining the available income of an individual for the QMB or SLMB program the agency shall exclude from countable income an amount equal to that expended on medical expenses.

3. Less restrictive methodologies are used in calculating countable resources.

- ☒ Yes
- ☐ No

The less restrictive resource methodologies are:

☒ All resources are disregarded. No resource test is applied.

Qualified Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0007O | WA-24-0018-2

Package Header

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	System-Derived		

C. Income Standard Used

The amount of the income standard for this group is 100% FPL.

D. Resource Standard Used

The resource standard is the same used to determine eligibility for the Medicare Part D full-benefit low-income subsidy (LIS) (but without regard to the life insurance policy exclusion applied in LIS resource eligibility determinations). This standard is three times the SSI resource standard, adjusted annually in accordance with the consumer price index.

E. Medical Assistance Provided

Medical assistance is limited to payment of co-insurance and deductibles for Medicare Parts A, B and C and payment for the premiums for Medicare Parts A and B.

Medical assistance begins the first day of the month following the month in which the individual is determined to qualify for this eligibility group.

Qualified Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0007O | WA-24-0018-2

Package Header

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	System-Derived		

F. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Specified Low Income Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0007O | WA-24-0018-2

Individuals with income above 100% and below 120% of the FPL who are entitled to Medicare Part A, who qualify for payment of Medicare Part B premiums.

Package Header

Package ID	WA2024MS0007O	SPA ID	WA-24-0018-2
Submission Type	Official	Initial Submission Date	4/3/2024
Approval Date	05/03/2024	Effective Date	4/1/2024
Superseded SPA ID	WA-22-0034		
	System-Derived		

The state covers the mandatory specified low income Medicare beneficiaries group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Would qualify as Qualified Medicare Beneficiaries (described in section 1905(p)(1) of the Act), except that their income exceeds the income level for that eligibility group.
2. Have income below the income standard and resources at or below the resource standard for this group.

Specified Low Income Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0007O | WA-24-0018-2

Package Header

Package ID	WA2024MS0007O	SPA ID	WA-24-0018-2
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Superseded SPA ID	WA-22-0034		
	System-Derived		

B. Financial Methodologies

1. SSI methodologies are used in calculating household income. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

- ☒ Yes
- ☐ No

The less restrictive income methodologies are:

☒ Census Bureau wages are disregarded.

Description of disregard:

Wages paid by the Census Bureau for temporary employment related to census activities are excluded.

☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
Income tax obligation	Unearned income withheld, prior receipt by the individual, for income tax purposes, or otherwise withheld beyond the individual's control, is considered exempt when determining eligibility
MSP	When determining the available income of an individual for the QMB or SLMB program the agency shall exclude from countable income an amount equal to that expended on medical expenses.

3. Less restrictive methodologies are used in calculating countable resources.

- ☒ Yes
- ☐ No

The less restrictive resource methodologies are:

☒ All resources are disregarded. No resource test is applied.

Specified Low Income Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0007O | WA-24-0018-2

Package Header

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Superseded SPA ID	WA-22-0034		
	System-Derived		

C. Income Standard Used

Family income must be above 100% FPL and below 120% FPL.

D. Resource Standard Used

The resource standard is the same used to determine eligibility for the Medicare Part D full-benefit low-income subsidy (LIS) (but without regard to the life insurance policy exclusion applied in LIS resource eligibility determinations). This standard is three times the SSI resource standard, adjusted annually in accordance with the consumer price index.

E. Medical Assistance Provided

Medical assistance is limited to payment for Medicare Part B premiums.

Specified Low Income Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0007O | WA-24-0018-2

Package Header

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F. Additional Information (optional)

SLMB FPL between 101-110% FPL is being subsumed into to the QMB group due to the requested expansion.

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Qualifying Individuals

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0007O | WA-24-0018-2

Individuals with income at or above 120% and below 135% of the FPL who are entitled to Medicare Part A, who qualify for payment of Medicare Part B premiums.

Package Header

Package ID	WA2024MS0007O	SPA ID	WA-24-0018-2
Submission Type	Official	Initial Submission Date	4/3/2024
Approval Date	05/03/2024	Effective Date	4/1/2024
Superseded SPA ID	WA-22-0034		
	System-Derived		

The state covers the mandatory qualifying individuals group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet all of the following criteria:

1. Would qualify as Qualified Medicare Beneficiaries (described in section 1905(p)(1) of the Act), except that their income exceeds the income level for that eligibility group.
2. Are not otherwise eligible for Medicaid under the state plan.
3. Have income below the income standard and resources at or below the resource standard for this group.

Qualifying Individuals

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0007O | WA-24-0018-2

Package Header

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Superseded SPA ID	WA-22-0034		
	System-Derived		

B. Financial Methodologies

1. SSI methodologies are used in calculating household income. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

- ☒ Yes
- ☐ No

The less restrictive income methodologies are:

- ☒ The difference between one income standard and another is disregarded.

☒ Between the following percentages of the FPL:

FPL 135.00%

and

FPL 138.00%

☐ Between the medically needy income limit and a percentage of the FPL:

☐ Between the SSI Federal Benefit Rate and:

☐ Between other income standards:

- ☒ Census Bureau wages are disregarded.

Description of disregard:

Wages paid by the Census Bureau for temporary employment related to census activities are excluded.

- ☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
Income tax obligation	Unearned income withheld, prior receipt by the individual, for income tax purposes, or otherwise withheld beyond the individual's control, is considered exempt when determining eligibility.

3. Less restrictive methodologies are used in calculating countable resources.

- ☒ Yes
- ☐ No

The less restrictive resource methodologies are:

- ☒ All resources are disregarded. No resource test is applied.

Qualifying Individuals

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0007O | WA-24-0018-2

Package Header

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Superseded SPA ID	WA-22-0034		
	System-Derived		

C. Income Standard Used

Family income must be at or above 120% FPL and below 135% FPL.

D. Resource Standard Used

The resource standard is the same used to determine eligibility for the Medicare Part D full-benefit low-income subsidy (LIS) (but without regard to the life insurance policy exclusion applied in LIS resource eligibility determinations). This standard is three times the SSI resource standard, adjusted annually in accordance with the consumer price index.

E. Medical Assistance Provided

Medical assistance is limited to payment for Medicare Part B premiums.

Qualifying Individuals

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0007O | WA-24-0018-2

Package Header

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	System-Derived		

F. Additional Information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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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WA - Submission Package - WA2024MS0011O - (WA-24-0048) - Eligibility

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CMS-10434 OMB 0938-1188

Medicaid State Plan Eligibility

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0011O | WA-24-0048

Package Header

Package ID	WA2024MS0011O	SPA ID	WA-24-0048
Submission Type	Official	Initial Submission Date	12/24/2024
Approval Date	02/26/2025	Effective Date	11/1/2024
Superseded SPA ID	WA-24-0003		
	System-Derived		

A. Options for Coverage

The state provides Medicaid to specified optional groups of individuals.

☒ Yes ☐ No

The optional eligibility groups covered in the state plan are (elections made in this screen may not be comprehensive during the transition period from the paper-based state plan to MACPro):

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Optional Coverage of Parents and Other Caretaker Relatives		☐	☐	☐	NEW
Reasonable Classifications of Individuals under Age 21		☒	☐	☐	APPROVED
Children with Non-IV-E Adoption Assistance		☒	☐	☐	APPROVED
Independent Foster Care Adolescents		☐	☐	☐	NEW
Optional Targeted Low Income Children		☐	☐	☐	NEW
Individuals above 133% FPL under Age 65		☒	☒	☐	APPROVED
Individuals Needing Treatment for Breast or Cervical Cancer		☒	☐	☐	APPROVED
Individuals Eligible for Family Planning Services		☐	☐	☐	NEW
Individuals with Tuberculosis		☐	☐	☐	NEW
Individuals Electing COBRA Continuation Coverage		☐	☐	☐	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Individuals Eligible for but Not Receiving Cash Assistance		☒	☐	☐	APPROVED
Individuals Eligible for Cash Except for Institutionalization		☒	☐	☐	APPROVED
Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules		☒	☐	☐	APPROVED
Optional State Supplement Beneficiaries		☐	☐	☐	NEW
Individuals in Institutions Eligible under a Special Income Level		☒	☐	☐	NEW
PACE Participants		☒	☐	☐	NEW
Individuals Receiving Hospice		☒	☐	☐	NEW
Children under Age 19 with a Disability		☐	☐	☐	NEW
Age and Disability-Related Poverty Level		☐	☐	☐	NEW
Work Incentives		☒	☐	☐	APPROVED
Ticket to Work Basic		☒	☐	☐	APPROVED
Ticket to Work Medical Improvements		☒	☐	☐	APPROVED
Family Opportunity Act Children with a Disability		☐	☐	☐	NEW
Individuals Receiving State Plan Home and Community-Based Services		☐	☐	☐	NEW
Individuals Receiving State Plan Home and Community-Based Services Who Are Otherwise Eligible for HCBS Waivers		☐	☐	☐	NEW

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0011O | WA-24-0048

Package Header

Package ID	WA2024MS0011O	SPA ID	WA-24-0048
Submission Type	Official	Initial Submission Date	12/24/2024
Approval Date	02/26/2025	Effective Date	11/1/2024
Superseded SPA ID	WA-24-0003		
System-Derived			

B. Medically Needy Options for Coverage

The state provides Medicaid to specified groups of individuals who are medically needy.

☒ Yes ☐ No

The medically needy eligibility groups covered in the state plan are:

1. Mandatory Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Medically Needy Pregnant Women		☒	☐	☐	NEW
Medically Needy Children under Age 18		☒	☐	☐	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Protected Medically Needy Individuals Who Were Eligible in 1973		☒	☐	☐	NEW

2. Optional Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Medically Needy Reasonable Classifications of Individuals under Age 21		☒	☐	☐	NEW
Medically Needy Parents and Other Caretaker Relatives		☐	☐	☐	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Medically Needy Populations Based on Age, Blindness or Disability		☒	☐	☐	APPROVED

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0011O | WA-24-0048

Package Header

Package ID	WA2024MS0011O	SPA ID	WA-24-0048
Submission Type	Official	Initial Submission Date	12/24/2024
Approval Date	02/26/2025	Effective Date	11/1/2024
Superseded SPA ID	WA-24-0003		
	System-Derived		

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Individuals above 133% FPL under Age 65

MEDICAID | Medicaid State Plan | Eligibility | WA2024MS0011O | WA-24-0048

Individuals under 65, not otherwise mandatorily or optionally eligible, with income above 133% FPL and at or below a standard established by the state.

Package Header

Package ID	WA2024MS0011O	SPA ID	WA-24-0048
Submission Type	Official	Initial Submission Date	12/24/2024
Approval Date	02/26/2025	Effective Date	11/1/2024
Superseded SPA ID	WA-13-0030		
	User-Entered		

The state covers the optional individuals above 133% FPL group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are under age 65
2. Are not otherwise eligible for and enrolled in mandatory coverage under the state plan
3. Are not otherwise eligible for and enrolled in optional full Medicaid coverage under the state plan
4. Have household income that exceeds 133% FPL but is at or below the standard set by the state

B. Financial Methodologies

MAGI-based methodologies are used in calculating household income. Please refer as necessary to MAGI-Based Methodologies, completed by the state.

C. Individuals Covered

1. The state covers all individuals who meet the characteristics described in section A.

☐ Yes ☒ No

2. The state covers the following populations:

- ☐ a. All children under a specified age limit:
- ☐ b. Reasonable classifications of children
- ☐ c. Parents and other caretaker relatives as defined in the Parents and Other Caretaker Relatives eligibility group, except for with respect to income
- ☒ d. Pregnant women
- ☐ e. Other

D. Income Standard Used

1. The state uses the same income standard for all individuals covered.

☒ Yes ☐ No

2. The income standard for this eligibility group is:

- ☒ a. Percentage of the federal poverty level. 210.00% FPL
- ☐ b. No income test (the income standard is infinite).

E. Coverage of Dependent Children

Parents or caretaker relatives living with a child under the age specified below are not covered unless the child is receiving benefits under Medicaid, CHIP or through the Exchange or otherwise enrolled in minimum essential coverage, as defined in 42 CFR 435.4.

- ☒ 1. Under age 19, or
- ☐ 2. A higher age of children, if any covered under the Reasonable Classifications of Children eligibility group (42 CFR 435.222) on March 23, 2010:

F. Phase-In

The state elects to phase-in coverage to individuals in this group.

☐ Yes ☒ No

G. Additional Information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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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WA - Submission Package - WA2013MH0001O - (WA-13-179-X) - Health Homes (WA SPA #13-08)

Summary Reviewable Units News Related Actions

CMS-10434 OMB 0938-1188

Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | WA2013MH0001O | WA-13-179-X | MIGRATED_HH.WA HHS

Package Header

Package ID	WA2013MH0001O	SPA ID	WA-13-179- (WA #13-08)
Submission Type	Official	Initial Submission Date	N/A
Approval Date	07/01/2013	Effective Date	7/1/2013
Superseded SPA ID			

Program Authority

1945 of the Social Security Act
The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

MIGRATED_HH.WA HHS

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

Under Washington State's approach, health homes are the bridge to integrate care within existing care systems. A health home is the central point for directing patient-centered care and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up; and improving patient outcomes by mobilizing and coordinating primary medical, specialist, behavioral health and long-term care services and supports. Care Coordinators must be embedded in community based settings to effectively manage the full breadth of beneficiary needs.

Washington has four high level goals to assess the effectiveness of their health home program - 1) Improve the beneficiary's clinical outcomes and experience of care; 2)Improve the beneficiary's self-management abilities; 3)Improve health care quality and promote efficient and evidence-based health care service delivery; and 4)Reduce future cost trends or at the very least attain cost neutrality with improved outcomes.

General Assurances

- ☒ The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- ☒ The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- ☒ The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- ☒ The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- ☒ The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- ☒ The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Homes Geographic Limitations

MEDICAID | Medicaid State Plan | Health Homes | WA2013MH0001O | WA-13-179-X | MIGRATED_HH.WA HHS

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- ☐ Health Homes services will be available statewide
- ☒ Health Homes services will be limited to the following geographic areas
- ☐ Health Homes services will be provided in a geographic phased-in approach

Specify the geographic limitations of the program

- ☒ By county
- ☐ By region
- ☐ By city/municipality
- ☐ Other geographic area

Specify which counties:

- Asotin
- Benton
- Clark
- Columbia
- Cowlitz
- Franklin
- Garfield
- Kittitas
- Klickitat
- Pierce
- Skamania
- Wahkiakum
- Walla Walla
- Yakima

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | WA2013MH0001O | WA-13-179-X | MIGRATED_HH.WA HHS

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Categories of Individuals and Populations Provided Health Home Services

The state will make Health Home services available to the following categories of Medicaid participants

- ☒ Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
- ☐ Medically Needy Eligibility Groups

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | WA2013MH0001O | WA-13-179-X | MIGRATED_HH.WA HHS

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Population Criteria

The state elects to offer Health Homes services to individuals with:

- ☐ Two or more chronic conditions
- ☒ One chronic condition and the risk of developing another

Specify the conditions included:

- ☒ Mental Health Condition
- ☒ Substance Use Disorder
- ☒ Asthma
- ☒ Diabetes
- ☒ Heart Disease
- ☐ BMI over 25
- ☒ Other (specify):

Name	Description
*cerebrovascular disease *chronic respiratory conditions *coronary artery disease *demential or Alzheimer's disease *gastrointestinal hematological conditions *HIV/AIDS *musculoskeletal conditions *neurological disease *renal failure *cancer *intellectual disability or disease	

	Description

Specify the criteria for at risk of developing another chronic condition:

At risk of a second is a minimum predictive risk score of 1.5. The predictive risk score of 1.5 means a beneficiary's expected future medical expenditures is expected to be 50% greater than the base reference group, the WA SSI disabled population. The WA risk score is based on the Chronic Illness & Disability Payment System and Medicaid-Rx risk groupers developed by Rick Kronick and Todd Gilmer at the University of California, San Diego, with risk weights normalized for the WA Medicaid population. Diagnoses, prescriptions, age and gender from the beneficiary's medical claims and eligibility history for the past 15 months (24 months for children) are analyzed, a risk score is calculated and chronic conditions checked across all categorically needy populations, and a clinical indicator (Y=qualifies; N=does not qualify) is loaded into the WA MMIS.

Potentially eligible beneficiaries with insufficient claims history may be referred to the program by contacting HCA. A tool has been developed to manually calculate risk. This tool will be on the Health Home website and distributed to the Designated Providers. Once a provider has determined a beneficiary is eligible by manually calculating their risk, that information will be sent to HCA for further analysis. If the beneficiary is eligible, they will be enrolled into a health home .

☐ One serious and persistent mental health condition

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | WA2013MH0001O | WA-13-179-X | MIGRATED_HH.WA HHS

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Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home:

- ☐ Opt-In to Health Homes provider
- ☒ Referral and assignment to Health Homes provider with opt-out
- ☐ Other (describe)

Describe the process used:

The state will identify Fee-for-Service beneficiaries who are eligible for health homes based upon their chronic condition and risk score, and will enroll them into a Fee-for-Service qualified health home designated provider. Enrollment will be based on zip codes and capacity. The designated provider will assign health home beneficiaries to one of their network affiliated Care Coordination Organizations (CCO), who, in turn, will assign the beneficiary to a Care Coordinator. Beneficiaries have the ability to opt-out of the assigned health home or change enrollment to another designated provider or subcontracted Health Home CCO within the qualified provider network. Eligible beneficiaries who opt-out have the option of enrolling in a Health Home with a contracted designated provider at any time.

Managed care beneficiaries are auto-enrolled into a Medicaid managed care organization (MCO). MCOs qualified to be Health Homes or contracted with a Health Home will identify eligible beneficiaries based upon their chronic condition and risk score, and automatically enroll them into their Health Homes. The Health Home, in turn, will assign the beneficiary to a one of their network affiliated CCOs and a Care Coordinator. Beneficiaries have the ability to opt-out of the health home or change enrollment to another designated provider or subcontracted Health Home CCO within the qualified provider network.

- ☒ The state provides assurance that it will clearly communicate the individual's right to opt out of the Health Home benefit or to change Health Home providers at any time and agrees to submit to CMS a copy of any letter or communication used to inform the individual of the Health Home benefit and their rights to choose or change Health Home providers or to elect not to receive the benefit.

Name	Date Created	
No items available		

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | WA2013MH0001O | WA-13-179-X | MIGRATED_HH.WA HHS

Package Header

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Types of Health Homes Providers

☒ Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

- ☐ Physicians
- ☒ Clinical Practices or Clinical Group Practices

Describe the Provider Qualifications and Standards

- Experience operating broad-based regional provider network;
- Contracts directly with the state as a Qualified Health Home;
- Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;
- Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);
- Subcontracts with CCOs to directly provide the Health Home care coordination services;
- Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
 - Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or
 - Optimizes beneficiary choice.
- Maintains a list of CCOs and their assigned Health Home population.
- Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable;
- Collects and reports encounters to the HCA;
- Disburses payment to CCOs based upon encounters;
- Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;
- Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

☒ Rural Health Clinics

Describe the Provider Qualifications and Standards

- Experience operating broad-based regional provider network;
- Contracts directly with the state as a Qualified Health Home;
- Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;
- Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);
- Subcontracts with CCOs to directly provide the Health Home care coordination services;
- Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
 - Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or
 - Optimizes beneficiary choice.
- Maintains a list of CCOs and their assigned Health Home population.
- Maintains Memoranda of Agreement (MOA) with the organizations that are

part of the Health Home provider network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable;

9. Collects and reports encounters to the HCA;
10. Disburses payment to CCOs based upon encounters;
11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;
12. Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

☒ Community Health Centers

Describe the Provider Qualifications and Standards

1. Experience operating broad-based regional provider network;
2. Contracts directly with the state as a Qualified Health Home;
3. Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;
4. Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);
5. Subcontracts with CCOs to directly provide the Health Home care coordination services;
6. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
 - a. Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or
 - b. Optimizes beneficiary choice.
7. Maintains a list of CCOs and their assigned Health Home population.
8. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable;
9. Collects and reports encounters to the HCA;
10. Disburses payment to CCOs based upon encounters;
11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;
12. Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

☒ Community Mental Health Centers

Describe the Provider Qualifications and Standards

1. Experience operating broad-based regional provider network;
2. Contracts directly with the state as a Qualified Health Home;
3. Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;
4. Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);
5. Subcontracts with CCOs to directly provide the Health Home care coordination services;
6. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
 - a. Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or
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8. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable;
9. Collects and reports encounters to the HCA;

- 10. Disburses payment to CCOs based upon encounters;
- 11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;
- 12. Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

☒ Home Health Agencies

Describe the Provider Qualifications and Standards

- 1. Experience operating broad-based regional provider network;
- 2. Contracts directly with the state as a Qualified Health Home;
- 3. Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;
- 4. Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);
- 5. Subcontracts with CCOs to directly provide the Health Home care coordination services;
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 - a. Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or
 - b. Optimizes beneficiary choice.
- 7. Maintains a list of CCOs and their assigned Health Home population.
- 8. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable;
- 9. Collects and reports encounters to the HCA;
- 10. Disburses payment to CCOs based upon encounters;
- 11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;
- 12. Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

☒ Case Management Agencies

Describe the Provider Qualifications and Standards

Area Agencies on Aging

- 1. Experience operating broad-based regional provider network;
- 2. Contracts directly with the state as a Qualified Health Home;
- 3. Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;
- 4. Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);
- 5. Subcontracts with CCOs to directly provide the Health Home care coordination services;
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 - a. Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or
 - b. Optimizes beneficiary choice.
- 7. Maintains a list of CCOs and their assigned Health Home population.
- 8. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable;
- 9. Collects and reports encounters to the HCA;
- 10. Disburses payment to CCOs based upon encounters;
- 11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care

coordinator;

12. Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals;

☒ Community/Behavioral Health Agencies

Describe the Provider Qualifications and Standards

Regional Support Networks

1. Experience operating broad-based regional provider network;
2. Contracts directly with the state as a Qualified Health Home;
3. Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;
4. Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);
5. Subcontracts with CCOs to directly provide the Health Home care coordination services;
6. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
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 - b. Optimizes beneficiary choice.
7. Maintains a list of CCOs and their assigned Health Home population.
8. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable;
9. Collects and reports encounters to the HCA;
10. Disburses payment to CCOs based upon encounters;
11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;
12. Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

☒ Federally Qualified Health Centers (FQHC)

Describe the Provider Qualifications and Standards

11. Experience operating broad-based regional provider network;
2. Contracts directly with the state as a Qualified Health Home;
3. Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;
4. Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);
5. Subcontracts with CCOs to directly provide the Health Home care coordination services;
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11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;
12. Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

☒ Other (Specify)

Provider Type	Description
HospitalsManaged Care OrganizationsSubstance Use Disorder Treatment ProvidersPrimary Care Case Management	1. Experience operating broad-based regional provider network; 2. Contracts directly with the state as a Qualified Health Home; 3. Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network; 4. Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO); 5. Subcontracts with CCOs to directly provide the Health Home care coordination services; 6. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process: a. Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or b. Optimizes beneficiary choice. 7. Maintains a list of CCOs and their assigned Health Home population. 8. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable; 9. Collects and reports encounters to the HCA; 10. Disburses payment to CCOs based upon encounters; 11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator; 12. Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.;1. Experience operating broad-based regional provider network; 2. Contracts directly with the state as a Qualified Health Home; 3. Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;

Provider Type

Description

4. Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);

5. Subcontracts with CCOs to directly provide the Health Home care coordination services;

6. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:

a. Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or

b. Optimizes beneficiary choice.

7. Maintains a list of CCOs and their assigned Health Home population.

8. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable;

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11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to-care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;

12. Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.;

1. Experience operating broad-based regional provider network;

2. Contracts directly with the state as a Qualified Health Home;

3. Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;

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HospitalsManaged Care
OrganizationsSubstance Use
Disorder Treatment

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Provider Type

ProvidersPrimary Care Case Management

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Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | WA2013MH0001O | WA-13-179-X | MIGRATED_HH.WA HHS

Package Header

Package ID	WA2013MH0001O	SPA ID	WA-13-179-X (WA #13-08)
Submission Type	Official	Initial Submission Date	N/A
Approval Date	07/01/2013	Effective Date	7/1/2013
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- ☐ Teams of Health Care Professionals
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Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

The delivery of Washington's health home service model is based on an inter-disciplinary array of medical care, behavioral health care, and community-based social services and supports for children and adults who meet Washington's defined chronic conditions and risk criteria. The integration of primary care, behavioral health services, and long term care services and supports are critical when improving health outcomes and reducing costs.

The Health Home qualification process will ensure the inclusion of ample designated providers, such as managed care organizations (MCOs), hospitals, Federally Qualified Health Centers (FQHC), Regional Support Networks, Area Agencies on Aging, Community Mental Health Agencies, Substance Use Disorder Treatment Providers, Specialty Care and Primary Care Providers, and Tribal Clinics.

The purpose of qualifying Health Homes is to provide HCA with a limited number of geographically based qualified Health Home providers, who through their respective networks, provide intensive Health Home care coordination services to Medicaid and Medicare/Medicare beneficiaries with chronic conditions to ensure that services delivered are integrated and coordinated across medical, mental health, chemical dependency and long term services and supports. Beneficiaries who are eligible for Health Homes receive direct services from HCA and DSHS, but the Health Home contracts are based in HCA.

Additionally, multidisciplinary team members will be recruited to support clinical decisions and evidenced-based care. Multidisciplinary team members will be composed of willing participants who provide direct service to the beneficiary or subject matter experts, such as primary care providers, mental health professionals, chemical dependency treatment providers, social workers, nutritionists/dieticians, direct care workers, pharmacists, peer specialists, family members or housing representatives.

The Health Home structure is built on the following hierarchy:

1. Designated Provider/Lead Entity - Healthcare systems, providers and authorizing entities with experience developing community based service provider network relationships, such as managed care organizations (MCOs), hospitals, Federally Qualified Health Centers (FQHC), Regional Support Networks, Area Agencies on Aging, Community Mental Health Agencies, Substance Use Disorder Treatment providers, Specialty Care and Primary Care Providers. The Designated Provider contracts directly with the state and is responsible for service delivery model and administration of the Health Home. Lead entities collect and submit encounters; disburse payment to network affiliated Care Coordination Organizations through the collection and submission of encounters, monitor quality; sub-contract; collect, analyze and report financial, health status and performance and outcome measures to objectively determine progress towards meeting overall Health Home goals; and provide customer service, such as toll-free lines or nursing advice lines.

2. Network Affiliated Care Coordination Organizations – Accountable for Care Coordination staffing and oversight of direct delivery of the six Health Home services. Care Coordination Organizations are responsible for implementing systematic processes and protocols to assure beneficiary access to Care Coordinators and care coordination functions. Care Coordination Organizations can be managed care organizations, hospitals, Federally Qualified Health Centers (FQHC), Regional Support Networks, Area Agencies on Aging, Community Mental Health Agencies, Substance Use Disorder Treatment providers, Home Health, Specialty providers, such as AIDS or ESRD clinics, Specialty Care and Primary Care Providers.

3. Care Coordinators – Operate under the direction of the Care Coordination Organizations by directly interacting with participating beneficiaries. Care Coordinators provide the six defined Health Home care coordination benefits in-person by actively engaging the beneficiary in developing a Health Action Plan; reinforcing the Health Action Plan and supporting the beneficiary to attain short and long term goals; coordinating with authorizing and prescribing entities as necessary to reinforce and support the beneficiary's health action goals; advocating, educating and supporting the beneficiary to attain and improve self-management skills; assuring the receipt of evidence-based care; supporting beneficiaries and families during discharge from hospital and institutional settings, including providing evidence-based transition planning; and accompanying the beneficiary to critical appointments when necessary. To better support beneficiary goals and ensure quality of care, they will coordinate services with authorizing entities for which the beneficiary is receiving services assistance. A Health Home Care Coordinator must provide service in the community in which the beneficiary resides so services can be provided in-person whenever needed, unless the beneficiary requests to receive their services elsewhere. Health Home Care Coordinators shall serve eligible individuals in the setting of the beneficiary's choice and may not establish policies that would restrict service because a beneficiary moves from one eligible setting to another.

Care Coordinators must be clinical or non-clinical professionals, such as RNs, ARNPs, Psychiatric ARNPs, Social Workers, Mental Health Social Workers, Chemical Dependency Professionals, and Counselors.

4. Allied health care staff, such as community health workers, peer counselors or other non-clinical personnel provides administrative support for the Health Home Care Coordinator, such as mailing health promotion material, arranging for beneficiary transportation to appointments, and calling the beneficiary to facilitate face-to-face Health Home visits with the Care Coordinator.

5. Additional network providers who have agreed to participate in the health home model through the use of memorandums of agreement, subcontracts, or operational agreements. For example, a clinic may agree to provide referrals to a designated provider, through the use of an operational agreement.

Supports for Health Homes Providers

Describe the methods by which the state will support providers of Health Homes services in addressing the following components

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services

5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

Description

The foundation of the State's health homes is the community network, which must be present in order to qualify as a Health Home. This ensures partnerships between mental health and substance abuse providers, long-term services and supports providers and the medical communities are developed to support care coordination and access through integrated health home services.

The beneficiary will be involved in improving their health through the development their Health Action Plan. Beneficiaries may choose to include their families and caregivers as part of their health home team.

Training of qualified health home designated/lead providers and Care Coordination Organizations will be sponsored between HCA and DSHS. DSHS nursing staff will develop a set of core curriculum materials for health homes to support the provision of timely, comprehensive, high-quality health homes services that are whole person focused. DSHS will offer technical assistance training for core skill building on relevant topics. Webinars, community network development meetings and/or learning collaborative will foster shared learning, information sharing and problem solving.

The State will provide access to PRISM, a secure web-based clinical support tool showing: the client's medical risk factors, demographics, eligibility, managed care status, housing, utilization of Medicaid and Medicare health services (inpatient, outpatient, ER, filled prescriptions, mental health services, long term care services and support, filled lab orders, dental), providers with contact information, long term care case manager assessments, patient activation measure assessments and completed health action plans. This resource will complement existing clinic-specific Electronic Health Records, with information sharing facilitated by the State's developing Health Information Exchange. This provides the necessary foundation for a continuous quality improvement program.

Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes providers are as follows

Health home providers/networks will be developed to meet the needs of the population. Care coordination should occur across service domains and therefore include many different disciplines. A health home is qualified by the State and is responsible for the integration and coordination of primary, acute, behavioral health (mental health and substance use disorder) and long-term services and supports for high cost/risk persons with chronic illness across the lifespan through contractual/operational arrangements with appropriate providers. A health home is the central point of contact working with the managed care or fee-for-service beneficiary to direct person-centered health action planning and implementation and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up, and improving patient outcomes by addressing health care needs.

Washington is in the process of "qualifying" the health home delivery system through a competitive Request for Application (RFA) for each region of implementation. The first RFA application was released on November 26, 2012. The second RFA was released on February 24, 2013. Proposals are scored on the following: 1) Minimum Qualifications – Applicant is a Medicaid provider in good standing, ability to serve 1,000 to 2,000 health home beneficiaries, experience operating broad based networks, agrees to serve the entire coverage area, assures 24 hours/seven days a week information and referrals, document beneficiary consent, subcontract with CCOs, ability to coordinate care and services after critical events, such as emergency department use and hospital inpatient admission and discharge, language access/translation capability, links to acute and outpatient medical, mental health and substance abuse services, links to community-based social services, including housing; 2) Provider Networks – must include authorizing entities, a wide-variety of Care Coordination organizations, such as CMHAs, Substance Abuse Treatment providers, long-term services and supports, FQHCs, Community Health Clinics, and PCCMs; 3) Organizational Infrastructure – ability to provide administrative functions, such as toll-free lines, customer service staff, policies on process and timelines for bringing in additional CCOs to preserve integrity of face-to-face health home care coordination activities, ability to track health home beneficiaries to CCO assignment, collecting and submitting claims and encounters, payment disbursement, taking into account intensity levels and/or movement between CCOs, quality monitoring, sub-contracting, collecting, analyzing and reporting financial, health status and performance and outcome measures. Ability to ensure hospitals have procedures in place for referring health home eligible beneficiaries for enrollment if they are seeking or need treatment in a hospital emergency room; 4) Core Health Home Requirements – ability to provide six health home care coordination functions and guarantee of non-duplication of efforts, health action planning, self-management of chronic conditions, setting short and long-term goals, cultural competency, motivational interviewing, identification of services and gaps in services, evidence-based interventions, sharing information with beneficiary's treating/authorizing entities, establishing multidisciplinary teams, accompanying beneficiary to visits when requested, arranging for priority appointments, notification systems for transitional care, follow-up on medication upon discharge and follow-up with pharmacy to get scripts filled, help the beneficiary access follow-up care, referrals, optimizing social supports and family, use of health information technology; and 5) Center for Medicare and Medicaid Services (CMS) Health Home Provider Functional Requirements – descriptions of process used to ensure 11 core health requirements are met.

Additional points are awarded to Health Homes which include housing, charity organizations, shelters, and organizations that help with Medicaid eligibility even though the additional outreach services are not through designated providers. Scores are weighted with core health home requirements and network adequacy receiving the most points. Following the announcement of apparently successful bidders, debriefing and protest period, HCA and DSHS will conduct desk audits and on-site readiness reviews to ascertain readiness to provide Health Home services. Contracts will be offered after the readiness reviews.

The period of performance of any contract(s) resulting from the RFA is an initial two years. The start and end date of the two year period of performance is based upon the start date for each awarded contract. After two years, the program will be evaluated and based upon results may be modified for quality. Other entities interested in applying as a Qualified Health Home will be invited to another Request for Application process, if more capacity is needed or there are gaps in care that would benefit from a more robust network.

Name	Date Created	
No items available		

Name	Date Created

Health Homes Service Delivery Systems

MEDICAID | Medicaid State Plan | Health Homes | WA2013MH0001O | WA-13-179-X | MIGRATED_HH.WA HHS

Package Header

Package ID	WA2013MH0001O	SPA ID	WA-13-179-X (WA #13-08)
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Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

- ☒ Fee for Service
- ☒ PCCM

The PCCMs will be a Designated Provider or part of a Team of Health Care Professionals

- ☒ Yes
- ☐ No

The PCCM/Health Homes providers will be paid based on the following payment methodology outlined in the payment methods section

- ☐ Fee for Service (describe in Payment Methodology section)
- ☐ Alternative Model of Payment (describe in Payment Methodology section)
- ☒ Other

Description PCCMs that contract with the Health Care Authority to provide health home services to American Indians/Alaska Natives will be paid an additional service based enhancement (SBE) rate for Health Home Care Coordination. SBEs will be submitted as encounters to the state and paid on the three tiered rate levels for 1) Engagement, Participation and Health Action Plan; 2) Intensive Care Coordination services; 3) Maintenance Care Coordination services.

Requirements for the PCCM participating in a Health Home as a Designated Provider or part of a Team of Health Care Professionals will be different from those of a regular PCCM

- ☒ Yes
- ☐ No

Describe how requirements will be different PCCMs who elect to become designated providers must contract with HCA and meet all the qualifications standards in the Request for Application (RFA). While PCCMs do not have to submit a proposal for the RFA, they do need to sign a health home contract to provide all the health home services in the manner dictated by the state. This means that PCCMs must have subcontracts in place with a wide range of Care Coordination Organizations that are staffed with care coordinators. Health Home care coordination services will be monitored to ensure non-duplication of services.

- ☐ The state provides assurance that these requirements will be incorporated into the next PCCM contract submitted to CMS.

Name	Date Created	
No items available		

Health Homes Service Delivery Systems

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☒ Risk Based Managed Care

The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals

- ☒ Yes
- ☐ No

Provide a summary of the contract language that you will impose on the Health Plans in order to deliver the Health Homes services

Contract language supports the requirement that all Medicaid health plans have to submit a proposal to become a Qualified Health Home through the Health Care Authority's Request for Applications (RFA); or subcontract with another Qualified Health Home to provide services to their Health Home eligible enrollees.

Contract language will contain:

- Standards for the six Health Home services - Comprehensive Care Management, Care Coordination and Health Promotion, Transitional Care, Individual and Family Support, Referrals to the Community and Use of Health Information Technology;
- The use of clinical and non-clinical care coordinators and support staff;
- Contracts, memorandums of agreement or operational agreements with hospitals for ER notification and hospitalization, including a referral process to refer beneficiaries for health home services;
- Standardized screening and assessments;
- Development of a Health Action Plan through an in-person visit by directly interacting with the enrollee to promote self-management through the identification of short and long-term goals;
- Process and outcome measures;
- Encounter data reporting and tracking methods to document delivered services to support encounters;
- The use of multidisciplinary care teams, that include the care coordinator, the beneficiary, and any other identified providers;
- If the Health Home beneficiary is a Medicaid managed care enrollee, the MCO will share critical data with the Health Home Care Coordination Organization. Data may include institutional admissions and discharge readiness for transitional health care services management and facilitation, lapses in pharmaceutical payments that may indicate need for client outreach and education regarding medication use and over-use patterns, such as emergency room use that may suggest a need for a Care Coordinator visit or intervention to address the clinical and Health Action Plan goals.

☒ The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.

Name	Date Created	
No items available		

The State intends to include the Health Home payments in the Health Plan capitation rate

- ☒ Yes
- ☐ No

Assurances ☒ The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:

- Any program changes based on the inclusion of Health Homes services in the health plan benefits

- Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)
- Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)
- Any risk adjustments made by plan that may be different than overall risk adjustments
- How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM

- ☒ The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services
- ☒ The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found

☐ Other Service Delivery System

Health Homes Payment Methodologies

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Payment Methodology

The State's Health Homes payment methodology will contain the following features

☒ Fee for Service

☒ Individual Rates Per Service

☒ Fee for Service Rates based on

- ☐ Severity of each individual's chronic conditions
- ☐ Capabilities of the team of health care professionals, designated provider, or health team
- ☒ Other

Describe below

Rates were built for three levels of payment using a clinical and non-clinical staffing model combined with monthly service intensity.

Three levels of payment are dependent upon who is providing the services and the intensity of the service determined by in-person, one-on-one, high touch interactions. This first care coordination stage encompasses three primary responsibilities, in addition to the health home service: health screening and assessments, development of a health action plan for care management, and assess the beneficiary for self-management and promote self-management skills to improve functional or health status or prevent or slow declines in functioning. There is no withhold for this component of care coordination.

This is a one-time only rate and is triggered by the submission of a Health Action Plan encounter and the documentation of a health home service. This encounter must be submitted before any other encounter can be paid.

The second level is for Intensive Health Home Care Coordination. It is assumed that for each full-time employee (FTE), 50 clients can be supported. This rate is paid once per month, per beneficiary and is triggered by documenting delivery of a health home service.

The third level of payment is for Low-Level Health Home Care Coordination. This rate is paid once per month with an encounter. Low-level payment will be paid on a monthly basis, and payment is made only for months in which an encounter occurred. An encounter is represented by documenting delivery of a health home service. It is assumed that for months in which an encounter

occurs, 2/3 will involve a phone call and
1/3 involves a home visit.

- ☒ Per Member, Per Month Rates
- ☐ Fee for Service Rates based on
- ☐ Comprehensive Methodology Included in the Plan
- ☒ Incentive Payment Reimbursement
- ☐ Fee for Service Rates based on

**Describe any variations in
payment based on provider
qualifications, individual care
needs, or the intensity of the
services provided**

- ☒ PCCM (description included in Service Delivery section)
- ☒ Risk Based Managed Care (description included in Service Delivery section)
- ☐ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Health Homes Payment Methodologies

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Agency Rates

Describe the rates used

- ☐ FFS Rates included in plan
- ☐ Comprehensive methodology included in plan
- ☐ The agency rates are set as of the following date and are effective for services provided on or after that date

Health Homes Payment Methodologies

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Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates;
2. Please identify the reimbursable unit(s) of service;
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit;
4. Please describe the state's standards and process required for service documentation, and;
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including:
 - the frequency with which the state will review the rates, and
 - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description

Health Homes Payment Methodologies

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Assurances

- ☒ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.
- Describe below how non-duplication of payment will be achieved**

Case management provided under the state's 1915(c) waivers is non-duplicative of health home services. The functions provided by 1915(c) case managers include determination of waiver eligibility, comprehensive assessment to determine unmet needs related to waiver services, service planning of services provided under the waiver, qualification of waiver providers, authorization of waiver services, and monitoring of service provision. This type of specialized case management for individuals receiving long term services and supports and developmental disabilities services will continue to be necessary for individuals served under waivers and health homes will not duplicate the functions provided by state and Area Agency on Aging staff that perform these functions.

Health Homes will be responsible for review of claims and social service use history, health screening (e.g., screening for common mental health conditions associated with chronic illness such as depression, patient activation assessments), examination of current clinical conditions and treatment, and PRISM application information. This assessment is used to identify care gaps, utilization patterns, where chronic care condition education and coaching may be most helpful and to assist the individual in development and implementation of their health care plan, including identification of self-care goals.

The health home will also be responsible for transitions, assessing individuals at higher risk for re-institutionalization and assisting the individual and their support network in gaining an understanding of discharge instructions and information, ensure appropriate follow-up primary and specialty care and that medication reconciliation occurs, and to assist with referrals for additional services the client may need.
- ☐ The State meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), 1902(a)(30)(A), and 1903 with respect to non-payment for provider-preventable conditions.
- ☒ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.
- ☒ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Health Homes Services

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Service Definitions

Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

Comprehensive Care Management

Definition

Care Coordinators will deliver comprehensive care management, primarily in-person with periodic follow-up. Care management services include state approved screens, demonstrate the ability to provide continuity and coordination of care through in-person visits, and the ability to accompany beneficiaries to health care provider appointments, as needed. Care Coordinators assess beneficiary readiness for self-management and promote self-management skills so the beneficiary is better able to engage with health and service providers and support the achievement of self-directed, individualized health goals to attain recovery, improve functional or health status or prevent or slow declines in functioning. Comprehensive care management service delivery uses the Health Action Plan (HAP) as the beneficiary directed care management plan. The HAP is created during a face-to-face initial visit with the beneficiary and updated periodically every 4, 6 and 8 months. It is also updated when there are any changes in beneficiary circumstances such as hospitalization or ER visits. The results of screenings and assessments are captured via the HAP and used to identify gaps in care and chart the beneficiary's progress towards meeting goals through active participation in comprehensive care management. Screens include clinical and functional screens, including depression, alcohol or substance use disorder, functional impairment, and pain appropriate to the age and risk profile of the individual. Screens will support referrals to services when needed, e.g., referral for assessment of need for chemical dependency treatment, specialty care or long term services and supports. Other screens and assessments that may supplement comprehensive care management are mental health treatment plans, chemical dependency treatment plans, and/or other pre-existing care plans which include assessment results.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All Health Home designated providers/lead entities will have access to the Medicaid Management Information System - ProviderOne (P1), the DSHS Predictive Risk Intelligence System (PRISM) and Insignia Health information technology sources. Authorizers and providers of long-term services and supports have access to the DSHS Comprehensive Assessment and Reporting Evaluation (CARE) data either electronically or in paper form. Data sharing agreements and Release of Information consent forms will be maintained by all Health Home Lead Entities to facilitate sharing electronic health information with their Health Home network affiliates.

- DSHS is responsible for maintenance and updates to the CARE and PRISM.
- Insignia Health is responsible through a DSHS licensing agreement for maintenance and updates to the Patient Activation Measure (PAM) and Caregiver Activation Measure (CAM) and administrative web site functions including Coaching for Activation.
- HCA's P1 data system is responsible for Medicaid eligibility, enrollment, disenrollment, claims and per member per month (PMPM) payment to MCOs, payment of health homes, encounter data collection and reporting.
- Emergency Department Information Exchange (EDIE) notification provides Medicaid claims data to ED physicians. EDIE is HIPAA compliant and can proactively alert care providers when high utilizing patients enter the ED through a variety of methods such as fax, phone, email, or integration with a facility's current EMR. Once notified, care providers can use EDIE to access care guidelines and crucial information on the patient from other participating facilities to better determine the patient's actual medical situation. A care management module is being developed for the EDIE system to facilitate defined treatment plans for frequent ED users in Washington State.

Scope of service

The service can be provided by the following provider types

☒ Behavioral Health Professionals or Specialists

☐ Nurse Practitioner

☒ Nurse Care Coordinators

Description

1. Psychologists licensed as a psychologist pursuant to chapter 18.83 RCW.
2. Child psychiatrists licensed as a physician and surgeon in this state, who has had a graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board eligible or board certified in child psychiatry.
3. Psychiatric nurse is a registered nurse who has a bachelor's degree from an accredited college or university, and 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" shall also mean any other registered nurse who has three years of such experience.
5. Counselor means an individual, practitioner, therapist, or analyst who engages in the practice of counseling to the public for a fee.

Description

1. Registered nurses licensed to practice registered nursing under chapter 18.79 RCW.
2. Nurse Practitioners licensed to practice advanced registered nursing under

☒ Nurses

☐ Medical Specialists

☐ Physicians

☒ Physician's Assistants

☐ Pharmacists

☒ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☒ Other (specify)

chapter 18.79 RCW.

3. Licensed Practical nurses licensed to practice practical nursing under chapter 18.79 RCW

Description

- 1. Registered nurses licensed to practice registered nursing under chapter 18.79 RCW.
- 2. Nurse Practitioners licensed to practice advanced registered nursing under chapter 18.79 RCW.
- 3. Licensed Practical nurses licensed to practice practical nursing under chapter 18.79 RCW

Description

Must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited extent only under the supervision of a physician as defined in chapter 18.71 RCW and who is academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services.

Physician Assistants must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the NCCPA examination.

Description

A master's or further advanced degree from an accredited school of social work or a degree deemed equivalent under rules adopted by the secretary.

Provider Type	Description
Chemical Dependency Professional	Must be certified in chemical dependency counseling under chapter 18.205 RCW. Certification is through the Department of Health.

Health Homes Services

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Care Coordination

Definition

The dedicated Health Home Care Coordinator shall play a central and active role in development and execution of cross-system care coordination to assist the beneficiary to access and navigate needed services. The Care Coordinator shall assure communication is fostered between the providers of care including the treating primary care provider and medical specialists and entities authorizing behavioral health and long-term services and supports. Care Coordination is the bridge between all the beneficiary's systems of care, including non-clinical support such as food, housing, and transportation.

When providing intensive care coordination to the beneficiary, the Care Coordinator caseload will be maintained at a level that ensures fidelity in providing required health home services, including interventions. Community health workers, peer counselors or other non-clinical staff may be used to facilitate the work of the assigned Health Home Care Coordinator.

Care coordination shall provide informed interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors impacting a beneficiary's health and health care choices. Care Coordinators will promote 1) optimal clinical outcomes, including a description of how progress toward outcomes will be measured through the Health Action Plan; 2) outreach and engagement activities that support the beneficiary's participation in their care and promotes continuity of care; 3) health education and coaching designed to assist beneficiaries to increase self-management skills and improve health outcomes; and 4) use of peer supports, support groups and self-care programs to increase the beneficiary's knowledge about their health care conditions and improve adherence to prescribed treatment.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

PRISM and Insignia Health are information technology sources that support the beneficiary and the Health Home Care Coordinator to identify the unmet needs, gaps in care, transitional support needs, clinical protocols required and current utilization of case management, medical and behavioral health services.

The Health Action Plan (HAP) may be shared via secure email or hard copy. The HAP includes:

- Beneficiary and Care Coordinator prioritized action items;
- Beneficiary identified goals (short and long term);
- Action steps for the beneficiary, the Health Home Care Coordinator and/or other direct service and medical providers; NS
- If the beneficiary has a personal care worker, the HAP will include action steps for them to support identified health action goals identified by the beneficiary.

The HAP is updated and modified by the Health Home Care Coordinator quarterly, and as needed to support care transition. The HAP is also updated and modified as needed according to:

- A change in the beneficiary's condition;
- New immediate goals to be addressed through the Health Home; and
- Resolution of goals or action steps.

Future HIT development includes addition of the HAP data elements to an electronic application.

The Health Home will promote the use of web-based health information technology registries and referral tracking systems.

Scope of service

The service can be provided by the following provider types

☒ Behavioral Health Professionals or Specialists

☐ Nurse Practitioner

Description

1. Behavioral Health Professionals or Specialists - 1) Psychologists licensed as a psychologist pursuant to chapter 18.83 RCW. 2) Child psychiatrists licensed as a physician and surgeon in this state, who has had a graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board eligible or board certified in child psychiatry. 3) Psychiatric nurse is a registered nurse who has a bachelor's degree from an accredited college or university, and 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" shall also mean any other registered nurse who has three years of such experience. 4) Counselor means an individual, practitioner, therapist, or analyst who engages in the practice of counseling to the public for a fee.

☒ Nurse Care Coordinators

☒ Nurses

☐ Medical Specialists

☐ Physicians

☒ Physician's Assistants

☐ Pharmacists

☒ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☒ Other (specify)

Description

Registered nurses licensed to practice registered nursing under chapter 18.79 RCW. Nurse Practitioners licensed to practice advanced registered nursing under chapter 18.79 RCW. Licensed Practical nurses licensed to practice practical nursing under chapter 18.79 RCW.

Description

Registered nurses licensed to practice registered nursing under chapter 18.79 RCW. Nurse Practitioners licensed to practice advanced registered nursing under chapter 18.79 RCW. Licensed Practical nurses licensed to practice practical nursing under chapter 18.79 RCW.

Description

Must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited extent only under the supervision of a physician as defined in chapter 18.71 RCW and who is academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services. Physician Assistants must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the NCCPA examination.

Description

A master's or further advanced degree from an accredited school of social work or a degree deemed equivalent under rules adopted by the secretary.

Provider Type	Description
Chemical Dependency Professionals	Must be certified in chemical dependency counseling under chapter 18.205 RCW. Certification is through the Department of Health.

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Health Promotion

Definition

Health promotion begins for health home beneficiaries with the commencement of the Health Action Plan. Each Washington health home must demonstrate use of self-management, recovery and resiliency principles using person-identified supports including family members, and paid and unpaid caregivers. The Health Home Care Coordinator will use the beneficiary's activation score and level (1-4) to determine the coaching methodology for each beneficiary and develop a teaching and support plan. Educational materials are customized and introduced according to the beneficiary's readiness for change and progressed with a beneficiary's level of confidence and self-management abilities. Opportunities for mentoring and modeling communication with health care providers are provided through joint office visits and communications with health care providers by the beneficiary and the Health Home Care Coordinator. The health home will provide wellness and prevention education specific to the beneficiary's chronic conditions, Health Action Plan, including assessment of need and facilitation of receipt of routine preventive care, support for improving social connections to community networks and linking beneficiaries with resources that support a health promoting lifestyle. Linkages include but are not limited to resources for smoking prevention and cessation, substance use disorder treatment and prevention, nutritional counseling, obesity reduction and prevention, increasing physical activity, disease specific or chronic care management self-help resources, and other services, such as housing based on individual needs and preferences.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Insignia Health is an information technology source and provides, in connection with the Patient Activation Measure (PAM)/Caregiver Activation Measures (CAM), the Coaching for Activation website. This site provides educational materials linked to a beneficiary's level of activation and can be sent electronically to a beneficiary or printed for review at a Home Visit or by phone.

PRISM contains the history of the PAM/CAM scores and responses for each survey administered to the beneficiary. The Health Home Care Coordinator is able to view the scores for each beneficiary alongside the medical, behavioral health claims and LTC services utilization and selected CARE characteristics (for those beneficiaries with long-term services and supports) so that education materials can be tailored to the individual's engagement and activation.

Scope of service

The service can be provided by the following provider types

☒ Behavioral Health Professionals or Specialists

Description

1. Behavioral Health Professionals or Specialists - 1) Psychologists licensed as a psychologist pursuant to chapter 18.83 RCW. 2) Child psychiatrists licensed as a physician and surgeon in this state, who has had a graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board eligible or board certified in child psychiatry. 3) Psychiatric nurse is a registered nurse who has a bachelor's degree from an accredited college or university, and 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" shall also mean any other registered nurse who has three years of such experience. 4) Counselor means an individual, practitioner, therapist, or analyst who engages in the practice of counseling to the public for a fee.

☐ Nurse Practitioner

☒ Nurse Care Coordinators

Description

Registered nurses licensed to practice registered nursing under chapter 18.79 RCW. Nurse Practitioners licensed to practice advanced registered nursing under chapter 18.79 RCW. Licensed Practical nurses licensed to practice practical nursing under chapter 18.79 RCW.

☒ Nurses

Description

Registered nurses licensed to practice registered nursing under chapter 18.79 RCW. Nurse Practitioners licensed to practice advanced registered nursing under chapter 18.79 RCW. Licensed Practical nurses licensed to practice practical nursing under chapter 18.79 RCW.

☐ Medical Specialists

☐ Physicians

☒ Physician's Assistants

Description

Must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited extent only under the supervision of a physician as defined in chapter 18.71 RCW and who is

academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services. Physician Assistants must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the NCCPA examination.

- ☐ Pharmacists
- ☒ Social Workers

Description

A master's or further advanced degree from an accredited school of social work or a degree deemed equivalent under rules adopted by the secretary.

- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
Chemical Dependency Professionals	Must be certified in chemical dependency counseling under chapter 18.205 RCW. Certification is through the Department of Health.

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | WA2013MH0001O | WA-13-179-X | MIGRATED_HH.WA HHS

Package Header

Package ID	WA2013MH0001O	SPA ID	WA-13-179-X (WA #13-08)
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Superseded SPA ID			

Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

Comprehensive transitional care shall be provided to prevent beneficiary avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing, substance use disorder treatment or residential habilitation setting) and to ensure proper and timely follow-up care.

The beneficiary's Health Action Plan shall include transitional care planning. Transitional care planning includes:

- 1) A notification system with managed care plans, hospitals, nursing homes and residential/rehabilitation facilities to provide the health home prompt communication of a beneficiary's admission and/or discharge from an emergency room, inpatient, nursing home or residential/rehabilitation and if proper permissions, a substance use disorder treatment setting. Progress notes or a case file will document the notification and the Health Action Plan should be updated with transition planning.
- 2) The use of a Health Home Care Coordinator as an active participant in all phases of care transition; including discharge planning visits during hospitalizations or nursing home stays post hospital/institutional stay home visits and telephone calls.
- 3) Beneficiary education that supports discharge care needs including medication management, encouragement and intervention to assure follow-up appointments and self-management of their chronic or acute conditions, including information on when to seek medical care and emergency care. Involvement of formal or informal caregivers shall be facilitated when requested by the beneficiary.
- 4) A systematic follow-up protocol to assure timely access to follow-up care post discharge and to identify and re-engage beneficiaries that do not receive post discharge care.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Emergency Department Information Exchange (EDIE) notification provides Medicaid claims data to ED physicians. EDIE is HIPAA compliant. EDIE can proactively alert care providers when high utilizing beneficiaries enter the ED through a variety of methods such as fax, phone, email, or integration with facility's current EMR. Once notified, care providers can use EDIE to access care guidelines and crucial information on the beneficiary from other participating facilities to better determine the beneficiary's actual medical situation.

Managed care organizations (MCOs) will notify Health Home Care Coordinators of beneficiary admission to hospital and tertiary care facilities to facilitate discharge planning and care transitions. MCOs will also inform the Health Home Care Coordinators of lapses in pharmacy refills for beneficiaries with chronic conditions requiring long-term use of medications. Health Home Care Coordinators are responsible for conducting outreach activities with the beneficiary to ensure medications have been picked up and are being used according to the clinical treatment plan.

Scope of service

The service can be provided by the following provider types

☒ Behavioral Health Professionals or Specialists

Description

1. Behavioral Health Professionals or Specialists - 1) Psychologists licensed as a psychologist pursuant to chapter 18.83 RCW. 2) Child psychiatrists licensed as a physician and surgeon in this state, who has had a graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board eligible or board certified in child psychiatry. 3) Psychiatric nurse is a registered nurse who has a bachelor's degree from an accredited college or university, and 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" shall also mean any other registered nurse who has three years of such experience. 4) Counselor means an individual, practitioner, therapist, or analyst who engages in the practice of counseling to the public for a fee.

☐ Nurse Practitioner

☒ Nurse Care Coordinators

Description

1. Registered nurses licensed to practice registered nursing under chapter 18.79 RCW.
2. Nurse Practitioners licensed to practice advanced registered nursing under chapter 18.79 RCW.
3. Licensed Practical nurses licensed to practice practical nursing under chapter 18.79 RCW

☒ Nurses

Description

- ☐ Medical Specialists
- ☐ Physicians
- ☒ Physician's Assistants

- ☐ Pharmacists
- ☒ Social Workers

- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☒ Other (specify)

- 1. Registered nurses licensed to practice registered nursing under chapter 18.79 RCW.
- 2. Nurse Practitioners licensed to practice advanced registered nursing under chapter 18.79 RCW.
- 3. Licensed Practical nurses licensed to practice practical nursing under chapter 18.79 RCW

Description

Must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited extent only under the supervision of a physician as defined in chapter 18.71 RCW and who is academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services.

Physician Assistants must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the NCCPA examination.

Description

A master's or further advanced degree from an accredited school of social work or a degree deemed equivalent under rules adopted by the secretary.

Provider Type	Description
Chemical Dependency Professionals	Must be certified in chemical dependency counseling under chapter 18.205 RCW. Certification is through the Department of Health.

Health Homes Services

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Individual and Family Support (which includes authorized representatives)

Definition

The Health Home Care Coordinator shall recognize the unique role the beneficiary may give family, identified decision makers and caregivers in assisting the beneficiary to access and navigate the health care and social service delivery system as well as support health action planning.

Peer supports, support groups, and self-management programs will be used by the Health Home Care Coordinator to increase beneficiary and caregiver's knowledge of the beneficiary's chronic conditions, promote the beneficiary's engagement and self-management capabilities and help the beneficiary improve adherence to their prescribed treatment.

The Health Home Care Coordinator and beneficiary shall 1) identify the role that families, informal supports and paid caregivers provide to achieve self-management and optimal levels of physical and cognitive function; 2) educate and support self-management; self-help recovery and other resources necessary for the beneficiary, their family and their caregivers to support the beneficiary's individualized health action goals; 3) discuss advance directives with beneficiaries and their families; 4) communicate and share information with individuals and their families and other caregivers with appropriate consideration of language, activation level, literacy and cultural preferences.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

PRISM software applications include the PRISM Health Report for selected beneficiaries. The PRISM report is provided to the beneficiary's primary care provider and any other health care provider identified by the beneficiary and supported by a signed release of information. This includes the Health Home Care Coordinator. The report includes:

- Beneficiary demographics
- Last dental appointment
- Health conditions
- Hospital stays
- Emergency room visits
- Office visits and procedures in the last 180 days, used by the Care Coordinator to assess sufficient clinical oversight of the client's chronic conditions
- Prescriptions filled in the last 90 days
- Prescriptions by drug class in last two years

Coaching for Activation educational materials are available electronically and are printed for beneficiary and family support.

Scope of service

The service can be provided by the following provider types

☒ Behavioral Health Professionals or Specialists

Description

1. Behavioral Health Professionals or Specialists - 1) Psychologists licensed as a psychologist pursuant to chapter 18.83 RCW. 2) Child psychiatrists licensed as a physician and surgeon in this state, who has had a graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board eligible or board certified in child psychiatry. 3) Psychiatric nurse is a registered nurse who has a bachelor's degree from an accredited college or university, and 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" shall also mean any other registered nurse who has three years of such experience. 4) Counselor means an individual, practitioner, therapist, or analyst who engages in the practice of counseling to the public for a fee.

☐ Nurse Practitioner

Description

1. Registered nurses licensed to practice registered nursing under chapter 18.79 RCW.
2. Nurse Practitioners licensed to practice advanced registered nursing under chapter 18.79 RCW.
3. Licensed Practical nurses licensed to practice practical nursing under chapter 18.79 RCW

☒ Nurse Care Coordinators

Description

1. Registered nurses licensed to practice registered nursing under chapter 18.79 RCW.
2. Nurse Practitioners licensed to practice advanced registered nursing under chapter 18.79 RCW.

☒ Nurses

3. Licensed Practical nurses licensed to practice practical nursing under chapter 18.79 RCW

- ☐ Medical Specialists
- ☐ Physicians
- ☒ Physician's Assistants

Description

Must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited extent only under the supervision of a physician as defined in chapter 18.71 RCW and who is academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services.

Physician Assistants must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the NCCPA examination.

- ☐ Pharmacists
- ☒ Social Workers

Description

A master's or further advanced degree from an accredited school of social work or a degree deemed equivalent under rules adopted by the secretary.

- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
Chemical Dependency Professional	Must be certified in chemical dependency counseling under chapter 18.205 RCW. Certification is through the Department of Health.

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Referral to Community and Social Support Services

Definition

The Health Home Care Coordinator identifies available community based resources and actively manages referrals, assists the beneficiary in advocating for access to care, and engagement with community and social supports related to goal achievement documented in the Health Action Plan. When needed and not provided through other case management systems, the Health Home Care Coordinator provides assistance to obtain and maintain eligibility for health care services, disability benefits, housing, personal needs and legal services. These services are coordinated with appropriate departments of local, state and federal governments and community based organizations. Referral to community and social support services includes long-term services and supports, mental health, substance use disorder and other community and social services support providers needed to support the beneficiary in support of health action goals.

The Health Home Care Coordinator shall document referrals to and access by the beneficiary of community based and other social support services.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

PRISM and Insignia Health are information technology sources supporting the beneficiary and the Health Home Care Coordinator to identify the unmet needs, gaps in care, transitional support needs, clinical protocols required and current utilization of case management, medical and behavioral health services.

Scope of service

The service can be provided by the following provider types

☒ Behavioral Health Professionals or Specialists

Description

1. Behavioral Health Professionals or Specialists - 1) Psychologists licensed as a psychologist pursuant to chapter 18.83 RCW. 2) Child psychiatrists licensed as a physician and surgeon in this state, who has had a graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board eligible or board certified in child psychiatry. 3) Psychiatric nurse is a registered nurse who has a bachelor's degree from an accredited college or university, and 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" shall also mean any other registered nurse who has three years of such experience. 4) Counselor means an individual, practitioner, therapist, or analyst who engages in the practice of counseling to the public for a fee.

☐ Nurse Practitioner

Description

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☒ Nurse Care Coordinators

Description

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3. Licensed Practical nurses licensed to practice practical nursing under chapter 18.79 RCW

☒ Nurses

☐ Medical Specialists

Description

Must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited extent only under the supervision of a physician as defined in chapter 18.71 RCW and who is academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services.

☐ Physicians

☒ Physician's Assistants

Physician Assistants must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the NCCPA examination.

Description

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- ☐ Pharmacists
- ☒ Social Workers
- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
Chemical Dependency Professionals	Must be certified in chemical dependency counseling under chapter 18.205 RCW. Certification is through the Department of Health.

Health Homes Services

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Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

Enrollment - based on chronic conditions and meeting the state's definition of "at risk for another" a clinical indicator (Y=qualifies) will be loaded into the WA MMIS. Beneficiaries with clinical indicators of "Y" will be enrolled into one of the qualified health home networks in the geographic region in which they reside. Outreach and education information will be generated by enrollment and sent from the State to the beneficiary by mail. The Health Home will receive the enrollment on a HIPAA compliant 837 and assign the beneficiary to one of their local Health Home Care Coordination Organizations (CCOs).

Beneficiaries may be referred to Health Homes by any health care provider. An example is a referral from a local emergency room department who has agreed with the Health Home to refer potentially eligible participants to the program.

Engagement - the assigned CCO places the beneficiaries with a Care Coordinator. The beneficiary is contacted and offered health home services. Once the beneficiary has agreed to participate in a Health Home, the CC prepopulates the Health Action Plan with PRISM claims utilization and arranges for an in-person visit. PRISM information includes episode information related to specific diagnoses or pharmacy utilization; inpatient and outpatient claims, emergency room visits and care, mental health claims, alcohol and other drug treatment claims, pharmacy claims and long-term care assessment data.

- During the home visit, the CC:
- 1. Conducts a brief health screening including mental, physical and chemical dependency
 - 2. Evaluates beneficiary's support system;
 - 3. Completes a Consent for Release of Information
 - 4. Administers and scores the 13-question Patient Activation (PAM) or Caregiver Activation Measure (CAM); and
 - 5. Introduces the Health Action Plan (HAP) to the beneficiary. Together, the CCO and beneficiary identify immediate and long-term goals, prioritize concerns and establish action steps.

Name	Date Created	
No items available		

Health Homes Monitoring, Quality Measurement and Evaluation

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Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates:

The State will calculate regional, risk adjusted, per member per month expenses in the target population in the baseline (FY2011), apply trend factors and estimate a projected per member per month figure. Cost savings will be calculated as the difference between actual and projected risk adjusted per member per month expenditures.

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

The State integrates fee-for-service claims data, managed care encounter data, eligibility, and enrollment data for medical, pharmacy, mental health, substance use disorder, long term services and supports, and Medicaid and dual eligible Medicare covered services in a secure web-based clinical decision support tool called PRISM. PRISM also pulls from other clinical assessment data within the state such as CARE. The State will use the PRISM tools to support the beneficiary and the Health Home Care Coordinator to identify the unmet needs, gaps in care, clinical protocols required and current utilization of case management, medical and behavioral health services. Use of these tools will enable the Health Home Care Coordinator to better coordinate care and ensure that the beneficiary's complex needs are met. Use of these tools will allow the State to monitor cost and utilization data to ensure program goals are met.

The State is currently planning to further develop HIT through OneHealthPort, an entity contracted with HCA to consult on building a statewide health information exchange. HCA will develop the Medicaid Health Profile clinical data repository, with clinical data passed through OneHealthPort HIE using the Continuity of Care Document (CCD) and the Admit/ Discharge/Transfer Document (ADT) transaction sets. Implementation will be phased in during 2013 and 2014.

Health Homes Monitoring, Quality Measurement and Evaluation

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Quality Measurement and Evaluation

- ☒ The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state.
- ☒ The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.
- ☒ The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.
- ☐ The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report.

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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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WA - Submission Package - WA2015MH0001O - (WA-15-011-X) - Health Homes

Summary Reviewable Units News Related Actions

CMS-10434 OMB 0938-1188

Health Homes Intro

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Program Authority

1945 of the Social Security Act
The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

MIGRATED_HH.WA HHS

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

SPA 15-0011 supersedes WA 13-0008 and WA 13-17.
Under Washington State's approach, health homes are the bridge to integrate care within existing care systems. A health home is the central point for directing patient-centered care and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up; and improving patient outcomes by mobilizing and coordinating primary medical, specialist, behavioral health and long-term care services and supports. Care Coordinators must be embedded in community based settings to effectively manage the full breadth of beneficiary needs.

Washington has four high level goals to assess the effectiveness of their health home program - 1) Improve the beneficiary's clinical outcomes and experience of care; 2) Improve the beneficiary's self-management abilities; 3) Improve health care quality and promote efficient and evidence-based health care service delivery; and 4) Reduce future cost trends or at the very least attain cost neutrality with improved outcomes.

General Assurances

- ☒ The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- ☒ The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- ☒ The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- ☒ The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- ☒ The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- ☒ The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Homes Geographic Limitations

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- ☐ Health Homes services will be available statewide
- ☒ Health Homes services will be limited to the following geographic areas
- ☐ Health Homes services will be provided in a geographic phased-in approach

Specify the geographic limitations of the program

- ☒ By county
- ☐ By region
- ☐ By city/municipality
- ☐ Other geographic area

Specify which counties:

- Adams
- Asotin
- Benton
- Chelan
- Clallam
- Clark
- Columbia
- Cowlitz
- Douglas
- Ferry
- Franklin
- Garfield
- Grant
- Grays Harbor
- Island
- Jefferson
- Kitsap
- Kittitas
- Klickitat
- Lewis
- Lincoln
- Mason
- Okanogan
- Pacific
- Pend Oreille
- Pierce
- San Juan
- Skagit
- Skamania
- Spokane
- Stevens
- Thurston
- Wahkiakum
- Walla Walla
- Whatcom
- Whitman
- Yakima

Health Homes Population and Enrollment Criteria

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Categories of Individuals and Populations Provided Health Home Services

The state will make Health Home services available to the following categories of Medicaid participants

- ☒ Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
- ☐ Medically Needy Eligibility Groups

Health Homes Population and Enrollment Criteria

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Population Criteria

The state elects to offer Health Homes services to individuals with:

- ☐ Two or more chronic conditions
- ☒ One chronic condition and the risk of developing another

Specify the conditions included:

- ☒ Mental Health Condition
- ☒ Substance Use Disorder
- ☒ Asthma
- ☒ Diabetes
- ☒ Heart Disease
- ☐ BMI over 25
- ☒ Other (specify):

Name	Description
cancer	
cerebrovascular disease	
coronary artery disease	
dementia or Alzheimer's disease	
intellectual disability or disease	
hematological and musculoskeletal conditions	
HIV/AIDS	
renal failure	
chronic respiratory conditions	
neurological disease	
gastrointestinal	

Specify the criteria for at risk of developing another chronic condition:

At risk of a second is a minimum predictive risk score of 1.5. The predictive risk score of 1.5 means a beneficiary's expected future medical expenditures is expected to be 50% greater than the base reference group, the WA SSI disabled population. The WA risk score is based on the Chronic Illness & Disability Payment System and Medicaid-Rx risk groupers developed by Rick Kronick and Todd Gilmer at the University of California, San Diego, with risk weights normalized for the WA Medicaid population. Diagnoses, prescriptions, age and gender from the beneficiary's medical claims and eligibility history for the past 15 months (24 months for children) are analyzed, a risk score is calculated and chronic conditions checked across all categorically needy populations, and a clinical indicator (Y=qualifies; N=does not qualify) is loaded into the WA MMIS.

Potentially eligible beneficiaries with insufficient claims history may be referred to the program by contacting HCA. A tool has been developed to manually calculate risk. This tool will be on the Health Home website and distributed to the Designated Providers. Once a provider has determined a beneficiary is eligible by manually calculating their risk, that information will

be sent to HCA for further analysis. If the beneficiary is eligible, they will be enrolled into a health home.

☐ One serious and persistent mental health condition

Health Homes Population and Enrollment Criteria

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Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home:

- ☐ Opt-In to Health Homes provider
- ☒ Referral and assignment to Health Homes provider with opt-out
- ☐ Other (describe)

Describe the process used:

The state identifies Fee-for-Service beneficiaries who are eligible for health homes based upon their chronic condition and risk score, and enrolls them into a Fee-for-Service qualified health home designated provider. Enrollment will be based on zip codes, amount of available enrollees within those zip codes, and capacity to provide health home services. The designated provider will assign health home beneficiaries to one of their network affiliated Care Coordination Organizations (CCO), who, in turn, will assign the beneficiary to a Care Coordinator. Beneficiaries have the ability to opt-out of the assigned health home or change enrollment to another designated provider or subcontracted Health Home CCO within the qualified provider network. Eligible beneficiaries who opt-out have the option of enrolling in a Health Home with a contracted designated provider at any time.

Managed care beneficiaries are auto-enrolled into a Medicaid managed care organization (MCO). The state identifies MCO enrollees who are eligible for health homes based upon their chronic condition and risk score and sends the information to their MCO. MCOs who are qualified to be designated providers assign their eligible, identified health home enrollees to one of their network affiliated Care Coordination Organizations (CCO), who, in turn, will assign the beneficiary to a Care Coordinator. MCOs who are not qualified as a designated provider must delegate health services to a qualified designated provider and assign their eligible/identified enrollees to their delegated designated provider. The designated provider, in turn, will assign the beneficiary to a one of their network affiliated CCOs and a Care Coordinator. Beneficiaries have the ability to opt-out of the health home or change enrollment to another designated provider or subcontracted Health Home CCO within the qualified provider network.

- ☒ The state provides assurance that it will clearly communicate the individual's right to opt out of the Health Home benefit or to change Health Home providers at any time and agrees to submit to CMS a copy of any letter or communication used to inform the individual of the Health Home benefit and their rights to choose or change Health Home providers or to elect not to receive the benefit.

Name	Date Created	
No items available		

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | WA2015MH0001O | WA-15-011-X | MIGRATED_HH.WA HHS

Package Header

Package ID	WA2015MH0001O	SPA ID	WA-15-011-X
Submission Type	Official	Initial Submission Date	N/A
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Superseded SPA ID			

Types of Health Homes Providers

☒ Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

☒ Physicians

Describe the Provider Qualifications and Standards

- 1.Experience operating broad-based regional provider network;
- 2.Contracts directly with the state as a Qualified Health Home;
- 3.Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;
- 4.Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);
- 5.Subcontracts with CCOs to directly provide the Health Home care coordination services;
- 6.Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
 - a.Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or
 - b.Optimizes beneficiary choice.
- 7.Maintains a list of CCOs and their assigned Health Home population.
- 8.Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable;
- 9.Collects and reports encounters to the HCA;
- 10.Disburses payment to CCOs based upon encounters;
- 11.Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;
- 12.Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

☒ Clinical Practices or Clinical Group Practices

Describe the Provider Qualifications and Standards

- 1.Experience operating broad-based regional provider network;
- 2.Contracts directly with the state as a Qualified Health Home;
- 3.Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;
- 4.Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);
- 5.Subcontracts with CCOs to directly provide the Health Home care coordination services;
- 6.Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
 - a.Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or
 - b.Optimizes beneficiary choice.
- 7.Maintains a list of CCOs and their assigned Health Home population.
- 8.Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure

coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable;

9.Collects and reports encounters to the HCA;

10.Disburses payment to CCOs based upon encounters;

11.Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;

12.Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

☒ Rural Health Clinics

Describe the Provider Qualifications and Standards

1.Experience operating broad-based regional provider network;

2.Contracts directly with the state as a Qualified Health Home;

3.Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;

4.Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);

5.Subcontracts with CCOs to directly provide the Health Home care coordination services;

6.Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:

a.Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or

b.Optimizes beneficiary choice.

7.Maintains a list of CCOs and their assigned Health Home population.

8.Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable;

9.Collects and reports encounters to the HCA;

10.Disburses payment to CCOs based upon encounters;

11.Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;

12.Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

☒ Community Health Centers

Describe the Provider Qualifications and Standards

1.Experience operating broad-based regional provider network;

2.Contracts directly with the state as a Qualified Health Home;

3.Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;

4.Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);

5.Subcontracts with CCOs to directly provide the Health Home care coordination services;

6.Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:

a.Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or

b.Optimizes beneficiary choice.

7.Maintains a list of CCOs and their assigned Health Home population.

8.Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable;

9.Collects and reports encounters to the HCA;

10.Disburses payment to CCOs based upon encounters;

11.Ensures person-centered and integrated Health Action Planning. This

includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;

12.Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

☒ Community Mental Health Centers

Describe the Provider Qualifications and Standards

- 1.Experience operating broad-based regional provider network;
- 2.Contracts directly with the state as a Qualified Health Home;
- 3.Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;
- 4.Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);
- 5.Subcontracts with CCOs to directly provide the Health Home care coordination services;
- 6.Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
 - a.Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or
 - b.Optimizes beneficiary choice.
- 7.Maintains a list of CCOs and their assigned Health Home population.
- 8.Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable;
- 9.Collects and reports encounters to the HCA;
- 10.Disburses payment to CCOs based upon encounters;
- 11.Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;
- 12.Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

☒ Home Health Agencies

Describe the Provider Qualifications and Standards

- 1.Experience operating broad-based regional provider network;
- 2.Contracts directly with the state as a Qualified Health Home;
- 3.Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;
- 4.Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);
- 5.Subcontracts with CCOs to directly provide the Health Home care coordination services;
- 6.Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
 - a.Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or
 - b.Optimizes beneficiary choice.
- 7.Maintains a list of CCOs and their assigned Health Home population.
- 8.Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable;
- 9.Collects and reports encounters to the HCA;
- 10.Disburses payment to CCOs based upon encounters;
- 11.Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;
- 12.Collects, analyzes, and reports financial, health status and performance

and outcome measures to objectively determine progress towards meeting Health Home goals.

☒ Case Management Agencies

Describe the Provider Qualifications and Standards

- 1.Experience operating broad-based regional provider network;
- 2.Contracts directly with the state as a Qualified Health Home;
- 3.Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;
- 4.Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);
- 5.Subcontracts with CCOs to directly provide the Health Home care coordination services;
- 6.Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
 - a.Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or
 - b.Optimizes beneficiary choice.
- 7.Maintains a list of CCOs and their assigned Health Home population.
- 8.Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable;
- 9.Collects and reports encounters to the HCA;
- 10.Disburses payment to CCOs based upon encounters;
- 11.Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;
- 12.Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

☒ Community/Behavioral Health Agencies

Describe the Provider Qualifications and Standards

- 1.Experience operating broad-based regional provider network;
- 2.Contracts directly with the state as a Qualified Health Home;
- 3.Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;
- 4.Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);
- 5.Subcontracts with CCOs to directly provide the Health Home care coordination services;
- 6.Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
 - a.Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or
 - b.Optimizes beneficiary choice.
- 7.Maintains a list of CCOs and their assigned Health Home population.
- 8.Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable;
- 9.Collects and reports encounters to the HCA;
- 10.Disburses payment to CCOs based upon encounters;
- 11.Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;
- 12.Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

☒ Federally Qualified Health Centers (FQHC)

Describe the Provider Qualifications and Standards

- 1.Experience operating broad-based regional provider network;
- 2.Contracts directly with the state as a Qualified Health Home;
- 3.Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;
- 4.Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);
- 5.Subcontracts with CCOs to directly provide the Health Home care coordination services;
- 6.Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
 - a.Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or
 - b.Optimizes beneficiary choice.
- 7.Maintains a list of CCOs and their assigned Health Home population.
- 8.Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable;
- 9.Collects and reports encounters to the HCA;
- 10.Disburses payment to CCOs based upon encounters;
- 11.Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;
- 12.Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

☒ Other (Specify)

Provider Type	Description
Hospitals	1.Experience operating broad-based regional provider network; 2.Contracts directly with the state as a Qualified Health Home; 3.Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network; 4.Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO); 5.Subcontracts with CCOs to directly provide the Health Home care coordination services; 6.Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process: a.Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or b.Optimizes beneficiary choice. 7.Maintains a list of CCOs and their assigned Health Home population. 8.Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider network. At minimum, MOAs will be executed with organizations that authorize

Provider Type	Description
	Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable; 9.Collects and reports encounters to the HCA; 10.Disburses payment to CCOs based upon encounters; 11.Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator; 12.Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.
MCOs	1.Experience operating broad-based regional provider network; 2.Contracts directly with the state as a Qualified Health Home; 3.Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network; 4.Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO); 5.Subcontracts with CCOs to directly provide the Health Home care coordination services; 6.Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process: a.Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or b.Optimizes beneficiary choice. 7.Maintains a list of CCOs and their assigned Health Home population. 8.Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable; 9.Collects and reports encounters to the HCA;

Provider Type	Description
	10.Disburses payment to CCOs based upon encounters; 11.Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator; 12.Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.
Substance Use Disorder Treatment providers	1.Experience operating broad-based regional provider network; 2.Contracts directly with the state as a Qualified Health Home; 3.Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network; 4.Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO); 5.Subcontracts with CCOs to directly provide the Health Home care coordination services; 6.Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process: a.Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or b.Optimizes beneficiary choice. 7.Maintains a list of CCOs and their assigned Health Home population. 8.Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable; 9.Collects and reports encounters to the HCA; 10.Disburses payment to CCOs based upon encounters; 11.Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the

Provider Type	Description
	work of the care coordinator; 12.Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.
Tribal Clinics	1.Experience operating broad-based regional provider network; 2.Contracts directly with the state as a Qualified Health Home; 3.Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network; 4.Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO); 5.Subcontracts with CCOs to directly provide the Health Home care coordination services; 6.Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process: a.Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or b.Optimizes beneficiary choice. 7.Maintains a list of CCOs and their assigned Health Home population. 8.Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable; 9.Collects and reports encounters to the HCA; 10.Disburses payment to CCOs based upon encounters; 11.Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator; 12.Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

Health Homes Providers

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- ☐ Teams of Health Care Professionals
- ☐ Health Teams

Health Homes Providers

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Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

The delivery of Washington's health home service model is based on an inter-disciplinary array of medical care, behavioral health care, and community-based social services and supports for children and adults who meet Washington's defined chronic conditions and risk criteria. The integration of primary care, behavioral health services, and long-term care services and supports are critical when improving health outcomes and reducing costs.

Qualifying the Health Home designated providers ensures that managed care organizations (MCOs), hospitals, Federally Qualified Health Centers (FQHC), Regional Support Networks, Area Agencies on Aging, Community Mental Health Agencies, Substance Use Disorder Treatment Providers, Specialty Care and Primary Care Providers, and Tribal Clinics have the necessary skills and infrastructure to provide health home services.

Designated providers, through their respective networks, provide intensive Health Home care coordination services to Medicaid and Medicare/Medicare beneficiaries with chronic conditions to ensure that services delivered are integrated and coordinated across medical, mental health, chemical dependency and long-term care services and supports. Beneficiaries who are eligible for Health Homes receive direct services from HCA and DSHS, but the Health Home contracts are based in HCA.

Additionally, multidisciplinary team members are recruited to support engagement and outreach, clinical decisions and evidenced-based care. Multidisciplinary team members may be composed of willing participants who provide direct service to the beneficiary and subject matter experts, such as primary care providers, mental health professionals, chemical dependency treatment providers, social workers, nutritionists/dieticians, direct care workers, pharmacists, peer specialists, community health navigators, family members or housing representatives.

The Health Home structure is built on the following hierarchy:

1. Qualified Designated Provider/Lead - Healthcare systems, providers and authorizing entities with experience developing community based service provider network relationships, such as managed care organizations (MCOs), hospitals, Federally Qualified Health Centers (FQHC), Regional Support Networks, Area Agencies on Aging, Community Mental Health Agencies, Substance Use Disorder Treatment providers, Specialty Care and Primary Care Providers. The Designated Provider contracts directly with the state and is responsible for service delivery model and administration of the Health Home. The designated providers collect and submit encounters; disburse payment to network affiliated Care Coordination Organizations through the collection and submission of encounters; monitor quality; sub-contract; collect, analyze and report financial, health status and performance and outcome measures to objectively determine progress towards meeting overall Health Home goals; and provide customer service, such as toll-free lines or nursing advise lines.
2. Network Affiliated Care Coordination Organizations – Accountable for Care Coordination staffing and oversight of direct delivery of the six Health Home services. Care Coordination Organizations are responsible for implementing systematic processes and protocols to assure beneficiary access to Care Coordinators and care coordination functions. Care Coordination Organizations can be managed care organizations, hospitals, Federally Qualified Health Centers (FQHC), Regional Support Networks, Area Agencies on Aging, Community Mental Health Agencies, Substance Use Disorder Treatment providers, Home Health, Specialty providers, such as AIDS or ESRD clinics, Specialty Care and Primary Care Providers.
3. Care Coordinators – Operate under the direction of the Care Coordination Organizations by directly interacting with participating beneficiaries. Care Coordinators provide the six defined Health Home care coordination benefits in-person by actively engaging the beneficiary in developing a Health Action Plan; reinforcing the Health Action Plan and supporting the beneficiary to attain short and long-term goals; coordinating with authorizing and prescribing entities as necessary to reinforce and support the beneficiary's health action goals; advocating, educating, and supporting the beneficiary to attain and improve self-management skills; assuring the receipt of evidence-based care; supporting beneficiaries and families during discharge from hospital and institutional settings, including providing evidence-based transition planning; and accompanying the beneficiary to critical appointments when necessary. To better support beneficiary goals and ensure quality of care, they will coordinate services with authorizing entities for which the beneficiary is receiving services assistance. A Health Home Care Coordinator must provide service in the community in which the beneficiary resides so services can be provided in-person whenever needed, unless the beneficiary requests to receive their services elsewhere. Health Home Care Coordinators serve eligible individuals in the setting of the beneficiary's choice and may not establish policies that would restrict service because a beneficiary moves from one eligible setting to another. Care Coordinators must be clinical or non-clinical professionals, such as RNs, ARNPs, Psychiatric ARNPs, Social Workers, Mental Health Social Workers, Chemical Dependency Professionals, and Counselors.
4. Allied health care staff, such as community health workers, peer counselors or other non-clinical personnel provide administrative support for the Health Home Care Coordinator, such as mailing health promotion material, arranging for beneficiary transportation to appointments, and calling the beneficiary to facilitate face-to-face Health Home visits with the Care Coordinator.
5. Additional network providers who have agreed to participate in the health home model through the use of memorandums of agreement, subcontracts, or operational agreements. For example, a clinic may agree to provide referrals to a designated provider, through the use of an operational agreement.

Supports for Health Homes Providers

Describe the methods by which the state will support providers of Health Homes services in addressing the following components

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services

5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

Description

The foundation of health homes (HH) is the community network, which must be present to qualify as a designated provider to ensure partnerships between mental health and substance abuse providers, long-term care services and supports providers, and medical communities that support care coordination and access through HH services. The client is involved in improving their health through the development of their Health Action Plan (HAP). HAPs are shared with the client during development and when they are updated. Clients may include their families and caregivers as part of their team.

Training for Health Home service delivery is sponsored by HCA and DSHS. Nursing staff develop core curriculum materials to support the provision of timely, comprehensive, high-quality services with a whole person focus. DSHS offers technical assistance training for core skills relevant topics. Webinars, community network meetings and/or learning collaboratives foster shared learning, information sharing and problem solving.

The State will provide access to PRISM, a secure web-based clinical support tool showing the client's medical risk factors, demographics, eligibility, managed care status, housing, utilization of Medicaid and Medicare health services (inpatient, outpatient, ER, filled prescriptions, mental health services, long-term care services and supports, filled lab orders, dental), provider contact information, long-term care case manager assessments, and patient activation measure assessments. This resource complements existing clinic-specific Electronic Health Records and provides the foundation for a continuous quality improvement program.

HAP data is electronically submitted to the State and is kept in a secure Health Information Exchange. This allows the State to analyze metrics on quality of care and health outcomes. HAPs are electronically filed with the Designated Providers to inform them of a client's progress towards managing their chronic conditions.

Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes providers are as follows

Health home designated providers and their networks are developed to meet the needs of the population. Care coordination should occur across service domains and therefore include many different disciplines. A designated provider is qualified by the State and is responsible for the integration and coordination of primary, acute, behavioral health (mental health and substance use disorder) and long-term services and supports for persons with chronic illness across the lifespan through contractual/operational arrangements with appropriate providers. The care coordinator is the central point of contact working with the managed care or fee-for-service beneficiary to direct person-centered health action planning and implementation and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up, and improving patient outcomes by addressing health care needs.

Washington will qualify the designated provider through a contracting process for each phase of implementation. Qualifications include:

1. Applicant is a Medicaid provider in good standing, ability to serve 1,000 to 2,000 health home beneficiaries, experience operating broad-based networks, agrees to serve the entire coverage area, assures 24 hours/seven days a week information and referrals, documents beneficiary consent, subcontracts with CCOs, ability to coordinate care and services after critical events, such as emergency department use and hospital inpatient admission and discharge, language access/translation capability, links to acute and outpatient medical, mental health and substance abuse services, links to community-based social services, including housing;
2. Provider Networks – must include authorizing entities, such as the DSHS Functional and Financial Eligibility section, Regional Support Networks, Disability Determinations, and a wide-variety of Care Coordination organizations, such as CMHAs, Substance Abuse Treatment providers, long-term services and supports, FQHCs, and Community Health;
3. Organizational Infrastructure – ability to provide administrative functions, such as toll-free lines, customer service staff, policies on process and timelines for bringing in additional CCOs to preserve integrity of face-to-face health home care coordination activities, ability to track health home beneficiaries to CCO assignment, collecting and submitting claims and encounters, payment disbursement, taking into account intensity levels and/or movement between CCOs, quality monitoring, subcontracting, collecting, analyzing and reporting financial, health status and performance and outcome measures. Ability to ensure hospitals have procedures in place for referring health home eligible beneficiaries for enrollment if they are seeking or need treatment in a hospital emergency room;
4. Core Health Home Requirements – ability to provide six health home care coordination functions and guarantee of non-duplication of efforts, engagement and outreach, health action planning, self-management of chronic conditions, setting short and long-term goals, cultural competency, motivational interviewing, identification of services and gaps in services, evidence-based interventions, sharing information with beneficiary's treating/authorizing entities, establishing multidisciplinary teams, accompanying beneficiary to visits when requested, arranging for priority appointments, notification systems for transitional care, follow-up on medication upon discharge and follow-up with pharmacy to get scripts filled, help the beneficiary access follow-up care, referrals, optimizing social supports and family, use of health information technology; and
5. Center for Medicare and Medicaid Services (CMS) Health Home Provider Functional Requirements – descriptions of process used to ensure 11 core health requirements are met.

HCA and DSHS will conduct desk audits and on-site readiness reviews before awarding Designated Provider status to ascertain readiness to provide Health Home services. Contracts will only be offered after the readiness reviews and any identified deficiencies are mitigated through a corrective action plan.

The period of performance for FFS Health Home contract(s) is an initial two years. For managed care organizations who apply to become qualified designated providers, the period of performance will be based upon their managed care contract. The program will be audited during annual contract compliance audits.

Based upon results of the audit, the designated provider may be put on corrective action or have their qualification status terminated.

Other entities interested in applying to become a designated provider may submit a request to the Health Care Authority, at which time, the process for contracting will take effect.

Name	Date Created	
No items available		

Health Homes Service Delivery Systems

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Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

- ☒ Fee for Service
- ☒ PCCM

The PCCMs will be a Designated Provider or part of a Team of Health Care Professionals

☒ Yes

☐ No

The PCCM/Health Homes providers will be paid based on the following payment methodology outlined in the payment methods section

☐ Fee for Service (describe in Payment Methodology section)

☒ Alternative Model of Payment (describe in Payment Methodology section)

☐ Other

Requirements for the PCCM participating in a Health Home as a Designated Provider or part of a Team of Health Care Professionals will be different from those of a regular PCCM

☒ Yes

☐ No

Describe how requirements will be different

Tribal clinics are allowed to contract with HCA to become a designated provider and provide services under a Health Home contract if they meet all the contracting requirements, including systems capability to receive 834 HIPAA compliant enrollment notifications, ability to submit encounter data to the ProviderOne payment system and ability to submit Health Action Plans into the HCA secure Medicaid database through HCA Health Information Exchange (HIE). If the clinic also has a PCCM contract with HCA, the tribal member may be enrolled in the PCCM or in the Health Home program, but are not allowed to be enrolled in both at the same time to avoid duplication of services. To enroll in the Tribal Health Home, tribal members must meet Health Home eligibility criteria, agree to participate in the Health Home and agree to disenroll from the PCCM. The tribal member, if eligible for Health Homes, has a choice between remaining in the PCCM program or agreeing to enroll in the Health Home program.

☐ The state provides assurance that these requirements will be incorporated into the next PCCM contract submitted to CMS.

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☒ Risk Based Managed Care

The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals

- ☒ Yes
- ☐ No

Provide a summary of the contract language that you will impose on the Health Plans in order to deliver the Health Homes services

Managed care contracts contain language to support the health home benefit for eligible enrollees. A MCO has two paths to choose from when providing those benefits. They may either become a qualified designated provider through the readiness review process or they may provide their health home benefits through a delegation agreement with another qualified designated provider.

Contract language will contain:

- Standards for the six Health Home services - Comprehensive Care Management, Care Coordination and Health Promotion, Transitional Care, Individual and Family Support, Referrals to the Community and Use of Health Information Technology;
- The use of clinical and non-clinical care coordinators and support staff;
- Contracts, memorandums of agreement or operational agreements with hospitals for ER notification and hospitalization, including a referral process to refer beneficiaries for health home services;
- Standardized screening and assessments;
- Development of a Health Action Plan through an in-person visit to promote self-management through the identification of the enrollee's short and long-term goals;
- Process and outcome measures;
- Encounter data reporting and documentation of delivered services to support encounters;
- The use of multidisciplinary care teams, that include the care coordinator, the beneficiary, and any other identified providers;
- If the Health Home beneficiary is a Medicaid managed care enrollee, the MCO will share critical data with the Health Home Care Coordination Organization. Data may include institutional admissions and discharge readiness for transitional health care services management and facilitation, lapses in pharmaceutical payments that may indicate need for client outreach and education regarding medication use and over-use patterns, such as emergency room use that may suggest a need for a Care Coordinator visit or intervention to address the clinical and Health Action Plan goals.

☒ The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.

Name	Date Created	
No items available		

The State intends to include the Health Home payments in the Health Plan capitation rate

- ☒ Yes
- ☐ No

Assurances ☒ The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:

- Any program changes based on the inclusion of Health Homes services in the health plan benefits

- Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)
- Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)
- Any risk adjustments made by plan that may be different than overall risk adjustments
- How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM

☒ The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services

☒ The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found

☐ Other Service Delivery System

Health Homes Payment Methodologies

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Payment Methodology

The State's Health Homes payment methodology will contain the following features

☒ Fee for Service

☒ Individual Rates Per Service

☒ Fee for Service Rates based on

- ☐ Severity of each individual's chronic conditions
- ☐ Capabilities of the team of health care professionals, designated provider, or health team
- ☒ Other

Describe below

Rates were built for three levels of payment using a clinical and non-clinical staffing model combined with monthly service intensity.

Three levels of payment are dependent upon who is providing the services and the intensity of the service determined by in-person, one-on-one, high touch interactions. This first care coordination stage encompasses three primary responsibilities, in addition to the health home service: health screening and assessments, development of a health action plan for care management, and assess the beneficiary for self-management and promote self-management skills to improve functional or health status or prevent or slow declines in functioning. There is no withhold for this component of the rate.

This is a one-time only rate and is triggered by the submission of a Health Action Plan encounter and the documentation of a health home service.

The second level is for Intensive Health Home Care Coordination. It is assumed that for each full -time employee (FTE), 50 clients can be supported. This rate is paid once per month, per beneficiary and is triggered by documenting delivery of a health home service.

The third level of payment is for Low-Level Health Home Care Coordination. This rate is paid once per month with an encounter. Low-level payment will be paid on a monthly basis, and payment is made only for months in which an encounter occurred. An encounter is represented by documenting delivery of a health home service. It is assumed that for months in which an encounter

occurs, 2/3 will involve a phone call and
1/3 involves a home visit.

- ☒ Per Member, Per Month Rates
- ☐ Fee for Service Rates based on
- ☐ Comprehensive Methodology Included in the Plan
- ☒ Incentive Payment Reimbursement
- ☐ Fee for Service Rates based on

**Describe any variations in
payment based on provider
qualifications, individual care
needs, or the intensity of the
services provided**

- ☐ PCCM (description included in Service Delivery section)
- ☐ Risk Based Managed Care (description included in Service Delivery section)
- ☐ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Health Homes Payment Methodologies

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Agency Rates

Describe the rates used

- ☐ FFS Rates included in plan
- ☐ Comprehensive methodology included in plan
- ☐ The agency rates are set as of the following date and are effective for services provided on or after that date

Health Homes Payment Methodologies

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Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates;
2. Please identify the reimbursable unit(s) of service;
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit;
4. Please describe the state's standards and process required for service documentation, and;
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including:
 - the frequency with which the state will review the rates, and
 - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description

Health Homes Payment Methodologies

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Assurances

- ☒ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.
- Describe below how non-duplication of payment will be achieved**

Case management provided under the state’s 1915(c) waivers are non-duplicative of health home services. The functions provided by 1915(c) case managers include determination of waiver eligibility, comprehensive assessment to determine unmet needs related to waiver services, service planning of services provided under the waiver, qualification of waiver providers, authorization of waiver services, and monitoring of service provision. This type of specialized case management for individuals receiving long term services and supports and developmental disabilities services will continue to be necessary for individuals served under waivers and health homes will not duplicate the functions provided by state and Area Agency on Aging staff that perform these functions.

Health Homes will be responsible for review of claims and social service use history, health screening (e.g., screening for common mental health conditions associated with chronic illness such as depression, patient activation assessments), examination of current clinical conditions and treatment, and PRISM application information. This assessment is used to identify care gaps, utilization patterns, where chronic care condition education and coaching may be most helpful and to assist the individual in development and implementation of their health care plan,including identification of self-care goals.

The health home will also be responsible for transitions, assessing individuals at higher risk for re-institutionalization and assisting the individual and their support network in gaining an understanding of discharge instructions and information, ensure appropriate follow-up primary and specialty care and that medication reconciliation occurs, and to assist with referrals for additional services the client may need.

For Tribal PCCMs, the state will not allow an eligible Health Home enrollee to be enrolled in a Tribal PCCM and a Tribal Health Home at the same time. A tribal member, if enrolled in a PCCM, must make a choice about what method they wish to use for case management. If they decide to become enrolled in a Tribal Health Home, they must disenroll from their Tribal PCCM.

Health Home enrollment is managed by the State and the ProviderOne enrollment and payment system, does not allow a tribal member to be enrolled in a Health Home and a PCCM at the same time.
- ☐ The State meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), 1902(a)(30)(A), and 1903 with respect to non-payment for provider-preventable conditions.
- ☒ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.
- ☒ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

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Service Definitions

Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

Comprehensive Care Management

Definition

Care Coordinators will deliver comprehensive care management, primarily in-person with periodic follow-up. Care management services include state approved screens, demonstrate the ability to provide continuity and coordination of care through in-person visits, and the ability to accompany beneficiaries to health care provider appointments, as needed. Care Coordinators assess beneficiary readiness for self-management and promote self-management skills so the beneficiary is better able to engage with health and service providers and support the achievement of self-directed, individualized health goals to attain recovery, improve functional or health status or prevent or slow declines in functioning. Comprehensive care management service delivery uses the Health Action Plan (HAP) as the beneficiary directed care management plan. The HAP is created during a face-to-face initial visit with the beneficiary and updated periodically every 4, 6 and 8 months. It is also updated when there are any changes in beneficiary circumstances such as hospitalization or ER visits. The results of screenings and assessments are captured via the HAP and used to identify gaps in care and chart the beneficiary's progress towards meeting goals through active participation in comprehensive care management.

Screens include clinical and functional screens, including depression, alcohol or substance use disorder, functional impairment, and pain appropriate to the age and risk profile of the individual. Screens will support referrals to services when needed, e.g., referral for assessment of need for chemical dependency treatment, specialty care or long term services and supports. Other screens and assessments that may supplement comprehensive care management are mental health treatment plans, chemical dependency treatment plans, and/or other pre-existing care plans which include assessment results.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All Health Home designated providers/lead entities will have access to the Medicaid Management Information System - ProviderOne (P1), the DSHS Predictive Risk Intelligence System (PRISM) and Insignia Health information technology sources. Authorizers and providers of long-term services and supports have access to the DSHS Comprehensive Assessment and Reporting Evaluation (CARE)

data either electronically or in paper form. Data sharing agreements and Release of Information consent forms will be maintained by all Health Home Lead Entities to facilitate sharing electronic health information with their Health Home network affiliates.

- 1.DSHS is responsible for maintenance and updates to the CARE and PRISM.
2. Insignia Health is responsible through a DSHS licensing agreement for maintenance and updates to the Patient Activation Measure (PAM) and Caregiver Activation Measure (CAM) and administrative web site functions including Coaching for Activation.
- 3.HCA's P1 data system is responsible for Medicaid eligibility, enrollment, disenrollment, claims and per member per month (PMPM) payment to MCOs, payment of health homes, encounter data collection and reporting.
- 4.Emergency Department Information Exchange (EDIE) notification provides Medicaid claims data to ED physicians. EDIE is HIPAA compliant and can proactively alert care providers when high utilizing patients enter the ED through a variety of methods such as fax, phone, email, or integration with a facility's current EMR. Once notified, care providers can use EDIE to access care guidelines and crucial information on the patient from other participating facilities to better determine the patient's actual medical situation. A care management module is being developed for the EDIE system to facilitate defined treatment plans for frequent ED users in Washington State.

Scope of service

The service can be provided by the following provider types

- ☒ Behavioral Health Professionals or Specialists

Description

- 1.Psychologists must have a doctoral degree from a regionally accredited institution, with at least 40 semester hours or sixty quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, supervised experience requirement of no fewer than two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).
- 2.Child psychiatrists are licensed as physicians and surgeons, with graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board eligible or board certified in child psychiatry.
- 3.Licensed mental health counselors must graduate with a MA or PhD level educational program in mental health counseling or a related discipline and complete 36 months of supervised full-time counseling or 3000 hours of postgraduate mental health counseling under the supervision of a qualified licensed mental health counselor. Licensed mental health counselors must pass an examination administered by the National Board of Certified Counselors. Licensed mental health counselors are not required to have supervised postgraduate experience prior to becoming an associate.
4. Licensed marriage and family therapists must graduate with a master's

- ☐ Nurse Practitioner
- ☒ Nurse Care Coordinators

- ☒ Nurses

- ☐ Medical Specialists
- ☐ Physicians
- ☒ Physician's Assistants

degree or doctoral degree educational program in marriage and family therapy or a behavioral science MA or PhD with equivalent course work from an approved school. The licensed marriage and family therapists must complete a minimum of 2 years of supervised full-time marriage and family therapy. For full licensure, a licensed marriage and family therapists must take and pass the Association of Marital and Family Therapy Regulatory Boards examination. Licensed marriage and family therapist associate applicants are not required to have supervised postgraduate experience prior to becoming an associate.

Description

1. Licensed Practical Nurses (LPN) must successfully complete a commission approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice and pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington State before practicing.
2. Registered Nurses (RN) RNs must successfully complete a commission approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington State before practicing.
3. Advanced registered Nurse Practitioners (ARNP) must have formal graduate education and achieve a national specialty certification for the nurse practitioner, nurse anesthetist or nurse midwife role. ARNPs must hold a registered nurse license in Washington State before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.
4. Psychiatric advanced registered nurse practitioner" means a person who is licensed as an advanced registered nurse practitioner; and who is board certified in advanced practice psychiatric and mental health nursing.
5. Psychiatric nurses are registered nurses with a bachelor's degree from an accredited college or university, and have, 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.

Description

1. Licensed Practical Nurses (LPN) must successfully complete a commission approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice and pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington State before practicing.
2. Registered Nurses (RN) RNs must successfully complete a commission approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington State before practicing.
3. Advanced registered Nurse Practitioners (ARNP) must have formal graduate education and achieve a national specialty certification for the nurse practitioner, nurse anesthetist or nurse midwife role. ARNPs must hold a registered nurse license in Washington State before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.
4. Psychiatric advanced registered nurse practitioner" means a person who is licensed as an advanced registered nurse practitioner; and who is board certified in advanced practice psychiatric and mental health nursing.
5. Psychiatric nurses are registered nurses with a bachelor's degree from an accredited college or university, and have, 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.

Description

Must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited extent under the supervision of a physician and who is academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services. Physician Assistants must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the National Commission of Certification of Physician Assistants (NCCPA) examination. Physician assistants must have 4 clock hours of AID education and an active DEA registration.

- ☐ Pharmacists
- ☒ Social Workers

Description

All social workers listed below must pass either the American Association of State Social Work Board's advanced or clinical examination for licensure. The Associate social workers listed below are not required to have supervised postgraduate experience prior to becoming an associate.

1. Licensed Independent Social Worker must graduate with a MA or PhD social work and complete a minimum of 4,000 hours of supervised experience or which 1,000 hours must be direct client contact, over a three-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.
2. Licensed Advanced Social Worker must graduate with a MA or PhD social work program and complete 3,200 hours with supervision. At least 90 hours are direct supervision as specified by a licensed independent clinical social worker, a licensed advanced social worker, or an equally qualified licensed mental health professional. At least 40 hours must be in one-to-one supervision and 50 hours may be in one-to-one supervision or group supervision.
3. Licensed independent clinical social worker must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and successfully complete a supervised experience of at least 4,000 hours of experience, of which 1,000 hours must be direct client contact, over a 3-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.
4. Licensed social worker associate-independent clinical must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.
5. Licensed social worker associate-advanced must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dietitians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
Chemical Dependency Professionals	Chemical Dependency Professionals (CDPs) must pass the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination. CDPs must complete 1,000 to 2,500 hours of supervised experience, dependent upon the following, associate degree, baccalaureate degree, masters or doctoral degree, licensed as an advance registered nurse practitioner, marriage and family therapists, mental health counselors, advanced social workers, independent clinical social worker or licensed as a psychologist, that include clinical evaluation and face-to-face counseling.

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Care Coordination

Definition

The dedicated Health Home Care Coordinator shall play a central and active role in development and execution of cross-system care coordination to assist the beneficiary to access and navigate needed services. The Care Coordinator shall assure communication is fostered between the providers of care including the treating primary care provider and medical specialists and entities authorizing behavioral health and long-term services and supports. Care Coordination is the bridge between all the beneficiary's systems of care, including non-clinical support such as food, housing, and transportation.

When providing intensive care coordination to the beneficiary, the Care Coordinator caseload will be maintained at a level that ensures fidelity in providing required health home services, including interventions. Community health workers, peer counselors or other non-clinical staff may be used to facilitate the work of the assigned Health Home Care Coordinator.

Care coordination shall provide informed interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors impacting a beneficiary's health and health care choices. Care Coordinators will promote:

- 1.Optimal clinical outcomes, including a description of how progress toward outcomes will be measured through the Health Action Plan;
- 2.Outreach and engagement activities that support the beneficiary's participation in their care and promotes continuity of care;
- 3.Health education and coaching designed to assist beneficiaries to increase self-management skills and improve health outcomes; and
- 4.Use of peer supports, support groups and self-care programs to increase the beneficiary's knowledge about their health care conditions and improve adherence to prescribed treatment.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

PRISM and Insignia Health are information technology sources that support the beneficiary and the Health Home Care Coordinator to identify the unmet needs, gaps in care, transitional support needs, clinical protocols required and current utilization of case management, medical and behavioral health services.

The Health Action Plan (HAP) may be shared via secure email or hard copy. The HAP includes:

- 1.Beneficiary and Care Coordinator prioritized action items;
- 2.Beneficiary identified goals (short and long term);
- 3.Action steps for the beneficiary, the Health Home Care Coordinator and/or other direct service and medical providers; and
- 4.If the beneficiary has a personal care worker, the HAP will include action steps for them to support identified health action goals identified by the beneficiary.

The HAP is updated and modified by the Health Home Care Coordinator quarterly, and as needed to support care transition. The HAP is also updated and modified as needed according to:

- 1.A change in the beneficiary's condition;
- 2.New immediate goals to be addressed through the Health Home; and
- 3.Resolution of goals or action steps.

Future HIT development may include the addition of the HAP data elements to an electronic application, such as a web-based portal. The Health Home will promote the use of web-based health information technology registries and referral tracking systems.

Scope of service

The service can be provided by the following provider types

- ☒ Behavioral Health Professionals or Specialists

Description

- 1.Psychologists must have a doctoral degree from a regionally accredited institution, with at least 40 semester hours or sixty quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, supervised experience requirement of no fewer than two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).
- 2.Child psychiatrists are licensed as physicians and surgeons, with graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board eligible or board certified in child psychiatry.
- 3.Licensed mental health counselors must graduate with a MA or PhD level educational program in mental health counseling or a related discipline and complete 36 months of supervised full-time counseling or 3000 hours of postgraduate mental health counseling under the supervision of a qualified licensed mental health counselor. Licensed mental health counselors must pass an examination administered by the National Board of Certified Counselors. Licensed mental health counselors are not required to have supervised postgraduate experience prior to becoming an associate.
- 4. Licensed marriage and family therapists must graduate with a master's degree or doctoral degree educational program in marriage and family therapy or a behavioral science MA or PhD with equivalent course work from

- ☐ Nurse Practitioner
- ☒ Nurse Care Coordinators

- ☒ Nurses

- ☐ Medical Specialists
- ☐ Physicians
- ☒ Physician's Assistants

an approved school. The licensed marriage and family therapists must complete a minimum of 2 years of supervised full-time marriage and family therapy. For full licensure, a licensed marriage and family therapists must take and pass the Association of Marital and Family Therapy Regulatory Boards examination. Licensed marriage and family therapist associate applicants are not required to have supervised postgraduate experience prior to becoming an associate.

Description

1. Licensed Practical Nurses (LPN) must successfully complete a commission approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice and pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington State before practicing.
2. Registered Nurses (RN) RNs must successfully complete a commission approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington State before practicing.
3. Advanced registered Nurse Practitioners (ARNP) must have formal graduate education and achieve a national specialty certification for the nurse practitioner, nurse anesthetist or nurse midwife role. ARNPs must hold a registered nurse license in Washington State before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.
4. Psychiatric advanced registered nurse practitioner" means a person who is licensed as an advanced registered nurse practitioner; and who is board certified in advanced practice psychiatric and mental health nursing.
5. Psychiatric nurses are registered nurses with a bachelor's degree from an accredited college or university, and have, 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.

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Description

Must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited extent under the supervision of a physician and who is academically and clinically prepared to provide health

care services and perform diagnostic, therapeutic, preventative, and health maintenance services. Physician Assistants must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the National Commission of Certification of Physician Assistants (NCCPA) examination. Physician assistants must have 4 clock hours of AID education and an active DEA registration.

- ☐ Pharmacists
- ☒ Social Workers

Description

All social workers listed below must pass either the American Association of State Social Work Board's advanced or clinical examination for licensure. The Associate social workers listed below are not required to have supervised postgraduate experience prior to becoming an associate.

1. Licensed Independent Social Worker must graduate with a MA or PhD social work and complete a minimum of 4,000 hours of supervised experience or which 1,000 hours must be direct client contact, over a three-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

2. Licensed Advanced Social Worker must graduate with a MA or PhD social work program and complete 3,200 hours with supervision. At least 90 hours are direct supervision as specified by a licensed independent clinical social worker, a licensed advanced social worker, or an equally qualified licensed mental health professional. At least 40 hours must be in one-to-one supervision and 50 hours may be in one-to-one supervision or group supervision.

3. Licensed independent clinical social worker must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and successfully complete a supervised experience of at least 4,000 hours of experience, of which 1,000 hours must be direct client contact, over a 3-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

4. Licensed social worker associate-independent clinical must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

5. Licensed social worker associate-advanced must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
Chemical Dependency Professionals	Chemical Dependency Professionals (CDPs) must pass the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination. CDPs must complete 1,000 to 2,500 hours of supervised experience, dependent upon the following, associate degree, baccalaureate degree, masters or doctoral degree, licensed as an advance registered nurse practitioner, marriage and family therapists, mental health counselors, advanced social workers, independent clinical social worker or licensed as a psychologist, that include clinical evaluation and face-to-face counseling.

Health Homes Services

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Package Header

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Health Promotion

Definition

Health promotion begins for health home beneficiaries with the commencement of the Health Action Plan. Each Washington health home must demonstrate use of self-management, recovery and resiliency principles using person-identified supports including family members, and paid and unpaid caregivers. The Health Home Care Coordinator will use the beneficiary's activation score and level (1-4) to determine the coaching methodology for each beneficiary and develop a teaching and support plan. Educational materials are customized and introduced according to the beneficiary's readiness for change and progressed with a beneficiary's level of confidence and self-management abilities. Opportunities for mentoring and modeling communication with health care providers are provided through joint office visits and communications with health care providers by the beneficiary and the Health Home Care Coordinator. The health home will provide wellness and prevention education specific to the beneficiary's chronic conditions, Health Action Plan, including assessment of need and facilitation of receipt of routine preventive care, support for improving social connections to community networks and linking beneficiaries with resources that support a health promoting lifestyle. Linkages include but are not limited to resources for smoking prevention and cessation, substance use disorder treatment and prevention, nutritional counseling, obesity reduction and prevention, increasing physical activity, disease specific or chronic care management self-help resources, and other services, such as housing based on individual needs and preferences.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Insignia Health is an information technology source and provides, in connection with the Patient Activation Measure (PAM)/Caregiver Activation Measures (CAM), the Coaching for Activation website. This site provides educational materials linked to a beneficiary's level of activation and can be sent electronically to a beneficiary or printed for review at a Home Visit or by phone.

PRISM contains the history of the PAM/CAM scores and responses for each survey administered to the beneficiary. The Health Home Care Coordinator is able to view the scores for each beneficiary alongside the medical, behavioral health claims and LTC services utilization and selected CARE characteristics (for those beneficiaries with long-term services and supports) so that education materials can be tailored to the individual's engagement and activation.

Scope of service

The service can be provided by the following provider types

☒ Behavioral Health Professionals or Specialists

Description

1. Psychologists must have a doctoral degree from a regionally accredited institution, with at least 40 semester hours or sixty quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, supervised experience requirement of no fewer than two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).
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☐ Nurse Practitioner

☒ Nurse Care Coordinators

Description

1. Licensed Practical Nurses (LPN) must successfully complete a commission approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice and pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®)

☒ Nurses

☐ Medical Specialists

☐ Physicians

☒ Physician's Assistants

☐ Pharmacists

☒ Social Workers

for their LPN nurse certificate. All LPNs must have an active status license in Washington State before practicing.

2. Registered Nurses (RN) RNs must successfully complete a commission approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington State before practicing.

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1. Licensed Independent Social Worker must graduate with a MA or PhD social

work and complete a minimum of 4,000 hours of supervised experience of which 1,000 hours must be direct client contact, over a three-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

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4. Licensed social worker associate-independent clinical must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

5. Licensed social worker associate-advanced must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
Chemical Dependency Professionals	Chemical Dependency Professionals (CDPs) must pass the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination. CDPs must complete 1,000 to 2,500 hours of supervised experience, dependent upon the following, associate degree, baccalaureate degree, masters or doctoral degree, licensed as an advance registered nurse practitioner, marriage and family therapists, mental health counselors, advanced social workers, independent clinical social worker or licensed as a psychologist, that include clinical evaluation and face-to-face counseling.

Health Homes Services

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Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

Comprehensive transitional care shall be provided to prevent beneficiary avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing, substance use disorder treatment or residential habilitation setting) and to ensure proper and timely follow-up care.

The beneficiary's Health Action Plan shall include transitional care planning. Transitional care planning includes:

- 1.A notification system with managed care plans, hospitals, nursing homes and residential/rehabilitation facilities to provide the health home prompt communication of a beneficiary's admission and/or discharge from an emergency room, inpatient, nursing home or residential/rehabilitation and if proper permissions, a substance use disorder treatment setting. Progress notes or a case file will document the notification and the Health Action Plan should be updated with transition planning.
- 2.The use of a Health Home Care Coordinator as an active participant in all phases of care transition; including discharge planning visits during hospitalizations or nursing home stays post hospital/institutional stay home visits and telephone calls.
- 3.Beneficiary education that supports discharge care needs including medication management, encouragement and intervention to assure follow-up appointments and self-management of their chronic or acute conditions, including information on when to seek medical care and emergency care. Involvement of formal or informal caregivers shall be facilitated when requested by the beneficiary.
- 4.A systematic follow-up protocol to assure timely access to follow-up care post discharge and to identify and re-engage beneficiaries that do not receive post discharge care.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Emergency Department Information Exchange (EDIE) notification provides Medicaid claims data to ED physicians. EDIE is HIPAA compliant. EDIE can proactively alert care providers when high utilizing beneficiaries enter the ED through a variety of methods such as fax, phone, email, or integration with facility's current EMR. Once notified, care providers can use EDIE to access care guidelines and crucial information on the beneficiary from other participating facilities to better determine the beneficiary's actual medical situation.

Managed care organizations (MCOs) will notify Health Home Care Coordinators of beneficiary admission to hospital and tertiary care facilities to facilitate discharge planning and care transitions. MCOs will also inform the Health Home Care Coordinators of lapses in pharmacy refills for beneficiaries with chronic conditions requiring long-term use of medications. Health Home Care Coordinators are responsible for conducting outreach activities with the beneficiary to ensure medications have been picked up and are being used according to the clinical treatment plan.

Scope of service

The service can be provided by the following provider types

- ☒ Behavioral Health Professionals or Specialists

Description

- 1.Psychologists must have a doctoral degree from a regionally accredited institution, with at least 40 semester hours or sixty quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, supervised experience requirement of no fewer than two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).
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applicants are not required to have supervised postgraduate experience prior to becoming an associate.

- ☐ Nurse Practitioner
- ☒ Nurse Care Coordinators

Description

1. Licensed Practical Nurses (LPN) must successfully complete a commission approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice and pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington State before practicing.
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- ☒ Nurses

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- ☐ Medical Specialists
- ☐ Physicians
- ☒ Physician's Assistants

Description

Must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited extent under the supervision of a physician and who is academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services. Physician Assistants must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the National Commission of Certification

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Provider Type	Description
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Individual and Family Support (which includes authorized representatives)

Definition

The Health Home Care Coordinator shall recognize the unique role the beneficiary may give family, identified decision makers and caregivers in assisting the beneficiary to access and navigate the health care and social service delivery system as well as support health action planning.

Peer supports, support groups, and self-management programs will be used by the Health Home Care Coordinator to increase beneficiary and caregiver’s knowledge of the beneficiary’s chronic conditions, promote the beneficiary’s engagement and self-management capabilities and help the beneficiary improve adherence to their prescribed treatment.

The Health Home Care Coordinator and beneficiary shall:

- 1. Identify the role that families, informal supports and paid caregivers provide to achieve self-management and optimal levels of physical and cognitive function;
- 2. Educate and support self-management; self-help recovery and other resources necessary for the beneficiary, their family and their caregivers to support the beneficiary’s individualized health action goals;
- 3. Discuss advance directives with beneficiaries and their families; and
- 4. Communicate and share information with individuals and their families and other caregivers with appropriate consideration of language, activation level, literacy and cultural preferences.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

PRISM software applications include the PRISM Health Report for selected beneficiaries. The PRISM report is provided to the beneficiary’s primary care provider and any other health care provider identified by the beneficiary and supported by a signed release of information. This includes the Health Home Care Coordinator. The report includes:

- 1. Beneficiary demographics
- 2. Last dental appointment
- 3. Health conditions
- 4. Hospital stays
- 5. Emergency room visits
- 6. Office visits and procedures in the last 180 days, used by the Care Coordinator to assess sufficient clinical oversight of the client’s chronic conditions
- 7. Prescriptions filled in the last 90 days
- 8. Prescriptions by drug class in last two years

Coaching for Activation educational materials are available electronically and are printed for beneficiary and family support.

Scope of service

The service can be provided by the following provider types

- ☒ Behavioral Health Professionals or Specialists

Description

- 1. Psychologists must have a doctoral degree from a regionally accredited institution, with at least 40 semester hours or sixty quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, supervised experience requirement of no fewer than two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).
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Description

- 1. Licensed Practical Nurses (LPN) must successfully complete a commission approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice and pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington State before practicing.
- 2. Registered Nurses (RN) RNs must successfully complete a commission approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington State before practicing.
- 3. Advanced registered Nurse Practitioners (ARNP) must have formal graduate education and achieve a national specialty certification for the nurse practitioner, nurse anesthetist or nurse midwife role. ARNPs must hold a registered nurse license in Washington State before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.
- 4. Psychiatric advanced registered nurse practitioner" means a person who is licensed as an advanced registered nurse practitioner; and who is board certified in advanced practice psychiatric and mental health nursing.
- 5. Psychiatric nurses are registered nurses with a bachelor's degree from an accredited college or university, and have, 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.

- ☒ Nurses

Description

- 1. Licensed Practical Nurses (LPN) must successfully complete a commission approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice and pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington State before practicing.
- 2. Registered Nurses (RN) RNs must successfully complete a commission approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington State before practicing.
- 3. Advanced registered Nurse Practitioners (ARNP) must have formal graduate education and achieve a national specialty certification for the nurse practitioner, nurse anesthetist or nurse midwife role. ARNPs must hold a registered nurse license in Washington State before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.
- 4. Psychiatric advanced registered nurse practitioner" means a person who is licensed as an advanced registered nurse practitioner; and who is board certified in advanced practice psychiatric and mental health nursing.
- 5. Psychiatric nurses are registered nurses with a bachelor's degree from an accredited college or university, and have, 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.

- ☐ Medical Specialists
- ☐ Physicians
- ☒ Physician's Assistants

Description

Must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited extent under the supervision of a physician and who is academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services. Physician Assistants must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the National Commission of Certification

of Physician Assistants (NCCPA) examination. Physician assistants must have 4 clock hours of AID education and an active DEA registration.

- ☐ Pharmacists
- ☒ Social Workers

Description

All social workers listed below must pass either the American Association of State Social Work Board's advanced or clinical examination for licensure. The Associate social workers listed below are not required to have supervised postgraduate experience prior to becoming an associate.

1. Licensed Independent Social Worker must graduate with a MA or PhD social work and complete a minimum of 4,000 hours of supervised experience or which 1,000 hours must be direct client contact, over a three-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.
2. Licensed Advanced Social Worker must graduate with a MA or PhD social work program and complete 3,200 hours with supervision. At least 90 hours are direct supervision as specified by a licensed independent clinical social worker, a licensed advanced social worker, or an equally qualified licensed mental health professional. At least 40 hours must be in one-to-one supervision and 50 hours may be in one-to-one supervision or group supervision.
3. Licensed independent clinical social worker must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and successfully complete a supervised experience of at least 4,000 hours of experience, of which 1,000 hours must be direct client contact, over a 3-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.
4. Licensed social worker associate-independent clinical must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.
5. Licensed social worker associate-advanced must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
Chemical Dependency Professionals	Chemical Dependency Professionals (CDPs) must pass the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination. CDPs must complete 1,000 to 2,500 hours of supervised experience, dependent upon the following, associate degree, baccalaureate degree, masters or doctoral degree, licensed as an advance registered nurse practitioner, marriage and family therapists, mental health counselors, advanced social workers, independent clinical social worker or licensed as a psychologist, that include clinical evaluation and face-to-face counseling.

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | WA2015MH0001O | WA-15-011-X | MIGRATED_HH.WA HHS

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Referral to Community and Social Support Services

Definition

The Health Home Care Coordinator identifies available community based resources and actively manages referrals, assists the beneficiary in advocating for access to care, and engagement with community and social supports related to goal achievement documented in the Health Action Plan. When needed and not provided through other case management systems, the Health Home Care Coordinator provides assistance to obtain and maintain eligibility for health care services, disability benefits, housing, personal needs and legal services. These services are coordinated with appropriate departments of local, state and federal governments and community based organizations. Referral to community and social support services includes long-term services and supports, mental health, substance use disorder and other community and social services support providers needed to support the beneficiary in support of health action goals.

The Health Home Care Coordinator shall document referrals to and access by the beneficiary of community based and other social support services.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

PRISM and Insignia Health are information technology sources supporting the beneficiary and the Health Home Care Coordinator to identify the unmet needs, gaps in care, transitional support needs, clinical protocols required and current utilization of case management, medical and behavioral health services.

Scope of service

The service can be provided by the following provider types

☒ Behavioral Health Professionals or Specialists

Description

1. Psychologists must have a doctoral degree from a regionally accredited institution, with at least 40 semester hours or sixty quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, supervised experience requirement of no fewer than two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).

2. Child psychiatrists are licensed as physicians and surgeons, with graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board eligible or board certified in child psychiatry.

3. Licensed mental health counselors must graduate with a MA or PhD level educational program in mental health counseling or a related discipline and complete 36 months of supervised full-time counseling or 3000 hours of postgraduate mental health counseling under the supervision of a qualified licensed mental health counselor. Licensed mental health counselors must pass an examination administered by the National Board of Certified Counselors. Licensed mental health counselors are not required to have supervised postgraduate experience prior to becoming an associate.

4. Licensed marriage and family therapists must graduate with a master's degree or doctoral degree educational program in marriage and family therapy or a behavioral science MA or PhD with equivalent course work from an approved school. The licensed marriage and family therapists must complete a minimum of 2 years of supervised full-time marriage and family therapy. For full licensure, a licensed marriage and family therapists must take and pass the Association of Marital and Family Therapy Regulatory Boards examination. Licensed marriage and family therapist associate applicants are not required to have supervised postgraduate experience prior to becoming an associate.

☐ Nurse Practitioner

☒ Nurse Care Coordinators

Description

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☒ Nurses

☐ Medical Specialists

☐ Physicians

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☐ Pharmacists

☒ Social Workers

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Health Homes Services

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Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

Enrollment - based on chronic conditions and meeting the state's definition of "at risk for another" a clinical indicator (Y=qualifies) will be loaded into the WA MMIS. Beneficiaries with clinical indicators of "Y" will be enrolled into one of the qualified health home networks in the geographic region in which they reside. Outreach and education information will be generated by enrollment and sent from the State to the beneficiary by mail. The Health Home will receive the enrollment on a HIPAA compliant 837 and assign the beneficiary to one of their local Health Home Care Coordination Organizations (CCOs).

Beneficiaries may be referred to Health Homes by any health care provider. An example is a referral from a local emergency room department who has agreed with the Health Home to refer potentially eligible participants to the program.

Engagement - the assigned CCO places the beneficiaries with a Care Coordinator. The beneficiary is contacted and offered health home services. Once the beneficiary has agreed to participate in a Health Home, the CC prepopulates the Health Action Plan with PRISM claims utilization and arranges for an in-person visit. PRISM information includes episode information related to specific diagnoses or pharmacy utilization; inpatient and outpatient claims, emergency room visits and care, mental health claims, alcohol and other drug treatment claims, pharmacy claims and long-term care assessment data.

During the home visit, the CC:

- 1.Conducts a brief health screening including mental, physical and chemical dependency
- 2.Evaluates beneficiary's support system;
- 3.Completes a Consent for Release of Information;
- 4.Administers and scores the 13-question Patient Activation (PAM) or Caregiver Activation Measure (CAM; and
- 5.Introduces the Health Action Plan (HAP) to the beneficiary. Together, the CCO and beneficiary identify immediate and long-term goals, prioritize concerns and establish action steps.

Name	Date Created	
No items available		

Health Homes Monitoring, Quality Measurement and Evaluation

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Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates:

The State will calculate regional, risk adjusted, per member per month expenses in the target population in the baseline (FY2011), apply trend factors and estimate a projected per member per month figure. Cost savings will be calculated as the difference between actual and projected risk adjusted per member per month expenditures.

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

The State integrates fee-for-service claims data, managed care encounter data, eligibility, and enrollment data for medical, pharmacy, mental health, substance use disorder, long term services and supports, and Medicaid and dual eligible Medicare covered services in a secure web-based clinical decision support tool called PRISM. PRISM also pulls from other clinical assessment data within the state such as CARE. The State will use the PRISM tools to support the beneficiary and the Health Home Care Coordinator to identify the unmet needs, gaps in care, clinical protocols required and current utilization of case management, medical and behavioral health services. Use of these tools will enable the Health Home Care Coordinator to better coordinate care and ensure that the beneficiary's complex needs are met. Use of these tools will allow the State to monitor cost and utilization data to ensure program goals are met.

The State has developed HIT through OneHealthPort, an entity contracted with HCA to consult on building a statewide health information exchange. HCA has developed the Medicaid Health Profile clinical data repository, with clinical data passed through OneHealthPort HIE using the Continuity of Care Document (CCD) and the Admit/ Discharge/Transfer Document (ADT) transaction sets. Updates to the Medicaid Database to refine or to correct identified data collection errors occur whenever a need is identified.

Health Homes Monitoring, Quality Measurement and Evaluation

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Quality Measurement and Evaluation

- ☒ The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state.
- ☒ The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.
- ☒ The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.
- ☐ The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report.

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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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WA - Submission Package - WA2016MH0001O - (WA-16-0026) - Health Homes

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CMS-10434 OMB 0938-1188

Health Homes Intro

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Program Authority

1945 of the Social Security Act
The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

Washington State Health Home Program

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

Washington’s original Health Homes SPAs were WA 13-0008 (approved June 28, 2013) and WA 13-17 (approved December 11, 2013). SPA WA 15-0011 (approved June 11, 2015) superseded both of these SPAs; this SPA 16-0026 supersedes 15-0011.

Under Washington's approach, Health Homes are the bridge to integrate care within existing delivery systems for both managed care and Fee-for-Service beneficiaries. Washington's Medicaid delivery systems are undergoing a great deal of change as the Health Care Authority (HCA) integrates physical and behavioral health services through its managed care program. As HCA phases in statewide integration, Washington's Health Home program will become more managed care focused while continuing to serve beneficiaries who remain in the Fee-for-Service delivery system, such as full-dual eligibles and American Indian/Alaska Natives.

Washington has three high level goals to assess the effectiveness of its Health Home program: 1) Building care coordination capacity in all areas of the state; 2) Improve the beneficiary's self-management abilities; and 3) Reduce future cost trends or at the very least attain cost neutrality with improved outcomes.

The Health Home program is designed as the central point for directing person-centered care through one-on-one interactions between the Health Home Care Coordinators and their assigned beneficiaries. Beneficiaries are identified as having one or more of the chronic conditions on the chronic condition list and at risk for a 2nd chronic condition using a tool that identifies those clients expected to have high costs in the future due to all their chronic conditions .

The Department of Social and Health Services (DSHS) generates and submits a list of eligible Health Homes beneficiaries to HCA, who enrolls them into a Qualified Fee-for Service Health Home Lead Entity (designated provider) or notifies the Qualified Managed Care Health Home Lead Entity (designated provider) that one of their enrollees is eligible for Health Home services with a Health Home indicator on the 834 file. Lead Entities are permitted to provide Health Home services internally but must also subcontract with a wide-range of community-based Care Coordination Organizations (CCOs) to effectively manage the full breadth of beneficiary needs, increasing Washington’s capacity to provide statewide Health Home services, especially in rural areas of the state.

Lead Entities are qualified by HCA and DSHS through both a contracting process and a Request for Application (RFA) process. Contracting is used if a Lead Entity has already been qualified through the RFA process and wants to broaden their Health Home service areas to other counties, while the RFA process is used to solicit new Lead Entities when adding counties that are not part of the Health Home program.

Health home services are composed of the six required Health Home services, with each individual service further defined by embedded activities which make up the composition of the service.

General Assurances

- ☒ The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- ☒ The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- ☒ The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- ☒ The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.

- ☒ The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- ☒ The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Homes Geographic Limitations

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- ☐ Health Homes services will be available statewide
- ☐ Health Homes services will be limited to the following geographic areas
- ☒ Health Homes services will be provided in a geographic phased-in approach

Health Homes Geographic Limitations

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Phase 1

Title of phase	Implementation Date
Phase 1	7/1/2013
Phase-in will be done by the following geographic area	Specify which counties:
By county	1. Asotin 2. Benton 3. Clark 4. Columbia 5. Cowlitz 6. Franklin 7. Garfield 8. Kittitas 9. Klickitat 10. Pierce 11. Skamania 12. Wahkiakum 13. Walla Walla 14. Yakima

Health Homes services are now available state-wide

No

Enter any additional narrative necessary to fully describe this phase

Phase One: The first 14 counties were phased in beginning July 1, 2013 through two Requests for Application (RFA). HCA and DSHS qualified Lead Entities according to which counties they were proposing to serve, their Care Coordination Organization network, and their responses to RFA questions regarding their proposed processes to deliver Health Home services.

Name	Date Created	
No items available		

Health Homes Geographic Limitations

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Phase 2

Title of phase	Implementation Date
Phase 2	10/1/2013
Phase-in will be done by the following geographic area	Specify which counties:
By county	1. Adams
	2. Chelan
	3. Clallam
	4. Douglas
	5. Ferry
	6. Grant
	7. Grays Harbor
	8. Island
	9. Jefferson
	10. Kitsap
	11. Lewis
	12. Lincoln
	13. Mason
	14. Okanogan
	15. Pacific
	16. Pend Oreille
	17. San Juan
	18. Skagit
	19. Spokane
	20. Stevens
	21. Thurston
	22. Whatcom
	23. Whitman

Health Homes services are now available state-wide

No

Enter any additional narrative necessary to fully describe this phase

23 more counties were phased in beginning October 1, 2013 through an RFA. HCA and DSHS qualified Lead Entities according to which counties they were proposing to serve, their Care Coordination Organization network, and responses to RFA questions regarding their proposed processes to deliver Health Home services.

Name	Date Created	
No items available		

Health Homes Geographic Limitations

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Phase 3

Title of phase	Implementation Date
Phase 3	4/1/2017
Phase-in will be done by the following geographic area	Specify which counties:
By county	1. King 2. Snohomish
Health Homes services are now available state-wide	Effective date of state-wide service implementation
Yes	4/1/2017

Enter any additional narrative necessary to fully describe this phase

King and Snohomish counties will be added in 4/1/2017 to make the Health Home program statewide. A combination RFA and contracting process will be used to qualify Lead Entities to provide Health Home services in King and Snohomish counties. Organizations that did not become Qualified Lead Entities during Phase One or Two will be required to become qualified through the third RFA. Lead Entities qualified in Phase One and Phase Two will be allowed to add King and Snohomish counties to their existing Health Home coverage areas through the contracting process by submitting their Care Coordination networks for analysis.

Note: Two RFAs were completed for the addition of King and Snohomish Counties. The first RFA 1862 did not have enough responses to support the implementation of the Health Home program in King County. A second RFA was done (RFA 1992) in December 2016 to see if other organizations were interested in becoming Qualified Lead Entities for King. As of the submittal of this SPA, the results have not been finalized yet.

Name	Date Created	
No items available		

Health Homes Population and Enrollment Criteria

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Superseded SPA ID	N/A		

Categories of Individuals and Populations Provided Health Home Services

The state will make Health Home services available to the following categories of Medicaid participants

- ☒ Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
- ☐ Medically Needy Eligibility Groups

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | WA2016MH0001O | WA-16-0026 | Washington State Health Home Program

Package Header

Package ID	WA2016MH0001O	SPA ID	WA-16-0026
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Population Criteria

The state elects to offer Health Homes services to individuals with:

- ☐ Two or more chronic conditions
- ☒ One chronic condition and the risk of developing another

Specify the conditions included:

- ☒ Mental Health Condition
- ☒ Substance Use Disorder
- ☒ Asthma
- ☒ Diabetes
- ☒ Heart Disease
- ☐ BMI over 25
- ☒ Other (specify):

Name	Description
cancer	As defined by UC San Diego CDPS and Medicaid RX disease categories.
cerebrovascular disease	As defined by UC San Diego CDPS and Medicaid RX disease categories.
coronary artery disease	As defined by UC San Diego CDPS and Medicaid RX disease categories.
dementia or Alzheimer's disease	As defined by UC San Diego CDPS and Medicaid RX disease categories.
intellectual disability or disease	As defined by UC San Diego CDPS and Medicaid RX disease categories.
hematological and musculoskeletal conditions	As defined by UC San Diego CDPS and Medicaid RX disease categories.
HIV/AIDS	As defined by UC San Diego CDPS and Medicaid RX disease categories.
renal failure	As defined by UC San Diego CDPS and Medicaid RX disease categories.
chronic respiratory conditions	As defined by UC San Diego CDPS and Medicaid RX disease categories.
neurological disease	As defined by UC San Diego CDPS and Medicaid RX disease categories.
gastrointestinal	As defined by UC San Diego CDPS and Medicaid RX disease

Name	Description categories.

Specify the criteria for at risk of developing another chronic condition:

At-risk for a second condition is a minimum predictive risk score of 1.5, meaning a beneficiary's expected future medical expenditures is expected to be 50% greater than the base reference group (the Washington SSI-disabled population). The Washington risk score is based on the Chronic Illness & Disability Payment System (CDPS) and Medicaid-Rx risk groupers developed by Rick Kronick and Todd Gilmer at the University of California-San Diego, with risk weights normalized for the Washington Medicaid population. Diagnoses, prescriptions, age and gender indicated in a beneficiary's medical claims and eligibility history for the past 15 months (24 months for children) are produce a risk score, with chronic conditions checked across all categorically needy populations, and a clinical indicator (Y=qualifies, N=does not qualify) is loaded into Washington's Medicaid Management System (MMIS).

Potentially eligible beneficiaries with insufficient claims history may be referred to the program by contacting HCA. A tool has been developed to manually calculate risk. This tool is on the Health Home website and distributed to the Lead Entities. Once a provider has determined a potentially beneficiary is eligible by manually calculating their risk, that information is sent to HCA for further analysis. If the beneficiary is eligible, they will be enrolled into a Health Home.

☐ One serious and persistent mental health condition

Health Homes Population and Enrollment Criteria

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Package Header

Package ID	WA2016MH00010	SPA ID	WA-16-0026
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Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home:

- ☐ Opt-In to Health Homes provider
- ☒ Referral and assignment to Health Homes provider with opt-out
- ☐ Other (describe)

Describe the process used:

The state identifies Fee-for-Service beneficiaries who are eligible for the Health Home program based on their chronic condition and risk score, then enrolls them into a Qualified Fee-for-Service Lead Entity/Designated Provider. Enrollment is based on zip code, amount of available beneficiaries within each zip code, and capacity to provide Health Home services. The Lead Entity assigns Health Home beneficiaries to one of their network affiliated Care Coordination Organizations (CCO), who, in turn, assigns the beneficiary to a Care Coordinator. Beneficiaries have the ability to opt out of the assigned Health Home or change enrollment to another Health Home provider within the Health Home network. Eligible beneficiaries who opt out of participation and retain their 1.5 or higher risk score have the option of re-enrolling the Health Home program at any time by contacting HCA's customer service line.

Managed care beneficiaries are auto-enrolled into a Medicaid managed care organization (MCO). The state identifies MCO beneficiaries who are eligible for Health Homes based upon their chronic condition and risk score and sends the information to their MCO. MCOs that are qualified to be Lead Entities, assign their Health Home beneficiaries to one of their network-affiliated Care Coordination Organizations (CCOs), who, in turn, assign the beneficiary to a Care Coordinator. MCOs that are not qualified as a Lead Entity/designated provider must delegate Health Home services to a qualified Lead Entity and assign their eligible/identified beneficiaries to their delegated Lead Entity. The delegated Lead Entity, in turn, will assign the beneficiary to one of their network affiliated CCOs and a Care Coordinator. Beneficiaries have the ability to opt-out of the Health Home or change enrollment to another MCO or subcontracted Health Home CCO within the Health Home program.

Beneficiaries lose Health Home eligibility when their risk score has dropped below 1.0 for six continual months and have not been participating or engaged in the program during those six months. Beneficiaries who are participating and engaged do not lose eligibility if their risk scores drops below 1.0.

- ☒ The state provides assurance that it will clearly communicate the individual's right to opt out of the Health Home benefit or to change Health Home providers at any time and agrees to submit to CMS a copy of any letter or communication used to inform the individual of the Health Home benefit and their rights to choose or change Health Home providers or to elect not to receive the benefit.

Name	Date Created	
22-851 613	6/24/2016 12:49 PM EDT	
Final Beneficiary Letter Managed FFS - English	6/24/2016 12:50 PM EDT	

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | WA2016MH0001O | WA-16-0026 | Washington State Health Home Program

Package Header

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Types of Health Homes Providers

☒ Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

- ☐ Physicians
- ☒ Clinical Practices or Clinical Group Practices

Describe the Provider Qualifications and Standards

- HIPAA compliant data systems for enrollment, collecting and reporting encounters to HCA;
- Disburses payment to Care Coordination Organizations (CCOs) based upon claims;
- Experience operating broad-based regional provider networks;
- Contracts directly with the state as a Qualified Health Home;
- Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network;
- Subcontracts with community based CCOs to provide Health Home services;
- Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
 - Uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary; or
 - Optimizes beneficiary choice.
- Maintains a list of CCOs and their assigned Health Home population;
- Monitors CCOs to ensure fidelity to the Health Home model;
- Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols;
- Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management;
- Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator;
- Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA.
- Maintains an adequate network of Care Coordination Organizations.
- Employs Care Coordinators to supplement CCOs in areas where qualified Care Coordinators are hard to find.

☒ Rural Health Clinics

Describe the Provider Qualifications and Standards

- HIPAA compliant data systems for enrollment, collecting and reporting encounters to HCA;
- Disburses payment to Care Coordination Organizations (CCOs) based upon claims;
- Experience operating broad-based regional provider networks;
- Contracts directly with the state as a Qualified Health Home;
- Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network;
- Subcontracts with community based CCOs to provide Health Home services;
- Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
 - Uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary; or
 - Optimizes beneficiary choice.
- Maintains a list of CCOs and their assigned Health Home population;
- Monitors CCOs to ensure fidelity to the Health Home model;
- Maintains Memoranda of Agreement (MOA) with the organizations that

are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols;

11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management;
12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator;
13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA.
14. Maintains an adequate network of Care Coordination Organizations.

☒ Community Health Centers

Describe the Provider Qualifications and Standards

1. HIPAA compliant data systems for enrollment, collecting and reporting encounters to HCA;
2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims;
3. Experience operating broad-based regional provider networks;
4. Contracts directly with the state as a Qualified Health Home;
5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network;
6. Subcontracts with community based CCOs to provide Health Home services;
7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
 - a. Uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary; or
 - b. Optimizes beneficiary choice.
8. Maintains a list of CCOs and their assigned Health Home population;
9. Monitors CCOs to ensure fidelity to the Health Home model;
10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols;
11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management;
12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator;
13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA.
14. Maintains an adequate network of Care Coordination Organizations.

☒ Community Mental Health Centers

Describe the Provider Qualifications and Standards

1. HIPAA compliant data systems for enrollment, collecting and reporting encounters to HCA;
2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims;
3. Experience operating broad-based regional provider networks;
4. Contracts directly with the state as a Qualified Health Home;
5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network;
6. Subcontracts with community based CCOs to provide Health Home services;
7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
 - a. Uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary; or
 - b. Optimizes beneficiary choice.
8. Maintains a list of CCOs and their assigned Health Home population;
9. Monitors CCOs to ensure fidelity to the Health Home model;
10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols;
11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management;
12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator;
13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA.

14. Maintains an adequate network of Care Coordination Organizations.
15. Employs Care Coordinators to supplement CCOs in areas where qualified Care Coordinators are hard to find.

☐ Home Health Agencies

☒ Case Management Agencies

Describe the Provider Qualifications and Standards

1. HIPAA compliant data systems for enrollment, collecting and reporting encounters to HCA;
2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims;
3. Experience operating broad-based regional provider networks;
4. Contracts directly with the state as a Qualified Health Home;
5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network;
6. Subcontracts with community based CCOs to provide Health Home services;
7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
 - a. Uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary; or
 - b. Optimizes beneficiary choice.
8. Maintains a list of CCOs and their assigned Health Home population;
9. Monitors CCOs to ensure fidelity to the Health Home model;
10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols;
11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management;
12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator;
13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA.
14. Maintains an adequate network of Care Coordination Organizations.

☒ Community/Behavioral Health Agencies

Describe the Provider Qualifications and Standards

1. HIPAA compliant data systems for enrollment, collecting and reporting encounters to HCA;
2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims;
3. Experience operating broad-based regional provider networks;
4. Contracts directly with the state as a Qualified Health Home;
5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network;
6. Subcontracts with community based CCOs to provide Health Home services;
7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
 - a. Uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary; or
 - b. Optimizes beneficiary choice.
8. Maintains a list of CCOs and their assigned Health Home population;
9. Monitors CCOs to ensure fidelity to the Health Home model;
10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols;
11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management;
12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator;
13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA.
14. Maintains an adequate network of Care Coordination Organizations.

☒ Federally Qualified Health Centers (FQHC)

Describe the Provider Qualifications and Standards

1. HIPAA compliant data systems for enrollment, collecting and reporting encounters to HCA;
2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims;
3. Experience operating broad-based regional provider networks;
4. Contracts directly with the state as a Qualified Health Home;
5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network;
6. Subcontracts with community based CCOs to provide Health Home services;
7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
 - a. Uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary; or
 - b. Optimizes beneficiary choice.
8. Maintains a list of CCOs and their assigned Health Home population;
9. Monitors CCOs to ensure fidelity to the Health Home model;
10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols;
11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management;
12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator;
13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA.
14. Maintains an adequate network of Care Coordination Organizations.

☒ Other (Specify)

Provider Type	Description
Behavioral Health Organizations	1. HIPAA compliant data systems for enrollment, collecting and reporting encounters to HCA; 2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims; 3. Experience operating broad-based regional provider networks; 4. Contracts directly with the state as a Qualified Health Home; 5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network; 6. Subcontracts with community based CCOs to provide Health Home services; 7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process: a. Uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary; or b. Optimizes beneficiary choice. 8. Maintains a list of CCOs and their assigned Health Home population; 9. Monitors CCOs to ensure fidelity to the Health Home model; 10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed

Provider Type	Description
	with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols; 11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; 12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator; 13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA. 14. Maintains an adequate network of Care Coordination Organizations. 15. Employs Care Coordinators to supplement CCOs in areas where qualified Care Coordinators are hard to find.
Hospitals	1. HIPAA compliant data systems for enrollment, collecting and reporting encounters to HCA; 2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims; 3. Experience operating broad-based regional provider networks; 4. Contracts directly with the state as a Qualified Health Home; 5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network; 6. Subcontracts with community based CCOs to provide Health Home services; 7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process: a. Uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary; or b. Optimizes beneficiary choice. 8. Maintains a list of CCOs and their assigned Health Home population; 9. Monitors CCOs to ensure fidelity to the Health Home model; 10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols; 11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management;

Provider Type	Description
	12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator; 13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA. 14. Maintains an adequate network of Care Coordination Organizations. 15. Employs Care Coordinators to supplement CCOs in areas where qualified Care Coordinators are hard to find.
MCOs	1. HIPAA compliant data systems for enrollment, collecting and reporting encounters to HCA; 2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims; 3. Experience operating broad-based regional provider networks; 4. Contracts directly with the state as a Qualified Health Home; 5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network; 6. Subcontracts with community based CCOs to provide Health Home services; 7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process: a. Uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary; or b. Optimizes beneficiary choice. 8. Maintains a list of CCOs and their assigned Health Home population; 9. Monitors CCOs to ensure fidelity to the Health Home model; 10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols; 11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; 12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator; 13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA. 14. Maintains an adequate network of Care Coordination Organizations.

Provider Type	Description
	15. Employs Care Coordinators to supplement CCOs in areas where qualified Care Coordinators are hard to find.
Substance Use Disorder Treatment providers	1. HIPAA compliant data systems for enrollment, collecting and reporting encounters to HCA; 2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims; 3. Experience operating broad-based regional provider networks; 4. Contracts directly with the state as a Qualified Health Home; 5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network; 6. Subcontracts with community based CCOs to provide Health Home services; 7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process: a. Uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary; or b. Optimizes beneficiary choice. 8. Maintains a list of CCOs and their assigned Health Home population; 9. Monitors CCOs to ensure fidelity to the Health Home model; 10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols; 11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; 12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator; 13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA. 14. Maintains an adequate network of Care Coordination Organizations. 15. Employs Care Coordinators to supplement CCOs in areas where qualified Care Coordinators are hard to find.
Tribal Clinics	1. HIPAA compliant data systems for enrollment, collecting and reporting encounters to HCA; 2. Disburses payment to Care

Provider Type	Description
	Coordination Organizations (CCOs) based upon claims; 3. Experience operating broad-based regional provider networks; 4. Contracts directly with the state as a Qualified Health Home; 5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network; 6. Subcontracts with community based CCOs to provide Health Home services; 7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process: a. Uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary; or b. Optimizes beneficiary choice. 8. Maintains a list of CCOs and their assigned Health Home population; 9. Monitors CCOs to ensure fidelity to the Health Home model; 10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols; 11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; 12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator; 13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA. 14. Maintains an adequate network of Care Coordination Organizations. 15. Employs Care Coordinators to supplement CCOs in areas where qualified Care Coordinators are hard to find.

Health Homes Providers

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Package Header

Package ID	WA2016MH00010	SPA ID	WA-16-0026
Submission Type	Official	Initial Submission Date	12/20/2016
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☒ Teams of Health Care Professionals			

Indicate the composition of the Health Homes Teams of Health Care Professionals the state includes in its program. For each type of provider indicate the required qualifications and standards

- ☐ Physicians
- ☒ Nurse Practitioners

Describe the Provider Qualifications and Standards

- a. Licensed Practical Nurses (LPN) must successfully complete a commission-approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice, and must pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington before practicing.

b. Registered Nurses (RN) must successfully complete a commission approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington before practicing.

c. Advanced Registered Nurse Practitioners (ARNP) must have formal graduate education and obtain a national specialty certification as a nurse practitioner, nurse anesthetist or nurse midwife. ARNPs must hold a registered nurse license in Washington before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.

d. A psychiatric advanced registered nurse practitioner is a person who is licensed as an advanced registered nurse practitioner and is also board-certified in advanced practice psychiatric and mental health nursing.

e. Psychiatric nurses are registered nurses with a Bachelor's degree from an accredited college or university, and have, 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.
- ☒ Nurse Care Coordinators

Describe the Provider Qualifications and Standards

- a. Licensed Practical Nurses (LPN) must successfully complete a commission-approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice, and must pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington before practicing.

b. Registered Nurses (RN) must successfully complete a commission approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington before practicing.

c. Advanced Registered Nurse Practitioners (ARNP) must have formal graduate education and obtain a national specialty certification as a nurse practitioner, nurse anesthetist or nurse midwife. ARNPs must hold a registered nurse license in Washington before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.

d. A psychiatric advanced registered nurse practitioner is a person who is licensed as an advanced registered nurse practitioner and is also board-certified in advanced practice psychiatric and mental health nursing.

e. Psychiatric nurses are registered nurses with a Bachelor's degree from an

accredited college or university, and have, 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.

☐ Nutritionists

☒ Social Workers

Describe the Provider Qualifications and Standards

All social workers listed below must pass either the American Association of State Social Work Board's advanced or clinical examination for licensure. The Associate social workers listed below are not required to have supervised postgraduate experience prior to becoming an associate.

- a. Licensed Independent Social Worker must graduate with a MA or PhD social work and complete a minimum of 4000 hours of supervised experience or which 1000 hours must be direct client contact, over a three-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.
- b. Licensed Advanced Social Worker must graduate with a MA or PhD social work program and complete 3200 hours with supervision. At least 90 hours are direct supervision as specified by a licensed independent clinical social worker, a licensed advanced social worker, or an equally qualified licensed mental health professional. At least 40 hours must be in one-to-one supervision and 50 hours may be in one-to-one supervision or group supervision.
- c. Licensed independent clinical social worker must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and successfully complete a supervised experience of at least 4000 hours of experience, of which 1000 hours must be direct client contact, over a 3-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.
- d. Licensed social worker associate-independent clinical must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.
- e. Licensed social worker associate-advanced must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

☒ Behavioral Health Professionals

Describe the Provider Qualifications and Standards

- a. Psychologists must have a doctoral degree from a regionally-accredited institution, with at least 40 semester hours or 60 quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, and supervised experience consisting at least two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).
- b. Child psychiatrists must be licensed as physicians and surgeons, with graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board-eligible or board-certified in child psychiatry.
- c. Licensed mental health counselors must graduate with a MA or PhD level educational program in mental health counseling or a related discipline, and complete 36 months of supervised full-time counseling or 3000 hours of postgraduate mental health counseling under the supervision of a qualified licensed mental health counselor. Licensed mental health counselors must pass an examination administered by the National Board of Certified Counselors. Licensed mental health counselors are not required to have supervised postgraduate experience prior to becoming an associate.
- d. Licensed marriage and family therapists must have either an MA or PhD in marriage and family therapy or an MA or PhD in behavioral science with equivalent course work from an approved school. Licensed marriage and family therapists must complete a minimum of 2 years of supervised full-time marriage and family therapy. For full licensure, a licensed marriage and family therapists must take and pass the Association of Marital and Family Therapy Regulatory Boards examination. Licensed marriage and family therapist associate applicants are not required to have supervised postgraduate experience prior to becoming an associate.

☒ Other (Specify)

Provider Type	Description
Allied or Affiliated staff	Community health workers, peer counselors, wellness coaches or

Provider Type	Description
	other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator.
Physician Assistants	Physician Assistants (PA) must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited extent under the supervision of a physician. They must be academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services. PAs must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the National Commission of Certification of Physician Assistants (NCCPA) examination. Physician assistants must have 4 clock hours of AID education and an active DEA registration.
Chemical Dependency Professionals	Chemical Dependency Professionals (CDPs) must pass the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination. CDPs must complete 1,000 to 2,500 hours of supervised experience, dependent upon the following, associate degree, baccalaureate degree, masters or doctoral degree, licensed as an advance registered nurse practitioner, marriage and family therapists, mental health counselors, advanced social workers, independent clinical social worker or licensed as a psychologist, that include clinical evaluation and face-to-face counseling.

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | WA2016MH0001O | WA-16-0026 | Washington State Health Home Program

Package Header

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☐ Health Teams

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | WA2016MH00010 | WA-16-0026 | Washington State Health Home Program

Package Header

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Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

The delivery of Washington's Health Home service model is based on an multidisciplinary array of medical care, behavioral health care, and community-based social services and supports for children and adults who meet Washington's defined chronic conditions and risk criteria. The integration of primary care, behavioral health services, and long-term care services and supports are critical when improving health outcomes and reducing costs.

Qualifying the Health Home Lead Entities/Designated Providers ensures managed care organizations (MCOs), hospitals, Federally Qualified Health Centers (FQHC), Behavioral Health Organizations, Area Agencies on Aging, Community Mental Health Agencies, Substance Use Disorder Treatment Providers, Specialty Care and Primary Care Providers, and Tribal Clinics who may apply have the necessary skills and infrastructure to provide Health Home services.

Qualified Lead Entities, through their respective networks, provide intensive Health Home care coordination services to Medicaid and Medicare/Medicare beneficiaries with chronic conditions to ensure that services delivered are integrated and coordinated across medical, mental health, substance use disorder and long-term care services and supports. Beneficiaries who are eligible for Health Homes may receive direct services from both HCA and DSHS, but the Health Home contracts are based in HCA.

Additionally, multidisciplinary and affiliated staff are recruited to support engagement and outreach, clinical decisions and evidenced-based care. Multidisciplinary team members may be composed of willing participants who provide direct service to the beneficiary and subject matter experts, such as primary care providers, mental health professionals, chemical dependency treatment providers, social workers, nutritionists/dieticians, direct care workers, pharmacists, peer specialists, community health navigators, family members or housing representatives.

The Health Home structure is built on the following hierarchy:

1. Designated Provider/Qualified Health Home Lead Entities – Healthcare systems, providers and authorizing entities with experience developing community based service provider network relationships, such as managed care organizations (MCOs), hospitals, Federally Qualified Health Centers (FQHCs), Behavioral Health Organizations, Area Agencies on Aging (AAAs), Community Mental Health Agencies, Substance Use Disorder Treatment providers, Specialty Care, Primary Care Providers and tribal clinics. The Lead Entities contract directly with the state and are responsible for service delivery model and administration of the Health Home. Lead Entities assign Health Home eligible beneficiaries into Care Coordination Organizations (CCOs), collect and submit encounters; disburse payment to network affiliated CCOs through the collection and submission of encounters, monitor quality, sub-contract, collect, analyze and report financial, and health status to objectively determine progress towards meeting overall Health Home goals. Some Lead Entities also verify address and phone information, and engage participants through telephonic contact to determine willingness to participate. Some Lead Entities may also serve as internal CCOs as a means of reaching rural areas of the state that may not have enough non-Lead CCOs to support capacity.
2. Network Affiliated Care Coordination Organizations (CCO) – Accountable for Care Coordination staffing and oversight of direct delivery of the six Health Home services. CCOs are responsible for implementing systematic processes and protocols to assure service delivery and beneficiary access to Care Coordinators and affiliated staff. CCOs may be managed care organizations, hospitals, Federally Qualified Health Centers (FQHC), Behavioral Health Organizations, Area Agencies on Aging, Community Mental Health Agencies, Substance Use Disorder Treatment providers, Home Health, Specialty providers, such as AIDS or ESRD clinics, Specialty and Primary Care Providers, and Tribal Clinics.
3. Care Coordinators – Operate under the direction of the Care Coordination Organizations by directly interacting with participating beneficiaries. Care Coordinators provide the six defined Health Home care coordination benefits in-person by actively engaging the beneficiary in developing a Health Action Plan (HAP); reinforcing the HAP and supporting the beneficiary to attain short and long-term goals; coordinating with authorizing and prescribing entities as necessary to reinforce and support the beneficiary's health action goals; advocating, educating and supporting the beneficiary to attain and improve self-management skills; ensuring the receipt of evidence-based care; supporting beneficiaries and families during discharge from hospital and institutional settings, including providing evidence-based transition planning; and accompanying the beneficiary to critical appointments when necessary. To better support beneficiary goals and ensure quality of care, they coordinate services with authorizing entities for which the beneficiary is receiving services assistance. A Health Home Care Coordinator must provide service in the community in which the beneficiary resides so services can be provided in-person whenever needed, unless the beneficiary requests to receive their services elsewhere. Health Home Care Coordinators serve eligible beneficiaries in the setting of their choice and may not establish policies that would restrict service because a beneficiary moves from one eligible setting to another.
4. Affiliated health care staff, such as community health workers, peer counselors or other non-clinical personnel provides administrative support for the Health Home Care Coordinator, such as mailing health promotion material, arranging for beneficiary transportation to appointments, and calling the beneficiary to facilitate face-to-face Health Home visits with the Care Coordinator. Some affiliated staff may provide more direct care coordination functions under the supervision of a Care Coordinator.
5. Additional network providers who have agreed to participate in the Health Home model through the use of memorandums of agreement, subcontracts, or operational agreements. For example, a clinic may agree to provide referrals to a Lead Entity, through the use of an operational agreement.

Supports for Health Homes Providers

Describe the methods by which the state will support providers of Health Homes services in addressing the following components

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders

4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

Description

The foundation of the Health Home program is the community-based Care Coordination Organization (CCO) network, subcontracted to Lead Entities. CCOs are a wide variety of medical, behavioral health and social service providers who provide Health Home services through contracted Care Coordinators. Because many Health Home beneficiaries have existing relationships with one or more providers, broad-based CCO networks enable a smart assignment process. For example, the clinic where the beneficiary has their primary care provider may be their CCO, or an Area Agency on Aging who supports the beneficiary with their long-term services and supports may be their CCO.

Each activity defined under the six Health Home services is built into Lead Entity contracts, ensuring that coordination of services, access to services, and person-centered care is delivered to the Health Home beneficiary. For example, the beneficiary is involved in improving their health through the development of their Health Action Plan (HAP). HAPs are shared with the beneficiary during development and when they are updated on a four month cycle. Beneficiaries may include their families and caregivers as part of their support team and may authorize the release of the HAP to their family members, caregivers and providers. The HAP is both an electronic form and a paper form.

HCA and DSHS jointly sponsor training for Health Home service. Nursing staff developed core curriculum materials to support the provision of timely, comprehensive, high-quality services with a whole-person focus. DSHS offers technical assistance training for core skills relevant topics. Webinars, community network meetings and/or collaborative learning efforts continue to foster shared learning, information sharing and problem solving.

The state provides access to PRISM, a secure web-based clinical support tool showing the beneficiary's medical risk factors, demographics, eligibility, managed care status, housing, utilization of Medicaid and Medicare health services (including inpatient services, outpatient services, emergency department visits, filled prescriptions, mental health services, long term care services and supports, filled lab orders, and dental services), provider contact information, and long term care case manager assessments. This resource complements existing clinic-specific Electronic Health Records and provides the foundation for a continuous quality improvement program.

Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes providers are as follows

Qualified Health Home Lead Entities and their networks are developed to meet the needs of the populations they serve. Care coordination is necessary across numerous service domains and therefore may include many different disciplines. The state qualifies each Lead Entity, who is responsible for the integration and coordination of primary, acute, behavioral health (mental health and substance use disorder) and long-term services and supports for persons with chronic illness across the lifespan, through contractual/operational arrangements with appropriate providers. A Care Coordinator is the central point of contact working with the managed care or Fee-for-Service beneficiary to direct person-centered health action planning and implementation, and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable Emergency Department visits; providing timely post discharge follow-up, and improving beneficiary outcomes by addressing health care needs.

Washington qualifies the designated providers as Lead Entities through both a Request for Application (RFA) process and a contracting process. For the first two phases of implementation, Washington issued an RFA and qualified eight Lead Entities to provide Health Home services through their network of Care Coordination Organizations. For the last implementation phase of the program, HCA will issue an RFA for any new organizations who wish to be Qualified Lead Entities in Coverage Area 2, which consists of Snohomish county with Island, San Juan, Skagit, and Whatcom counties and Coverage Area 3, which consists of King county. Previously Qualified Health Home Lead Entities may contract for Health Home services in Coverage Area 2 and 3 without responding to an RFA if they demonstrate network adequacy.

The following are minimum requirements to become a Qualified Health Home Lead Entity:

1. Applicant is a Medicaid provider in good standing, has the ability to serve at least 300 Health Home beneficiaries, has experience operating broad-based networks, agrees to serve the entire coverage area, assures a referral system is in place, documents beneficiary consent, subcontracts with CCOs, has the ability to coordinate care and services after critical events, such as emergency department use and hospital inpatient admission and discharge, language access and interpretation capabilities, can provide links to acute and outpatient medical, mental health and substance abuse services, and community-based social services;
2. Provider networks must include a wide-variety of CCOs, such as Community Mental Health Agencies (CMHAs), Substance Use Disorder treatment providers, long-term services and support providers, FQHCs, and Community Health Centers;
3. Organizational infrastructure – ability to provide administrative functions, customer service staff, policies on process and timelines for bringing in additional CCOs to preserve integrity of face-to-face Health Home care coordination activities, ability to track Health Home beneficiaries to CCO assignment, collecting and submitting claims and encounters, payment disbursement, taking into account movement between payment levels and/or movement between CCOs, quality monitoring, subcontracting, collecting, analyzing and reporting financial, and health status. Ability to ensure hospitals have procedures in place for referring Health Home-eligible beneficiaries for enrollment if they are seeking or need treatment in a hospital emergency room;
4. Core Health Home requirements must be met, showing the ability to provide six Health Home care coordination functions and a guarantee of non-duplication of efforts, engagement and outreach, health action planning, self-management of chronic conditions, setting short and long-term goals, cultural competency, motivational interviewing, identification of services and gaps in services, evidence-based interventions, information-sharing with beneficiary's treating/authorizing entities, establishment of multidisciplinary teams, accompanying beneficiary to visits when requested, arranging for priority appointments, notification systems for transitional care, follow-up on medication upon discharge and follow-up with pharmacy to get scripts filled, help the beneficiary access follow-up care, referrals, optimizing social supports and family, use of health information technology.

Before contracts are awarded through the RFA process, HCA and DSHS conducts desk audits and on-site readiness reviews to ascertain readiness to provide Health Home services. Contracts will be offered only after the readiness reviews and after any identified deficiencies are mitigated through a corrective action plan. Before contracts are awarded to previously Qualified Lead Entities, HCA and DSHS will determine if their networks are adequate to provide Health Home services.

The period of performance for a Fee-for-Service Health Home contract is an initial two years. For managed care organizations who apply to become Lead Entities, the period of performance will be based upon their managed care contract. The program will be audited during annual contract compliance audits. Based upon results of the audit, the designated provider may be put on corrective action or have their qualification status terminated.

As the Health Home program matures, HCA may allow other entities interested in applying to become a Qualified Health Home Lead Entity to submit a request to HCA, at which point the process for contracting will take effect.

Name	Date Created	
No items available		

Health Homes Service Delivery Systems

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Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

- ☒ Fee for Service
- ☐ PCCM
- ☒ Risk Based Managed Care

The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals

- ☒ Yes
- ☐ No

Provide a summary of the contract language that you will impose on the Health Plans in order to deliver the Health Homes services

Managed care contracts contain language to support the Health Home benefit for eligible beneficiaries. An MCO has two paths to choose from when providing those benefits. They may either become a qualified Health Home Lead Entity through the Request for Application process or they may provide their Health Home benefits through a delegation agreement with another qualified Health Home Lead Entity.

Contract language will contain:

1. Standards for the six Health Home services - Comprehensive Care Management, Care Coordination and Health Promotion, Transitional Care, Individual and Family Support, Referrals to the Community and Use of Health Information Technology;
2. The use of clinical and non-clinical Care Coordinators and allied staff;
3. Contracts, memorandums of agreement or operational agreements with hospitals for emergency department and hospitalization notification, including a referral process to refer beneficiaries to HCA for Health Home enrollment;
4. Data security requirements;
5. Standardized screening and assessments;
6. Development of a Health Action Plan (HAP) through an in-person visit to promote self-management through the identification of the beneficiary's short and long-term goals;
7. Encounter data reporting and documentation of delivered services to support encounters;
8. The use of multidisciplinary care teams, that include the Care Coordinator, the beneficiary, and any other identified providers;
9. Training requirements;
10. Program Integrity;
11. Grievances and Appeals processes;
12. Access to the PRISM clinical decision support tool;
13. If the Health Home beneficiary is a Medicaid managed care enrollee, the MCO will share critical data with the Health Home Care Coordination Organization. Data may include institutional admissions and discharge readiness for transitional health care services management and facilitation, lapses in pharmaceutical payments that may indicate need for beneficiary outreach and education regarding medication use, lapses in pharmaceutical payments; and emergency department use that may suggest a need for a Care Coordinator visit or intervention to address the clinical and Health Action Plan goals.

- ☒ The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.

Name	Date Created	
No items available		

The State intends to include the Health Home payments in the Health Plan capitation rate

- ☒ Yes
- ☐ No

- Assurances
- ☒

The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:

Any program changes based on the inclusion of Health Homes services in the health plan benefits

Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)

Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)

Any risk adjustments made by plan that may be different than overall risk adjustments

How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM

☒

The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services

☒

The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found
- ☐ Other Service Delivery System
- https://macpro.cms.gov/suite/tempo/records/item/wx3_lI4_l3tU-K3fpHgVHrSVAH5jl6UbV6fRlxfCAeo4fdnEQ9w_Gd7WfNxy_BKkgh1U11kTq0P6V8...

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Health Homes Payment Methodologies

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Payment Methodology

The State's Health Homes payment methodology will contain the following features

☒ Fee for Service

☐ Individual Rates Per Service

☒ Per Member, Per Month Rates

☒ Fee for Service Rates based on

☐ Severity of each individual's chronic conditions

☐ Capabilities of the team of health care professionals, designated provider, or health team

☒ Other

Describe below

Completing the Health Action Plan and beginning work on individuals goals; One-on-one, face-to-face home visits, high touch interactions; and Low-level interactions to maintain progress.

☐ Comprehensive Methodology Included in the Plan

☐ Incentive Payment Reimbursement

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

Rates were built for three levels of payment using a clinical and non-clinical staffing model combined with monthly service intensity. Health home services are provided by Registered Nurses and Social Workers, with some lower-level services provided by allied or affiliated staff.

Only one encounter per beneficiary is accepted per month regardless of how many services are provided to that beneficiary during the month.

Three levels of payment are dependent upon the intensity of the service, determined by one-on-one, high touch interactions. This first care coordination stage encompasses three primary responsibilities, in addition to the health home service: health screening and assessments, development of a health action plan for care management, and assess the beneficiary for self-management and promote self-management skills to improve functional or health status or prevent or slow declines in functioning. The encounter for the first care coordination stage is paid only once per lifetime of the benefit.

The second level is for Intensive Health Home Care Coordination. It is assumed that for each full -time employee (FTE), 50 beneficiaries can be supported. This rate is paid once per month, per beneficiary and is triggered by submittal of an encounter. An encounter is represented by documenting delivery of a health home service. This rate is used extensively for most of the care coordination services.

The third level of payment is for Low-Level Health Home Care Coordination. This rate is paid once per month, per beneficiary and is triggered by submittal of an encounter. Low-level payment is made only for months in which an encounter occurred. An encounter is represented by documenting delivery of a health home service. It is assumed that for months in which an encounter occurs, 2/3 of the encounters will involve a phone call and 1/3 will involves a home visit.

☐ PCCM (description included in Service Delivery section)

☒ Risk Based Managed Care (description included in Service Delivery section)

☐ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

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Agency Rates

Describe the rates used

- ☐ FFS Rates included in plan
- ☐ Comprehensive methodology included in plan
- ☒ The agency rates are set as of the following date and are effective for services provided on or after that date

Effective Date

4/1/2017

Website where rates are displayed

<http://www.hca.wa.gov/billers-providers/programs-and-services/resources-0#contracts-and-rate-information>

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Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates;
2. Please identify the reimbursable unit(s) of service;
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit;
4. Please describe the state's standards and process required for service documentation, and;
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including:
 - the frequency with which the state will review the rates, and
 - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description When the Health Home program was implemented in 2013, there was no cost data available for the program, except data from the Intensive Chronic Care Management (ICCM) model, which preceded the Health Home program. The ICCM population was aged, blind and disabled Medicaid-only beneficiaries, age 21 and older who were currently receiving home and community based long-term services and supports (LTSS) and Fee-for-Service medical benefits. Beneficiaries receiving LTSS were not enrolled in managed care. Care Coordination was provided by five mostly rural Area Agencies on Aging vendors. The purpose of the program was to provide locally based chronic care management to eligible Medicaid clients through care coordination activities provided by nurse care managers. The program was voluntary and incorporated outreach, care management, education, and assistance to enrollees in managing their disease, along with coordination of medical, mental health, substance use disorder and other community services based on the needs of the individual enrollee.

ICCM premiums, developed by Mercer, covered staffing and resources to provide care coordination services that were similar to the Health Home services. Mercer developed caseload assumptions which considered historical program experience as well as input from Mercer clinicians experienced with CCM programs. The state provided fully loaded annual compensation levels for care management staff which represented actual costs for the program. The number of Full Time Employees (FTEs) and the total annual compensation levels were combined to produce an average PMPM costs. Mercer added management and overhead costs for an administrative load, which was calculated to be 18% of fully-loaded employee salaries based on the program's operational expenditures.

Mercer gave the state an ICCM premium rate range from the lower bound of \$172.55, best estimate of \$181.63, and upper bound of \$190.71.

Because the two chronic care management programs were similar and there was no experience data for Health Homes benefits, the state asked Milliman to develop FFS rates for the Health Home program (for Fee-for-Service enrollees), using the Mercer analysis as their baseline. Salary data was used to develop average salaries, adjusted to be consistent with those reported in the Seattle/Bellevue/Everett region which was one of the highest salary regions in the state and included supervisors at nurse salary levels, plus \$10,000 because of their additional responsibilities.

The assumed average distribution of staff time to provide Health Home services varies by stage of care coordination and on an average staffing distribution of time by care coordinators. For intensive level of services, Milliman assumed most benefits are provided by Registered Nurses at 50%, Case Managers at 38%, Case Aides at 10% and supervision at 2%. Baseline salaries were loaded by 42% to account for other costs such as 24% for employee benefits, 15% for other staff expenses and 3% for administration.

Other cost assumptions include salary distribution, geographic distribution, and high-touch vs. low-touch intensity of services. Care Coordinators must provide at least one Health Home service to claim reimbursement, with the expectation that high touch means in-person, face-to-face care coordination and low-touch means a combination of face-to-face or telephonic contact.

Washington State has three payment tiers that define the level of care coordination services provided: The Tier Level of the beneficiary is intended to reflect the overall level of:

1. Engagement and activation level of the beneficiary and/or their caregivers;
2. Activity in the Health Action Plan;
3. Provision of at least one of the qualified Health Home services; and
4. Frequency of contacts (face-to-face visits, phone calls, referrals, or care coordination).

All three tiers have a mix of clinical and non-clinical staffing elements.

Tier One is for initial engagement and health action planning. The reimbursable unit is \$252.93. This is a one-time payment to initiate participation in the Health Home, conduct a face-to-face home visit and complete the Health Action Plan.

Tier One includes:

- Contacting the beneficiary to introduce Health Home benefits, gain their approval to participate and schedule initial

Care Coordinator face-to-face visit;

- Conducting a comprehensive health assessment/reassessment inclusive of medical/behavioral /rehabilitative and long term care and social service needs; and
- Completing Health Action Plan (HAP), with a face-to-face visit with the beneficiary to identify the beneficiary's short and long-term goals and action steps. Development of the HAP may include family members, caregivers, and other social supports as appropriate.

Tier Two is for on-going, face-to-face and telephonic visits with the beneficiary to provide one or more of the six Health Home services. The reimbursement unit is \$172.61. Tier Two is paid once per month, per beneficiary. The minimum level of reimbursement is at least one face-to-face contact with the beneficiary during the month.

Tier Three is low-level care coordination for beneficiaries who either do not want frequent contact or face-to-face visits or have achieved a level self-management for their chronic conditions and no longer need high-level or intensive care coordination. The reimbursement unit is \$67.50 for the third tier. Tier 3 will be paid on a monthly basis and payment is made only for months in which an encounter occurred. An encounter is represented as either a phone call or home visit. Phone calls are assumed to last an average of 45 minutes. Home visits are assumed to take 2 hours and 15 minutes. For months in which an encounter occurs, 2/3 of the encounters will involve a phone call and 1/3 will involve a home visit.

Washington requires all Health Home Lead Entities to submit completed Health Action Plans (HAP) into a HAP database. The HAPs are reviewed against the Tier One encounters to ensure that a payment has been made for a completed HAP. HAPs are updated every four and eight months, or more frequently if there has been a change in circumstances, such as a hospital or Emergency Department visit. HAPs are updated when short and long-term goals have been finalized and new goals are set by the beneficiary.

Washington requires all Lead Entities to require documentation of the Health Home services provided by care coordinators in their contracts with Care Coordination Organizations. Case records and notes are audited annually during on-site contract compliance audits. Quarterly Quality reports are submitted to HCA by all the leads and must contain:

- Summary and overview of Health Home services:
 - o Activities;
 - o Strengths and best practices; and
 - o Barriers encountered during the reporting period.
- Updated list of the Contractor's Care Coordination network of providers;
- De-identified individual Health Home beneficiary success stories;

The 2013 FFS rates originally included a withhold portion for Tier Two and Three. HCA staff reviewed the FFS rates in late 2014 and determined the administrative portion of the rate payment was not enough to support infrastructure costs for Fee-for-Service Health Homes. The withhold portion of the rates was discontinued on January 1, 2015. The current FFS rates without the withholds are effective for services on or after January 1, 2015.

Reviewing and rebasing the rates for Health Home services was initially planned to happen every two years, but was curtailed due to legislative direction in April 2015 to discontinue the program by January 1, 2016 due to lack of funding. In November 2015, Washington was informed by CMS that it would receive Medicare shared savings attributable to the Duals Demonstration/Health Home program and that information prompted a renewed interest in keeping the program alive. Milliman was asked to review the current Health Home rate structure in May, 2016 in order to update them for January 1, 2017 and in August 2016, the draft rates were released to HCA and DSHS, with a caveat from Milliman that the data was not uniformly collected by the leads and their CCOs.

Reviewing and rebasing the rates for future updates will happen every three years or more frequently if cost trends warrant more frequent adjustments. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

Health Homes Payment Methodologies

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Package Header

Package ID	WA2016MH00010	SPA ID	WA-16-0026
Submission Type	Official	Initial Submission Date	12/20/2016
Approval Date	03/30/2017	Effective Date	4/1/2017
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Assurances

- ☒ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.
- Describe below how non-duplication of payment will be achieved**

Case management provided under the state’s 1915(c) waivers are non-duplicative of Health Home services. The functions provided by 1915(c) case managers include determination of waiver eligibility, comprehensive assessment to determine unmet needs related to waiver services, service planning of services provided under the waiver, qualification of waiver providers, authorization of waiver services, and monitoring of service provision. This type of specialized case management for both individuals receiving long term services and supports and individuals receiving developmental disabilities services will continue to be necessary for individuals served under waivers, and the Health Home program will not duplicate the functions provided by state and Area Agency on Aging (AAA) staff who perform these functions.

Health Homes will be responsible for review of claims and social service use history, health screening (e.g., screening for common mental health conditions associated with chronic illness such as depression, patient activation assessments), examination of current clinical conditions and treatment, and PRISM information. This assessment is used to identify care gaps, utilization patterns, where chronic care condition education and coaching may be most helpful and to assist the beneficiary in development and implementation of their Health Action Plan, including identification of self-care goals.

The Health Home will also be responsible for transitions, assessing beneficiaries at higher risk for re-institutionalization, assisting the beneficiary and their support network in gaining an understanding of discharge instructions and information, ensuring appropriate follow-up primary and specialty care and that medication reconciliation occurs, and assisting with referrals for additional services the beneficiary may need.

For Tribal PCCMs, the state will not allow an eligible Health Home enrollee to be enrolled in a Tribal PCCM and a Tribal Health Home at the same time. A Tribal member, if enrolled in a PCCM, must choose which method they wish to use for case management. If they decide to become enrolled in a Tribal Health Home, they must disenroll themselves from their Tribal PCCM.

Health Home enrollment is managed by the State and the ProviderOne enrollment and payment system which does not allow a tribal member to be enrolled in a Health Home and a PCCM at the same time.
- ☒ The State meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), 1902(a)(30)(A), and 1903 with respect to non-payment for provider-preventable conditions.
- ☒ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.
- ☒ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | WA2016MH0001O | WA-16-0026 | Washington State Health Home Program

Package Header

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Service Definitions

Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

Comprehensive Care Management

Definition

Care Coordinators deliver comprehensive care management, primarily in-person with periodic follow-up. Care management services include screening to assess gaps in care or establish baseline results, in-person visits to the beneficiary's home or location of their choice, and accompanying beneficiaries to health care provider appointments, as needed. Care Coordinators assess beneficiary readiness for self-management and promote self-management skills so the beneficiary is better able to engage with health and service providers and support the achievement of self-directed, individualized health goals to attain recovery, improve functional or health status or prevent or slow declines in functioning. Comprehensive care management service delivery uses the Health Action Plan (HAP) to document a beneficiary directed care management plan. The HAP is created during a face-to-face initial visit with the beneficiary, and is updated periodically on a four month cycle, as well as when there are changes in beneficiary circumstances such as hospitalization or emergency department visits. The results of screenings and assessments are documented in the HAP and used to identify gaps in care and chart the beneficiary's progress towards meeting their short and long-term goals through active Health Home participation.

State approved clinical and functional screens identify depression, alcohol or substance use disorder, functional impairment, and pain appropriate to the age and risk profile of the individual. Screens support referrals to services when needed, e.g., referral for assessment of need for substance use disorder treatment, specialty care or long term services and supports. Other assessments that may supplement comprehensive care management are mental health treatment plans, substance use disorder treatment plans, and/or other pre-existing care plans, including assessment results.

Care Coordinators may conduct client outreach and engagement activities to assess on-going emerging needs and to promote continuity of care and improved health outcomes. This may also be done by allied or affiliated staff under the direction of the Care Coordinator.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All Health Home Lead Entities will have access to the Medicaid Management Information System called ProviderOne (P1) and the DSHS Predictive Risk Intelligence System (PRISM). Authorizers and providers of long-term services and supports have access to DSHS's Comprehensive Assessment and Reporting Evaluation (CARE) data either electronically or in paper form. Most elements of CARE are also contained in PRISM. Data sharing agreements and Release of Information consent forms will be maintained by all Health Home Lead Entities to facilitate sharing electronic health information with their Health Home network affiliates.

1. DSHS is responsible for maintenance and updates to PRISM and reporting loss of eligibility on a monthly basis.
2. ProviderOne contains Medicaid eligibility, loss of eligibility, MCO and Health Home enrollment, disenrollment, claims, per member per month (PMPM) payment to MCOs, FFS payment for Health Home services for FFS Lead Entities, and the collection and reporting of encounter data.
3. Emergency Department Information Exchange (EDIE) notification provides Medicaid claims data to ED physicians. EDIE is HIPAA compliant and can proactively alert care providers when high utilizing patients enter the ED through a variety of methods such as fax, phone, email, or integration with a facility's current EMR. Once notified, care providers can use EDIE to access care guidelines and crucial information on the patient from other participating facilities to better determine the patient's actual medical situation.
4. PreManage is information exchange system that alerts providers when their beneficiary is accessing inpatient hospital services.

Scope of service

The service can be provided by the following provider types

- ☒ Behavioral Health Professionals or Specialists

Description

- a. Psychologists must have a doctoral degree from a regionally-accredited institution, with at least 40 semester hours or 60 quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, and supervised experience consisting at least two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).
- b. Child psychiatrists must be licensed as physicians and surgeons, with graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board-eligible or board-certified in child psychiatry.
- c. Licensed mental health counselors must graduate with a MA or PhD level educational program in mental health counseling or a related discipline, and complete 36 months of supervised full-time counseling or 3000 hours of postgraduate mental health counseling under the supervision of a qualified licensed mental health counselor. Licensed mental health counselors must pass an examination administered by the National Board of Certified Counselors. Licensed mental health counselors are not required to have supervised postgraduate experience prior to becoming an associate.
- d. Licensed marriage and family therapists must have either an MA or PhD

- ☐ Nurse Practitioner
- ☒ Nurse Care Coordinators

- ☒ Nurses

- ☐ Medical Specialists
- ☐ Physicians
- ☒ Physician's Assistants

in marriage and family therapy or an MA or PhD in behavioral science with equivalent course work from an approved school. Licensed marriage and family therapists must complete a minimum of 2 years of supervised full-time marriage and family therapy. For full licensure, a licensed marriage and family therapists must take and pass the Association of Marital and Family Therapy Regulatory Boards examination. Licensed marriage and family therapist associate applicants are not required to have supervised postgraduate experience prior to becoming an associate.

Description

- a. Licensed Practical Nurses (LPN) must successfully complete a commission-approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice, and must pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington before practicing.
- b. Registered Nurses (RN) must successfully complete a commission approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington before practicing.
- c. Advanced Registered Nurse Practitioners (ARNP) must have formal graduate education and obtain a national specialty certification as a nurse practitioner, nurse anesthetist or nurse midwife. ARNPs must hold a registered nurse license in Washington before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.
- d. A psychiatric advanced registered nurse practitioner is a person who is licensed as an advanced registered nurse practitioner and is also board-certified in advanced practice psychiatric and mental health nursing.
- e. Psychiatric nurses are registered nurses with a Bachelor's degree from an accredited college or university, and have, 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.

Description

- a. Licensed Practical Nurses (LPN) must successfully complete a commission-approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice, and must pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington before practicing.
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- d. A psychiatric advanced registered nurse practitioner is a person who is licensed as an advanced registered nurse practitioner and is also board-certified in advanced practice psychiatric and mental health nursing.
- e. Psychiatric nurses are registered nurses with a Bachelor's degree from an accredited college or university, and have, 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.

Description

Physician Assistants (PA) must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited

- ☐ Pharmacists
- ☒ Social Workers

extent under the supervision of a physician. They must be academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services. PAs must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the National Commission of Certification of Physician Assistants (NCCPA) examination. Physician assistants must have 4 clock hours of AID education and an active DEA registration.

Description

All social workers listed below must pass either the American Association of State Social Work Board's advanced or clinical examination for licensure. The Associate social workers listed below are not required to have supervised postgraduate experience prior to becoming an associate.

- a. Licensed Independent Social Worker must graduate with a MA or PhD social work and complete a minimum of 4000 hours of supervised experience or which 1000 hours must be direct client contact, over a three-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.
- b. Licensed Advanced Social Worker must graduate with a MA or PhD social work program and complete 3200 hours with supervision. At least 90 hours are direct supervision as specified by a licensed independent clinical social worker, a licensed advanced social worker, or an equally qualified licensed mental health professional. At least 40 hours must be in one-to-one supervision and 50 hours may be in one-to-one supervision or group supervision.
- c. Licensed independent clinical social worker must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and successfully complete a supervised experience of at least 4000 hours of experience, of which 1000 hours must be direct client contact, over a 3-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.
- d. Licensed social worker associate-independent clinical must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.
- e. Licensed social worker associate-advanced must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
Chemical Dependency Professionals	Chemical Dependency Professionals (CDPs) must pass the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination. CDPs must complete 1,000 to 2,500 hours of supervised experience, dependent upon the following, associate degree, baccalaureate degree, masters or doctoral degree, licensed as an advance registered nurse practitioner, marriage and family therapists, mental health counselors, advanced social workers, independent clinical social worker or licensed as a psychologist, that include clinical evaluation and face-to-face counseling.
Exception to Rule	Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills and knowledge and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and eligible for professional liability insurance as required by the hiring organization. The lead entity will provide HCA a letter of request for approval to hire a specific candidate. The letter will include the rationale for the potential care

Provider Type	Description coordinator (i.e. any special skills or knowledge such as bicultural or bilingual), employee background and experience and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request: • Resume • Letters of recommendation • Educational transcripts • Documentation of courses, classes and trainings • Certifications • Licenses Staff will review and rate each letter of request and documentation. Scores must be at least 80% in each section to qualify. Sections are identified as: 1. Education 2. Experience 3. Skills/Knowledge 4. Letters of Recommendation
Allied or Affiliated Staff	Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator. Allied or affiliated staff may: 1. Contact the client to introduce Health Home benefits and schedule initial Care Coordinator face-to-face visit. 2. Conduct client outreach and engagement activities to assess on-going emerging needs and to promote continuity of care and improved health outcomes.

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | WA2016MH00010 | WA-16-0026 | Washington State Health Home Program

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Care Coordination

Definition

The dedicated Health Home Care Coordinator and affiliated staff play a central and active role in development and execution of cross-system care coordination to assist the beneficiary to access and navigate needed services. The Care Coordinator assures communication is fostered between the providers of care, including the treating primary care provider and medical specialists and entities authorizing behavioral health and long-term services and supports. Care Coordination is the bridge between all the beneficiary's systems of care, including non-clinical support such as food, housing, and transportation.

When providing intensive care coordination to the beneficiary, the Care Coordinator caseload will be maintained at a level that ensures fidelity in providing required Health Home services, including interventions. Allied staff, such as community health workers, peer counselors or other non-clinical staff, may be used to facilitate the work of the assigned Health Home Care Coordinator.

Care coordination provides informed interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors impacting a beneficiary's health and health care choices. Care Coordinators and affiliated staff promote:

1. Optimal clinical outcomes, including a description of how progress toward outcomes will be measured through the Health Action Plan;
2. Outreach and engagement activities that support the beneficiary's participation in their care and promotes continuity of care;
3. Health education and coaching designed to assist beneficiaries to increase self-management skills and improve health outcomes; and
4. Use of peer supports, support groups and self-care programs to increase the beneficiary's knowledge about their health care conditions and improve adherence to prescribed treatment.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

PRISM is an information technology resource that supports the beneficiary and the Health Home Care Coordinator to identify the unmet needs, gaps in care, transitional support needs, clinical protocols required and current utilization of case management, medical and behavioral health services.

The Health Action Plan (HAP) may be shared, with beneficiary consent, via secure email or hard copy. The HAP includes:

1. Required and optional health screenings and assessments;
2. Beneficiary and Care Coordinator prioritized action items;
3. Beneficiary identified goals (short and long term);
4. Action steps for the beneficiary, the Health Home Care Coordinator and/or other direct service and medical providers; and
5. If the beneficiary has a personal care worker, action steps for them to support identified health action goals identified by the beneficiary.

The Health Home Care Coordinator updates and modifies the HAP on a four month cycle. The HAP is also updated and modified as needed to reflect:

1. A change in the beneficiary's condition;
2. New immediate goals to be addressed through the Health Home; and
3. Resolution of goals or action steps.

Scope of service

The service can be provided by the following provider types

- ☒ Behavioral Health Professionals or Specialists

Description

- a. Psychologists must have a doctoral degree from a regionally-accredited institution, with at least 40 semester hours or 60 quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, and supervised experience consisting at least two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).
- b. Child psychiatrists must be licensed as physicians and surgeons, with graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board-eligible or board-certified in child psychiatry.
- c. Licensed mental health counselors must graduate with a MA or PhD level educational program in mental health counseling or a related discipline, and complete 36 months of supervised full-time counseling or 3000 hours of postgraduate mental health counseling under the supervision of a qualified licensed mental health counselor. Licensed mental health counselors must pass an examination administered by the National Board of Certified Counselors. Licensed mental health counselors are not required to have supervised postgraduate experience prior to becoming an associate.
- d. Licensed marriage and family therapists must have either an MA or PhD in marriage and family therapy or an MA or PhD in behavioral science with equivalent course work from an approved school. Licensed marriage and family therapists must complete a minimum of 2 years of supervised full-time marriage and family therapy. For full licensure, a licensed marriage and family therapists must take and pass the Association of Marital and Family Therapy

- ☐ Nurse Practitioner
- ☒ Nurse Care Coordinators

☒ Nurses

- ☐ Medical Specialists
- ☐ Physicians
- ☒ Physician's Assistants

Regulatory Boards examination. Licensed marriage and family therapist associate applicants are not required to have supervised postgraduate experience prior to becoming an associate.

Description

- a. Licensed Practical Nurses (LPN) must successfully complete a commission-approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice, and must pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington before practicing.
- b. Registered Nurses (RN) must successfully complete a commission approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington before practicing.
- c. Advanced Registered Nurse Practitioners (ARNP) must have formal graduate education and obtain a national specialty certification as a nurse practitioner, nurse anesthetist or nurse midwife. ARNPs must hold a registered nurse license in Washington before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.
- d. A psychiatric advanced registered nurse practitioner is a person who is licensed as an advanced registered nurse practitioner and is also board-certified in advanced practice psychiatric and mental health nursing.
- e. Psychiatric nurses are registered nurses with a Bachelor's degree from an accredited college or university, and have, 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.

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- e. Psychiatric nurses are registered nurses with a Bachelor's degree from an accredited college or university, and have, 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.

Description

Physician Assistants (PA) must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited extent under the supervision of a physician. They must be academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services. PAs must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the National

Commission of Certification of Physician Assistants (NCCPA) examination. Physician assistants must have 4 clock hours of AID education and an active DEA registration.

- ☐ Pharmacists
- ☒ Social Workers

Description

All social workers listed below must pass either the American Association of State Social Work Board's advanced or clinical examination for licensure. The Associate social workers listed below are not required to have supervised postgraduate experience prior to becoming an associate.

a. Licensed Independent Social Worker must graduate with a MA or PhD social work and complete a minimum of 4000 hours of supervised experience or which 1000 hours must be direct client contact, over a three-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

b. Licensed Advanced Social Worker must graduate with a MA or PhD social work program and complete 3200 hours with supervision. At least 90 hours are direct supervision as specified by a licensed independent clinical social worker, a licensed advanced social worker, or an equally qualified licensed mental health professional. At least 40 hours must be in one-to-one supervision and 50 hours may be in one-to-one supervision or group supervision.

c. Licensed independent clinical social worker must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and successfully complete a supervised experience of at least 4000 hours of experience, of which 1000 hours must be direct client contact, over a 3-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

d. Licensed social worker associate-independent clinical must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

e. Licensed social worker associate-advanced must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
Exception to Rule	Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills and knowledge and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and eligible for professional liability insurance as required by the hiring organization. The lead entity will provide HCA a letter of request for approval to hire a specific candidate. The letter will include the rationale for the potential care coordinator (i.e. any special skills or knowledge such as bicultural or bilingual), employee background and experience and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request: • Resume • Letters of recommendation • Educational transcripts • Documentation of courses, classes and trainings • Certifications • Licenses Staff will review and rate each letter of request and documentation. Scores must be at least 80% in each section to qualify. Sections are identified as: 1. Education 2. Experience 3. Skills/Knowledge 4. Letters of Recommendation

Provider Type	Description
Allied or Affiliated Staff	Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator. Allied or Affiliated staff may: 1. Communicate with service providers and health plans as appropriate to secure necessary care and supports; 2. Link/refer client to needed services to support care plan/treatment goals, including medical/ behavioral health care; patient education, and self-help/recovery, medication adherence, health literacy, and self-management. 3. Advocate for services and assist with scheduling of needed services. 4. Assist and support client with scheduling medical and applicable appointments.

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Health Promotion

Definition

Health promotion begins for Health Home beneficiaries with the commencement of the Health Action Plan (HAP). Each Health Home must demonstrate use of self-management, recovery and resiliency principles using beneficiary-identified supports including family members and caregivers that are paid or unpaid. The Health Home Care Coordinator will use the beneficiary's activation score and level to determine the coaching methodology appropriate for each beneficiary to be used when working with the beneficiary towards reaching their health goals. Educational materials are customized and introduced according to the beneficiary's readiness for change, progressing with the beneficiary's level of confidence and self-management abilities. Opportunities for mentoring and modeling communication with health care providers are provided through joint office visits and communications with health care providers by the beneficiary and the Health Home Care Coordinator. The Health Home provides wellness and prevention education specific to the beneficiary's chronic conditions, HAP, including assessment of need and facilitation of receipt of routine preventive care, support for improving social connections to community networks, and links to resources that support a healthier lifestyle. Linkages include but are not limited to resources for smoking prevention and cessation, substance use disorder treatment and prevention, nutritional counseling, obesity reduction and prevention, increasing physical activity, disease specific or chronic care management self-help resources, and other services, such as housing based on beneficiary needs and preferences.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Insignia Health is an information technology resource which provides calculation of the Patient Activation Measure (PAM)/Caregiver Activation Measures (CAM), Parent/Patient Activation Measure (PPAM) and the Coaching for Activation website. This site provides educational materials linked to a beneficiary's level of activation and can be sent electronically to a beneficiary or printed for review at a Health Home visit or by phone.

The Health Home Care Coordinator is able to view the medical claims, behavioral health claims, prescription claims, and LTC services utilization and selected CARE characteristics (for those beneficiaries with long-term services and supports) in PRISM so that education materials can be tailored to the individual's engagement and activation.

Scope of service

The service can be provided by the following provider types

☒ Behavioral Health Professionals or Specialists

Description

- a. Psychologists must have a doctoral degree from a regionally-accredited institution, with at least 40 semester hours or 60 quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, and supervised experience consisting at least two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).
- b. Child psychiatrists must be licensed as physicians and surgeons, with graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board-eligible or board-certified in child psychiatry.
- c. Licensed mental health counselors must graduate with a MA or PhD level educational program in mental health counseling or a related discipline, and complete 36 months of supervised full-time counseling or 3000 hours of postgraduate mental health counseling under the supervision of a qualified licensed mental health counselor. Licensed mental health counselors must pass an examination administered by the National Board of Certified Counselors. Licensed mental health counselors are not required to have supervised postgraduate experience prior to becoming an associate.
- d. Licensed marriage and family therapists must have either an MA or PhD in marriage and family therapy or an MA or PhD in behavioral science with equivalent course work from an approved school. Licensed marriage and family therapists must complete a minimum of 2 years of supervised full-time marriage and family therapy. For full licensure, a licensed marriage and family therapists must take and pass the Association of Marital and Family Therapy Regulatory Boards examination. Licensed marriage and family therapist associate applicants are not required to have supervised postgraduate experience prior to becoming an associate.

☐ Nurse Practitioner

☒ Nurse Care Coordinators

Description

- a. Licensed Practical Nurses (LPN) must successfully complete a commission-approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice, and must pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in

☒ Nurses

☐ Medical Specialists

☐ Physicians

☒ Physician's Assistants

☐ Pharmacists

☒ Social Workers

- Washington before practicing.
- b. Registered Nurses (RN) must successfully complete a commission approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington before practicing.
- c. Advanced Registered Nurse Practitioners (ARNP) must have formal graduate education and obtain a national specialty certification as a nurse practitioner, nurse anesthetist or nurse midwife. ARNPs must hold a registered nurse license in Washington before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.
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- e. Psychiatric nurses are registered nurses with a Bachelor's degree from an accredited college or university, and have, 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.

Description

- a. Licensed Practical Nurses (LPN) must successfully complete a commission-approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice, and must pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington before practicing.
- b. Registered Nurses (RN) must successfully complete a commission approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington before practicing.
- c. Advanced Registered Nurse Practitioners (ARNP) must have formal graduate education and obtain a national specialty certification as a nurse practitioner, nurse anesthetist or nurse midwife. ARNPs must hold a registered nurse license in Washington before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.
- d. A psychiatric advanced registered nurse practitioner is a person who is licensed as an advanced registered nurse practitioner and is also board-certified in advanced practice psychiatric and mental health nursing.
- e. Psychiatric nurses are registered nurses with a Bachelor's degree from an accredited college or university, and have, 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.

Description

Physician Assistants (PA) must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited extent under the supervision of a physician. They must be academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services. PAs must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the National Commission of Certification of Physician Assistants (NCCPA) examination. Physician assistants must have 4 clock hours of AID education and an active DEA registration.

Description

All social workers listed below must pass either the American Association of State Social Work Board's advanced or clinical examination for licensure. The Associate social workers listed below are not required to have supervised postgraduate experience prior to becoming an associate.

a. Licensed Independent Social Worker must graduate with a MA or PhD

social work and complete a minimum of 4000 hours of supervised experience or which 1000 hours must be direct client contact, over a three-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

b. Licensed Advanced Social Worker must graduate with a MA or PhD social work program and complete 3200 hours with supervision. At least 90 hours are direct supervision as specified by a licensed independent clinical social worker, a licensed advanced social worker, or an equally qualified licensed mental health professional. At least 40 hours must be in one-to-one supervision and 50 hours may be in one-to-one supervision or group supervision.

c. Licensed independent clinical social worker must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and successfully complete a supervised experience of at least 4000 hours of experience, of which 1000 hours must be direct client contact, over a 3-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

d. Licensed social worker associate-independent clinical must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

e. Licensed social worker associate-advanced must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
Exception to Rule	Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills and knowledge and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and eligible for professional liability insurance as required by the hiring organization. The lead entity will provide HCA a letter of request for approval to hire a specific candidate. The letter will include the rationale for the potential care coordinator (i.e. any special skills or knowledge such as bicultural or bilingual), employee background and experience and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request: • Resume • Letters of recommendation • Educational transcripts • Documentation of courses, classes and trainings • Certifications • Licenses Staff will review and rate each letter of request and documentation. Scores must be at least 80% in each section to qualify. Sections are identified as: 1. Education 2. Experience 3. Skills/Knowledge 4. Letters of Recommendation
Allied or Affiliated Staff	Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator. Allied or Affiliated staff may: 1. Provide customized educational materials according to the needs and goals of the client, caregiver, or other social supports as appropriate. 2. Promote participation in community educational and support groups. 3. Provide links to health care resources that support the client's goals. 4. Support the execution of cross-system care coordination activities that

Provider Type	Description
	assist clients in accessing and navigating needed services. 5. Distribute health education and other materials. 6. Assist with follow up calls and provide appointment reminders.
Support Staff	Clerical or administrative staff who provide clerical supportive services under the direction of the Care Coordinator. Support staff may: 1. Distribute health education and other materials. 2. Assist with follow up calls and provide appointment reminders.
Chemical Dependency Professionals	Chemical Dependency Professionals (CDPs) must pass the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination. CDPs must complete 1,000 to 2,500 hours of supervised experience, dependent upon the following, associate degree, baccalaureate degree, masters or doctoral degree, licensed as an advance registered nurse practitioner, marriage and family therapists, mental health counselors, advanced social workers, independent clinical social worker or licensed as a psychologist, that include clinical evaluation and face-to-face counseling.

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | WA2016MH0001O | WA-16-0026 | Washington State Health Home Program

Package Header

Package ID	WA2016MH0001O	SPA ID	WA-16-0026
Submission Type	Official	Initial Submission Date	12/20/2016
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Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

Comprehensive transitional care is provided to prevent beneficiary avoidable readmission after discharge from an inpatient facility to ensure proper and timely follow-up care.

The beneficiary's Health Action Plan (HAP) includes transitional care planning. Transitional care planning includes:

1. A notification system with managed care plans, hospitals, nursing homes and residential/rehabilitation facilities to provide the Health Home prompt communication of a beneficiary's admission and/or discharge from an emergency department, inpatient, nursing home or residential/rehabilitation and if proper permissions, a substance use disorder treatment setting. Progress notes or a case file documents the notification and the HAP should be updated with transition planning.
2. The use of a Health Home Care Coordinator as an active participant in all appropriate phases of care transition, including discharge planning visits during hospitalizations or nursing home stays following hospital/institutional discharge, conducted via home visits and telephone calls.
3. Beneficiary education addressing discharge care needs, including medication management, encouragement and intervention to assure follow-up appointments and self-management of their chronic or acute conditions, including information on when to seek medical care and emergency care. Involvement of family and formal or informal caregivers are facilitated when requested by the beneficiary.
4. A systematic follow-up protocol to assure timely access to follow-up care post discharge and to identify and re-engage beneficiaries that do not receive post-discharge care.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Emergency Department Information Exchange (EDIE) notifications provide Medicaid claims data to ED physicians. EDIE is HIPAA-compliant. EDIE can proactively alert care providers through a variety of methods such as fax, phone, email, or integration with facility's current electronic medical record when high utilizing beneficiaries enter the ED. Once notified, care providers can use EDIE to access care guidelines and crucial information on the beneficiary from other participating facilities to better determine the beneficiary's overall medical situation.

PreManage is information exchange system alerts providers when their beneficiary is accessing inpatient hospital services.

Lead FFS Entities with access to EDIE and Pre-Manage can push real-time information on ED visits and inpatient hospital stays to their Care Coordination Organizations.

Managed care Lead Entities notify Health Home Care Coordinators of beneficiary admission to hospital and tertiary care facilities to facilitate discharge planning and care transitions. MCO Lead Entities also inform the Health Home Care Coordinators of lapses in pharmacy refills for beneficiaries with chronic conditions requiring long-term use of medications. Health Home Care Coordinators are responsible for conducting outreach activities with the beneficiary to ensure medications have been picked up and are being used according to the clinical treatment plan.

Scope of service

The service can be provided by the following provider types

- ☒ Behavioral Health Professionals or Specialists

Description

- a. Psychologists must have a doctoral degree from a regionally-accredited institution, with at least 40 semester hours or 60 quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, and supervised experience consisting at least two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).
- b. Child psychiatrists must be licensed as physicians and surgeons, with graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board-eligible or board-certified in child psychiatry.
- c. Licensed mental health counselors must graduate with a MA or PhD level educational program in mental health counseling or a related discipline, and complete 36 months of supervised full-time counseling or 3000 hours of postgraduate mental health counseling under the supervision of a qualified licensed mental health counselor. Licensed mental health counselors must pass an examination administered by the National Board of Certified Counselors. Licensed mental health counselors are not required to have supervised postgraduate experience prior to becoming an associate.
- d. Licensed marriage and family therapists must have either an MA or PhD in marriage and family therapy or an MA or PhD in behavioral science with equivalent course work from an approved school. Licensed marriage and

- ☐ Nurse Practitioner
- ☒ Nurse Care Coordinators

- ☒ Nurses

- ☐ Medical Specialists
- ☐ Physicians
- ☒ Physician's Assistants

family therapists must complete a minimum of 2 years of supervised full-time marriage and family therapy. For full licensure, a licensed marriage and family therapists must take and pass the Association of Marital and Family Therapy Regulatory Boards examination. Licensed marriage and family therapist associate applicants are not required to have supervised postgraduate experience prior to becoming an associate.

Description

- a. Licensed Practical Nurses (LPN) must successfully complete a commission-approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice, and must pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington before practicing.
- b. Registered Nurses (RN) must successfully complete a commission approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington before practicing.
- c. Advanced Registered Nurse Practitioners (ARNP) must have formal graduate education and obtain a national specialty certification as a nurse practitioner, nurse anesthetist or nurse midwife. ARNPs must hold a registered nurse license in Washington before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.
- d. A psychiatric advanced registered nurse practitioner is a person who is licensed as an advanced registered nurse practitioner and is also board-certified in advanced practice psychiatric and mental health nursing.
- e. Psychiatric nurses are registered nurses with a Bachelor's degree from an accredited college or university, and have, 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.

Description

- a. Licensed Practical Nurses (LPN) must successfully complete a commission-approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice, and must pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington before practicing.
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- d. A psychiatric advanced registered nurse practitioner is a person who is licensed as an advanced registered nurse practitioner and is also board-certified in advanced practice psychiatric and mental health nursing.
- e. Psychiatric nurses are registered nurses with a Bachelor's degree from an accredited college or university, and have, 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.

Description

Physician Assistants (PA) must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited extent under the supervision of a physician. They must be academically and clinically prepared to provide health care services and perform diagnostic,

- ☐ Pharmacists
- ☒ Social Workers

- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☒ Other (specify)

therapeutic, preventative, and health maintenance services. PAs must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the National Commission of Certification of Physician Assistants (NCCPA) examination. Physician assistants must have 4 clock hours of AID education and an active DEA registration.

Description

All social workers listed below must pass either the American Association of State Social Work Board's advanced or clinical examination for licensure. The Associate social workers listed below are not required to have supervised postgraduate experience prior to becoming an associate.

- a. Licensed Independent Social Worker must graduate with a MA or PhD social work and complete a minimum of 4000 hours of supervised experience or which 1000 hours must be direct client contact, over a three-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.
- b. Licensed Advanced Social Worker must graduate with a MA or PhD social work program and complete 3200 hours with supervision. At least 90 hours are direct supervision as specified by a licensed independent clinical social worker, a licensed advanced social worker, or an equally qualified licensed mental health professional. At least 40 hours must be in one-to-one supervision and 50 hours may be in one-to-one supervision or group supervision.
- c. Licensed independent clinical social worker must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and successfully complete a supervised experience of at least 4000 hours of experience, of which 1000 hours must be direct client contact, over a 3-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.
- d. Licensed social worker associate-independent clinical must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.
- e. Licensed social worker associate-advanced must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

Provider Type	Description
Exception to Rule	Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills and knowledge and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and eligible for professional liability insurance as required by the hiring organization. The lead entity will provide HCA a letter of request for approval to hire a specific candidate. The letter will include the rationale for the potential care coordinator (i.e. any special skills or knowledge such as bicultural or bilingual), employee background and experience and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request: • Resume • Letters of recommendation • Educational transcripts • Documentation of courses, classes and trainings • Certifications • Licenses Staff will review and rate each letter of request and documentation. Scores must be at least 80% in each section to qualify. Sections are identified as: 1. Education

Provider Type	Description
Allied or Affiliated Staff	2. Experience 3. Skills/Knowledge 4. Letters of Recommendation Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator. Allied or Affiliated staff may: 1. Support client with connecting to community supports to ensure that needed services or equipment are received.
Support Staff	Clerical or administrative staff who provide clerical supportive services under the direction of the Care Coordinator. Support staff may: 1. Support client with connecting to community supports to ensure that needed services or equipment are received.
Chemical Dependency Professionals	Chemical Dependency Professionals (CDPs) must pass the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination. CDPs must complete 1,000 to 2,500 hours of supervised experience, dependent upon the following, associate degree, baccalaureate degree, masters or doctoral degree, licensed as an advance registered nurse practitioner, marriage and family therapists, mental health counselors, advanced social workers, independent clinical social worker or licensed as a psychologist, that include clinical evaluation and face-to-face counseling.

Health Homes Services

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Package Header

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Superseded SPA ID	N/A		

Individual and Family Support (which includes authorized representatives)

Definition

The Health Home Care Coordinator recognizes the unique roles the beneficiary may assign to family, identified decision makers and caregivers in assisting them with accessing and navigating health care and social service delivery systems, as well as support health action planning.

The Health Home Care Coordinator uses peer supports, support groups, and self-management programs to increase beneficiary and caregivers' knowledge of the beneficiary's chronic conditions, promote the beneficiary's engagement and self-management capabilities, and help the beneficiary improve adherence to their prescribed treatment.

The Health Home Care Coordinator, affiliated staff and the beneficiary:

1. Identify the role that families, informal supports and paid caregivers provide to achieve self-management and optimal levels of physical and cognitive function;
2. Educate and support self-management, self-help recovery, and other resources necessary for the beneficiary, their family, and their caregivers to support the beneficiary's individualized health action goals;
3. Discuss advance directives with beneficiaries and their families; and
4. Communicate and share information with beneficiaries and their families and other caregivers with appropriate consideration of language, activation level, literacy and cultural preferences.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The PRISM software application includes the PRISM Health Report for all beneficiaries. The PRISM report is provided to the beneficiary's primary care provider and any other health care providers identified by the beneficiary and authorized by a signed release of information. This includes the Health Home Care Coordinator. The report includes:

1. Beneficiary demographics
2. Last dental appointment
3. Health conditions
4. Hospital stays
5. Emergency room visits
6. Office visits and procedures in the last 180 days, used by the Care Coordinator to assess sufficient clinical oversight of the beneficiary's chronic conditions
7. Prescriptions filled in the last 90 days
8. Prescriptions by drug class in last two years

Coaching for Activation educational materials are available electronically and are printed for beneficiary and family support.

Scope of service

The service can be provided by the following provider types

- ☒ Behavioral Health Professionals or Specialists

Description

- a. Psychologists must have a doctoral degree from a regionally-accredited institution, with at least 40 semester hours or 60 quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, and supervised experience consisting at least two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).
- b. Child psychiatrists must be licensed as physicians and surgeons, with graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board-eligible or board-certified in child psychiatry.
- c. Licensed mental health counselors must graduate with a MA or PhD level educational program in mental health counseling or a related discipline, and complete 36 months of supervised full-time counseling or 3000 hours of postgraduate mental health counseling under the supervision of a qualified licensed mental health counselor. Licensed mental health counselors must pass an examination administered by the National Board of Certified Counselors. Licensed mental health counselors are not required to have supervised postgraduate experience prior to becoming an associate.
- d. Licensed marriage and family therapists must have either an MA or PhD in marriage and family therapy or an MA or PhD in behavioral science with equivalent course work from an approved school. Licensed marriage and family therapists must complete a minimum of 2 years of supervised full-time marriage and family therapy. For full licensure, a licensed marriage and family therapists must take and pass the Association of Marital and Family Therapy Regulatory Boards examination. Licensed marriage and family therapist

associate applicants are not required to have supervised postgraduate experience prior to becoming an associate.

- ☐ Nurse Practitioner
- ☒ Nurse Care Coordinators

Description

- a. Licensed Practical Nurses (LPN) must successfully complete a commission-approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice, and must pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington before practicing.
- b. Registered Nurses (RN) must successfully complete a commission approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington before practicing.
- c. Advanced Registered Nurse Practitioners (ARNP) must have formal graduate education and obtain a national specialty certification as a nurse practitioner, nurse anesthetist or nurse midwife. ARNPs must hold a registered nurse license in Washington before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.
- d. A psychiatric advanced registered nurse practitioner is a person who is licensed as an advanced registered nurse practitioner and is also board-certified in advanced practice psychiatric and mental health nursing.
- e. Psychiatric nurses are registered nurses with a Bachelor's degree from an accredited college or university, and have, 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.

- ☒ Nurses

Description

- a. Licensed Practical Nurses (LPN) must successfully complete a commission-approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice, and must pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington before practicing.
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- c. Advanced Registered Nurse Practitioners (ARNP) must have formal graduate education and obtain a national specialty certification as a nurse practitioner, nurse anesthetist or nurse midwife. ARNPs must hold a registered nurse license in Washington before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.
- d. A psychiatric advanced registered nurse practitioner is a person who is licensed as an advanced registered nurse practitioner and is also board-certified in advanced practice psychiatric and mental health nursing.
- e. Psychiatric nurses are registered nurses with a Bachelor's degree from an accredited college or university, and have, 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.

- ☐ Medical Specialists
- ☐ Physicians
- ☒ Physician's Assistants

Description

Physician Assistants (PA) must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited extent under the supervision of a physician. They must be academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services. PAs must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the National Commission of Certification of Physician Assistants (NCCPA) examination.

Physician assistants must have 4 clock hours of AID education and an active DEA registration.

- ☐ Pharmacists
- ☒ Social Workers

Description

All social workers listed below must pass either the American Association of State Social Work Board's advanced or clinical examination for licensure. The Associate social workers listed below are not required to have supervised postgraduate experience prior to becoming an associate.

- a. Licensed Independent Social Worker must graduate with a MA or PhD social work and complete a minimum of 4000 hours of supervised experience or which 1000 hours must be direct client contact, over a three-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.
- b. Licensed Advanced Social Worker must graduate with a MA or PhD social work program and complete 3200 hours with supervision. At least 90 hours are direct supervision as specified by a licensed independent clinical social worker, a licensed advanced social worker, or an equally qualified licensed mental health professional. At least 40 hours must be in one-to-one supervision and 50 hours may be in one-to-one supervision or group supervision.
- c. Licensed independent clinical social worker must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and successfully complete a supervised experience of at least 4000 hours of experience, of which 1000 hours must be direct client contact, over a 3-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.
- d. Licensed social worker associate-independent clinical must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.
- e. Licensed social worker associate-advanced must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
Exception to Rule	Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills and knowledge and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and eligible for professional liability insurance as required by the hiring organization. The lead entity will provide HCA a letter of request for approval to hire a specific candidate. The letter will include the rationale for the potential care coordinator (i.e. any special skills or knowledge such as bicultural or bilingual), employee background and experience and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request: • Resume • Letters of recommendation • Educational transcripts • Documentation of courses, classes and trainings • Certifications • Licenses Staff will review and rate each letter of request and documentation. Scores must be at least 80% in each section to qualify. Sections are identified as: 1. Education 2. Experience 3. Skills/Knowledge 4. Letters of Recommendation

Provider Type	Description
Allied or Affiliated Staff	Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator. Allied or Affiliated staff may: 1. Educate client, family, or caregiver advance directives, client rights, and health care issues, as needed. 2. Meet with client and family, inviting any other providers to facilitate needed interpretation services. 3. Refer client/family to peer supports, support groups, social services, entitlement programs as needed.
Chemical Dependency Professionals	Chemical Dependency Professionals (CDPs) must pass the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination. CDPs must complete 1,000 to 2,500 hours of supervised experience, dependent upon the following, associate degree, baccalaureate degree, masters or doctoral degree, licensed as an advance registered nurse practitioner, marriage and family therapists, mental health counselors, advanced social workers, independent clinical social worker or licensed as a psychologist, that include clinical evaluation and face-to-face counseling.

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Referral to Community and Social Support Services

Definition

The Health Home Care Coordinator and affiliated staff identify available community based resources, actively manage referrals, assist the beneficiary in advocating for access to care, and engage with community and social supports related to goal achievement documented in the Health Action Plan. When needed and not otherwise provided through other case management systems, the Health Home Care Coordinator provides assistance in obtaining and maintaining eligibility for health care services, disability benefits, housing, personal needs and legal services. These services will be coordinated with appropriate local, state and federal governments and community based organizations. Referral to community and social support services includes long-term services and supports, mental health, substance use disorder and other community and social services support providers needed to support the beneficiary in support of health action goals.

The Health Home Care Coordinator documents referrals to and access by the beneficiary of community- based and other social support services.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

PRISM and Insignia Health are information technology sources supporting the beneficiary and the Health Home Care Coordinator to identify the unmet needs, gaps in care, transitional support needs, clinical protocols required and current utilization of case management, medical and behavioral health services.

Scope of service

The service can be provided by the following provider types

☒ Behavioral Health Professionals or Specialists

Description

- a. Psychologists must have a doctoral degree from a regionally-accredited institution, with at least 40 semester hours or 60 quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, and supervised experience consisting at least two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).
- b. Child psychiatrists must be licensed as physicians and surgeons, with graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board-eligible or board-certified in child psychiatry.
- c. Licensed mental health counselors must graduate with a MA or PhD level educational program in mental health counseling or a related discipline, and complete 36 months of supervised full-time counseling or 3000 hours of postgraduate mental health counseling under the supervision of a qualified licensed mental health counselor. Licensed mental health counselors must pass an examination administered by the National Board of Certified Counselors. Licensed mental health counselors are not required to have supervised postgraduate experience prior to becoming an associate.
- d. Licensed marriage and family therapists must have either an MA or PhD in marriage and family therapy or an MA or PhD in behavioral science with equivalent course work from an approved school. Licensed marriage and family therapists must complete a minimum of 2 years of supervised full-time marriage and family therapy. For full licensure, a licensed marriage and family therapists must take and pass the Association of Marital and Family Therapy Regulatory Boards examination. Licensed marriage and family therapist associate applicants are not required to have supervised postgraduate experience prior to becoming an associate.

☐ Nurse Practitioner

☒ Nurse Care Coordinators

Description

- 1. Licensed Practical Nurses (LPN) must successfully complete a commission approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice and pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington State before practicing.
- 2. Registered Nurses (RN) RNs must successfully complete a commission approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington State before

☒ Nurses

☐ Medical Specialists

☐ Physicians

☒ Physician's Assistants

☐ Pharmacists

☒ Social Workers

practicing.

3. Advanced registered Nurse Practitioners (ARNP) must have formal graduate education and achieve a national specialty certification for the nurse practitioner, nurse anesthetist or nurse midwife role. ARNPs must hold a registered nurse license in Washington State before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.

4. Psychiatric advanced registered nurse practitioner" means a person who is licensed as an advanced registered nurse practitioner; and who is board certified in advanced practice psychiatric and mental health nursing.

5. Psychiatric nurses are registered nurses with a bachelor's degree from an accredited college or university, and have, 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.

Description

1. Licensed Practical Nurses (LPN) must successfully complete a commission approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice and pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington State before practicing.

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4. Psychiatric advanced registered nurse practitioner" means a person who is licensed as an advanced registered nurse practitioner; and who is board certified in advanced practice psychiatric and mental health nursing.

5. Psychiatric nurses are registered nurses with a bachelor's degree from an accredited college or university, and have, 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.

Description

Physician Assistants (PA) must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited extent under the supervision of a physician. They must be academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services. PAs must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the National Commission of Certification of Physician Assistants (NCCPA) examination. Physician assistants must have 4 clock hours of AID education and an active DEA registration.

Description

All social workers listed below must pass either the American Association of State Social Work Board's advanced or clinical examination for licensure. The Associate social workers listed below are not required to have supervised postgraduate experience prior to becoming an associate.

a. Licensed Independent Social Worker must graduate with a MA or PhD social work and complete a minimum of 4000 hours of supervised experience or which 1000 hours must be direct client contact, over a three-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

b. Licensed Advanced Social Worker must graduate with a MA or PhD social work program and complete 3200 hours with supervision. At least 90 hours are direct supervision as specified by a licensed independent clinical social

worker, a licensed advanced social worker, or an equally qualified licensed mental health professional. At least 40 hours must be in one-to-one supervision and 50 hours may be in one-to-one supervision or group supervision.

c. Licensed independent clinical social worker must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and successfully complete a supervised experience of at least 4000 hours of experience, of which 1000 hours must be direct client contact, over a 3-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

d. Licensed social worker associate-independent clinical must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

e. Licensed social worker associate-advanced must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
Exception to Rule	Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills and knowledge and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and eligible for professional liability insurance as required by the hiring organization. The lead entity will provide HCA a letter of request for approval to hire a specific candidate. The letter will include the rationale for the potential care coordinator (i.e. any special skills or knowledge such as bicultural or bilingual), employee background and experience and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request: • Resume • Letters of recommendation • Educational transcripts • Documentation of courses, classes and trainings • Certifications • Licenses Staff will review and rate each letter of request and documentation. Scores must be at least 80% in each section to qualify. Sections are identified as: 1. Education 2. Experience 3. Skills/Knowledge 4. Letters of Recommendation
Allied or Affiliated Staff	Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator. Allied or Affiliated staff may: 1. Identify, refer and facilitate access to relevant community and social support services that support the client’s health action goals. 2. Assist client to apply for or maintain eligibility for health care services, disability benefits, housing, and legal services not provided through other case management systems. 3. Provide general information about upcoming community events.

Provider Type	Description
Support Staff	Clerical or administrative staff who provide clerical supportive services under the direction of the Care Coordinator. Support staff may: 1. Provide general information about upcoming community events.
Chemical Dependency Professionals	Chemical Dependency Professionals (CDPs) must pass the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination. CDPs must complete 1,000 to 2,500 hours of supervised experience, dependent upon the following, associate degree, baccalaureate degree, masters or doctoral degree, licensed as an advance registered nurse practitioner, marriage and family therapists, mental health counselors, advanced social workers, independent clinical social worker or licensed as a psychologist, that include clinical evaluation and face-to-face counseling.

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | WA2016MH00010 | WA-16-0026 | Washington State Health Home Program

Package Header

Package ID	WA2016MH00010	SPA ID	WA-16-0026
Submission Type	Official	Initial Submission Date	12/20/2016
Approval Date	03/30/2017	Effective Date	4/1/2017
Superseded SPA ID	N/A		

Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

Enrollment flow is dependent upon 1) whether the beneficiary is enrolled with a Managed Care Lead Entity, or 2) is not enrolled in managed care and is receiving their medical benefits in the FFS delivery system. Almost all Washington's Medicaid Health Home beneficiaries are enrolled in managed care. Those that remain in the FFS delivery system either reside in a voluntary managed care county, are a full-dual eligible, or have self-identified as American Indian/Alaska Native.

All Health Home beneficiaries, regardless of whether they receive their Medicaid benefits in managed care or in FFS, have the same eligibility criteria - one or more chronic conditions from the chronic condition list and meet the state's definition of "at risk for another."

Enrollment starts with the identification of eligibility and assignment of a clinical indicator (Y=qualifies). The indicator is loaded into ProviderOne.

1. FFS beneficiaries with "Y"clinical indicators are enrolled into one of the qualified FFS Health Home Lead Entities in the geographic region in which they reside. Health Home outreach and education information is generated automatically and sent to the beneficiary by mail. The Health Home Lead Entity receives notification of the enrollment via HIPAA 834 files and assigns the beneficiary to one of their local Health Home Care Coordination Organizations (CCOs).
2. Managed care organizations have their eligible Health Home beneficiaries identified with a "Y" clinical indicator and receive notification of eligibility via HIPAA 834 files. The MCO assigns the beneficiary to one of their local Health Home Care Coordination Organizations (CCOs). The MCO is responsible for making sure the enrollee is notified of their eligibility to receive Health Home services.
3. Any health care provider may refer beneficiaries to the Health Home program. An example is a local emergency room department who has agreed with the Health Home Lead Entity to refer potentially eligible participants to the program.

Engagement consists of the assigned CCO placing beneficiaries with a Care Coordinator, who contacts the beneficiary to offer Health Home services. Once the beneficiary has agreed to participate in a Health Home, the Care Coordinator prepopulates the Health Action Plan with PRISM claims utilization details and arranges for an in-person visit. PRISM provides episode information related to specific diagnoses or pharmacy utilization, inpatient and outpatient claims, emergency room visits, mental health claims, substance use disorder treatment claims, pharmacy claims, and long-term care assessment data.

During the home visit, the Care Coordinator:

1. Conducts the required and when needed optional brief screening;
2. Evaluates the beneficiary's support system;
3. Completes a Consent for Release of Information;
4. Administers and scores the 13-question Patient Activation (PAM) or Caregiver Activation Measure (CAM) or Parent/Patient Activation Measure (PPAM); and
5. Develops the Health Action Plan (HAP) with the beneficiary, who will work with the CCO to identify immediate and long-term goals, prioritize concerns and establish action steps.

Name	Date Created	
No items available		

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | WA2016MH0001O | WA-16-0026 | Washington State Health Home Program

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Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates:

The state will calculate regional, risk-adjusted, per member per month expenses in the target population in the baseline (FY2011), apply trend factors and estimate a projected per member per month figure. Cost savings will be calculated as the difference between actual and projected risk adjusted per member/per month expenditures. Cost savings for dual eligible will be determined by CMS.

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

The state integrates Fee-for-Service claims data, managed care encounter data, beneficiary eligibility, enrollment and claims data for medical, pharmacy, mental health, substance use disorder, long term services and supports, and Medicaid and dual eligible Medicare covered services in a secure web-based clinical decision support tool called PRISM. PRISM also pulls from other clinical assessment data within the state such as CARE. The state uses PRISM to support the beneficiary and the Health Home Care Coordinator to identify the unmet needs, gaps in care, clinical protocols required and current utilization of case management, medical and behavioral health services. Use of these tools enables the Health Home Care Coordinator to better coordinate care and ensure that the beneficiary's complex needs are met, and will assist the state in monitoring cost and utilization data to ensure program goals are met.

The state has developed Health Information Technology (HIT) through OneHealthPort (OHP), who HCA contracts with to consult on maintaining a statewide health information exchange. HCA is developing the Medicaid Health Profile clinical data repository, with clinical data passed through OneHealthPort HIE using the Continuity of Care Document (CCD) and the Admit/ Discharge/Transfer Document (ADT) transaction sets. Updates to the Medicaid clinical data repository to refine or to correct identified data collection errors occur whenever a need is identified.

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | WA2016MH0001O | WA-16-0026 | Washington State Health Home Program

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Quality Measurement and Evaluation

- ☒ The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state.
- ☒ The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.
- ☒ The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.
- ☒ The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report.

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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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WA - Submission Package - WA2018MS0006O - (WA-18-0028) - Health Homes

Summary Reviewable Units Versions Correspondence Log News Related Actions

CMS-10434 OMB 0938-1188

Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | WA2018MS0006O | WA-18-0028 | Washington State Health Home Program

Package Header

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	User-Entered		

Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

Washington State Health Home Program

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

Washington's original Health Homes SPAs were WA 13-0008 (approved June 28, 2013) and WA 13-17 (approved December 11, 2013). WA 15-0011 (approved June 11, 2015) superseded both of these SPAs. SPA 16-006 (approved March 31, 2017) superseded 15-0011, added a 20% performance incentive payment to increase beneficiary engagement rates, and expanded the Health Home program statewide, adding King and Snohomish counties. This SPA WA 18-0028 supersedes WA 16-0026, adds a 20% rate increase, and reduces the performance incentive payment to 5%.

Under Washington's approach, Health Homes are the bridge to integrate care within existing delivery systems for both managed care and Fee-for-Service beneficiaries. Washington's Medicaid delivery systems are undergoing a great deal of change as the Health Care Authority (HCA) integrates physical and behavioral health services through its managed care program. As HCA phases in statewide integration, Washington's Health Home program will become more managed care focused while continuing to serve beneficiaries who remain in the Fee-for-Service delivery system, such as full-dual eligibles and American Indian/Alaska Natives.

Washington has three high level goals to assess the effectiveness of its Health Home program: 1) Building care coordination capacity in all areas of the state; 2) Improve the beneficiary's self-management abilities; and 3) Reduce future cost trends or at the very least attain cost neutrality with improved outcomes.

The Health Home program is designed as the central point for directing person-centered care through one-on-one interactions between the Health Home Care Coordinators and their assigned beneficiaries. Beneficiaries are identified as having one or more of the chronic conditions on the chronic condition list and at risk for a 2nd chronic condition using a tool that identifies those clients expected to have high costs in the future due to all their chronic conditions .

The Department of Social and Health Services (DSHS) generates and submits a list of eligible Health Homes beneficiaries to HCA, who enrolls them into a Managed Fee for Service Health Home Lead Entity (designated provider) or notifies the Managed Care Organization (designated provider) that one of their enrollees is eligible for Health Home services with a Health Home indicator on the 834 file. Lead Entities are permitted to provide Health Home services internally but must also subcontract with a wide-range of community-based Care Coordination Organizations (CCOs) to effectively manage the full breadth of beneficiary needs, increasing Washington's capacity to provide statewide Health Home services, especially in rural areas of the state.

Lead Entities are qualified by HCA and DSHS through both a contracting process and a Request for Application (RFA) process. Contracting is used if a Lead Entity has already been qualified through the RFA process and wants to broaden their Health Home service areas to other counties, while the RFA process is used to solicit new Lead Entities when adding counties that are not part of the Health Home program.

There are six defined Health Home services, with each individual service further defined by embedded activities to make up the composition of the service.

General Assurances

- ☒ The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- ☒ The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- ☒ The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.

- ☒ The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- ☒ The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- ☒ The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Homes Geographic Limitations

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- ☐ Health Homes services will be available statewide
- ☐ Health Homes services will be limited to the following geographic areas
- ☒ Health Homes services will be provided in a geographic phased-in approach

Health Homes Geographic Limitations

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Phase 1

Title of phase	Implementation Date
Phase 1	7/1/2013
Phase-in will be done by the following geographic area	Specify which counties:
By county	1. Asotin
	2. Benton
	3. Clark
	4. Columbia
	5. Cowlitz
	6. Franklin
	7. Garfield
	8. Kittitas
	9. Klickitat
	10. Pierce
	11. Skamania
	12. Wahkiakum
	13. Walla Walla
	14. Yakima

Health Homes services are now available state-wide

No

Enter any additional narrative necessary to fully describe this phase

Phase One: The first 14 counties were phased in beginning July 1, 2013 through two Requests for Application (RFA). HCA and DSHS qualified Lead Entities according to which counties they were proposing to serve, their Care Coordination Organization network, and their responses to RFA questions regarding their proposed processes to deliver Health Home services.

Name	Date Created	
No items available		

Health Homes Geographic Limitations

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Phase 2

Title of phase	Implementation Date
Phase 2	10/1/2013
Phase-in will be done by the following geographic area	Specify which counties:
By county	1. Adams
	2. Chelan
	3. Clallam
	4. Douglas
	5. Ferry
	6. Grant
	7. Grays Harbor
	8. Island
	9. Jefferson
	10. Kitsap
	11. Lewis
	12. Lincoln
	13. Mason
	14. Okanogan
	15. Pacific
	16. Pend Oreille
	17. San Juan
	18. Skagit
	19. Spokane
	20. Stevens
	21. Thurston
	22. Whatcom
	23. Whitman

Health Homes services are now available state-wide

No

Enter any additional narrative necessary to fully describe this phase

23 more counties were phased in beginning October 1, 2013 through an RFA. HCA and DSHS qualified Lead Entities according to which counties they were proposing to serve, their Care Coordination Organization network, and responses to RFA questions regarding their proposed processes to deliver Health Home services.

Name	Date Created	
No items available		

Health Homes Geographic Limitations

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Phase 3

Title of phase	Implementation Date
Phase 3	4/1/2017
Phase-in will be done by the following geographic area	Specify which counties:
By county	1. King 2. Snohomish
Health Homes services are now available state-wide	Effective date of state-wide service implementation
Yes	4/1/2017

Enter any additional narrative necessary to fully describe this phase

King and Snohomish counties were added in 4/1/2017 to make the Health Home program statewide. A combination RFA and contracting process was used to qualify Lead Entities to provide Health Home services in King and Snohomish counties. Organizations that did not become Qualified Lead Entities during Phase One or Two were required to become qualified through the third RFA. Lead Entities qualified in Phase One and Phase Two are allowed to add King and Snohomish counties to their existing Health Home coverage areas through the contracting process by submitting their Care Coordination networks for analysis.

Note: Two RFAs were completed for the addition of King and Snohomish Counties. The first RFA 1862 did not have enough responses to support the implementation of the Health Home program in King County. A second RFA was done (RFA 1992) in December 2016 to see if other organizations were interested in becoming Qualified Lead Entities for King. As of the submittal of this SPA, both King and Snohomish Counties have a Managed Fee-for-Service Lead Entity and five MCOs serving the Health Home population.

Name	Date Created	
No items available		

Health Homes Population and Enrollment Criteria

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Categories of Individuals and Populations Provided Health Home Services

The state will make Health Home services available to the following categories of Medicaid participants

- ☒ Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
- ☐ Medically Needy Eligibility Groups

Health Homes Population and Enrollment Criteria

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Population Criteria

The state elects to offer Health Homes services to individuals with:

- ☐ Two or more chronic conditions
- ☒ One chronic condition and the risk of developing another

Specify the conditions included:

- ☒ Mental Health Condition
- ☒ Substance Use Disorder
- ☒ Asthma
- ☒ Diabetes
- ☒ Heart Disease
- ☐ BMI over 25
- ☒ Other (specify):

Name	Description
hematological	As defined by UC San Diego CDPS and Medicaid RX disease categories.
musculoskeletal	As defined by UC San Diego CDPS and Medicaid RX disease categories.
cancer	As defined by UC San Diego CDPS and Medicaid RX disease categories.
cerebrovascular disease	As defined by UC San Diego CDPS and Medicaid RX disease categories.
coronary artery disease	As defined by UC San Diego CDPS and Medicaid RX disease categories.
dementia or Alzheimer's disease	As defined by UC San Diego CDPS and Medicaid RX disease categories.
intellectual disability or disease	As defined by UC San Diego CDPS and Medicaid RX disease categories.
HIV/AIDS	As defined by UC San Diego CDPS and Medicaid RX disease categories.
renal failure	As defined by UC San Diego CDPS and Medicaid RX disease categories.
chronic respiratory conditions	As defined by UC San Diego CDPS and Medicaid RX disease categories.

Name	Description
neurological disease	As defined by UC San Diego CDPS and Medicaid RX disease categories.
gastrointestinal	As defined by UC San Diego CDPS and Medicaid RX disease categories.

Specify the criteria for at risk of developing another chronic condition:

At-risk for a second condition is a minimum predictive risk score of 1.5, meaning a beneficiary's expected future medical expenditures is expected to be 50% greater than the base reference group (the Washington SSI-disabled population). The Washington risk score is based on the Chronic Illness & Disability Payment System (CDPS) and Medicaid-Rx risk groupers developed by Rick Kronick and Todd Gilmer at the University of California-San Diego, with risk weights normalized for the Washington Medicaid population. Diagnoses, prescriptions, age and gender indicated in a beneficiary's medical claims and eligibility history for the past 15 months (24 months for children) produce a risk score, with chronic conditions checked across all categorically needy populations, and a clinical indicator (Y=qualifies, N=does not qualify) is loaded into Washington's Medicaid Management System (MMIS).

Potentially eligible beneficiaries with insufficient claims history may be referred to the program by contacting HCA. A tool has been developed to manually calculate risk. This tool is on the Health Home website and distributed to the Lead Entities. Once a provider has determined a potentially beneficiary is eligible by manually calculating their risk, that information is sent to HCA for further analysis. If the beneficiary is eligible and not receiving other Medicaid care coordination services, they will be enrolled into a Health Home.

☐ One serious and persistent mental health condition

Health Homes Population and Enrollment Criteria

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Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home:

- ☐ Opt-In to Health Homes provider
- ☒ Referral and assignment to Health Homes provider with opt-out
- ☐ Other (describe)

Describe the process used:

The state identifies Fee-for-Service beneficiaries who are eligible for the Health Home program based on their chronic condition and risk score, then enrolls them into a Managed Fee-for-Service Lead Entity/Designated Provider. Enrollment is based on zip code, amount of available beneficiaries within each zip code, and capacity to provide Health Home services. The Lead Entity assigns Health Home beneficiaries to one of their network affiliated Care Coordination Organizations (CCO), who, in turn, assigns the beneficiary to a Care Coordinator. Beneficiaries have the ability to opt out of the assigned Health Home or change enrollment to another Health Home provider within the Health Home network. Eligible beneficiaries who opt out of participation and retain their 1.5 or higher risk score have the option of re-enrolling the Health Home program at any time by contacting HCA's customer service line.

Managed care beneficiaries are auto-enrolled into a Medicaid managed care organization (MCO). The state identifies MCO beneficiaries who are eligible for Health Homes based upon their chronic condition and risk score and sends the information to their MCO. MCOs that are qualified to be Lead Entities, assign their Health Home beneficiaries to one of their network-affiliated Care Coordination Organizations (CCOs), who, in turn, assign the beneficiary to a Care Coordinator. MCOs that are not qualified as a Lead Entity/designated provider must delegate Health Home services to a qualified Lead Entity and assign their eligible/identified beneficiaries to their delegated Lead Entity. The delegated Lead Entity, in turn, will assign the beneficiary to one of their network affiliated CCOs and a Care Coordinator. Beneficiaries have the ability to opt-out of the Health Home or change enrollment to another MCO or subcontracted Health Home CCO within the Health Home program.

Beneficiaries lose Health Home eligibility when their risk score drops below 1.0 for at least six continual months and they have not participated or engaged in the program during those months. Beneficiaries who actively participate and are engaged do not lose eligibility if their risk scores drops below 1.0.

- ☒ The state provides assurance that it will clearly communicate the individual's right to opt out of the Health Home benefit or to change Health Home providers at any time and agrees to submit to CMS a copy of any letter or communication used to inform the individual of the Health Home benefit and their rights to choose or change Health Home providers or to elect not to receive the benefit.

Name	Date Created	
Health Homes Client Notice Letter-2018	8/21/2018 4:56 PM EDT	
Your WA State HH Booklet 22-851	8/21/2018 4:56 PM EDT	

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | WA2018MS0006O | WA-18-0028 | Washington State Health Home Program

Package Header

Package ID	WA2018MS0006O	SPA ID	WA-18-0028
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Types of Health Homes Providers

☒ Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

- ☐ Physicians
- ☒ Clinical Practices or Clinical Group Practices

Describe the Provider Qualifications and Standards

1. HIPAA-compliant data systems for enrollment, collecting and reporting encounters to HCA
2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims
3. Experience operating broad-based regional provider networks
4. Contracts directly with the state as a Qualified Health Home
5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network
6. Subcontracts with community based CCOs to provide Health Home services
7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary or optimizes beneficiary choice
8. Maintains a list of CCOs and their assigned Health Home population
9. Monitors CCOs to ensure fidelity to the Health Home model
10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols.
11. Ensures person-centered and integrated Health Action Planning, which includes providing high-touch care management
12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator
13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA
14. Maintains an adequate network of Care Coordination Organizations
15. Employs Care Coordinators to supplement CCOs in areas where qualified Care Coordinators are hard to find

☒ Rural Health Clinics

Describe the Provider Qualifications and Standards

1. HIPAA-compliant data systems for enrollment, collecting and reporting encounters to HCA; 2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims
3. Experience operating broad-based regional provider networks
4. Contracts directly with the state as a Qualified Health Home
5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network
6. Subcontracts with community based CCOs to provide Health Home services
7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary or optimizes beneficiary choice
8. Maintains a list of CCOs and their assigned Health Home population
9. Monitors CCOs to ensure fidelity to the Health Home model
10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols

11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management
12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator
13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA
14. Maintains an adequate network of Care Coordination Organizations

☒ Community Health Centers

Describe the Provider Qualifications and Standards

1. HIPAA-compliant data systems for enrollment, collecting and reporting encounters to HCA
2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims
3. Experience operating broad-based regional provider networks
4. Contracts directly with the state as a Qualified Health Home
5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network
6. Subcontracts with community based CCOs to provide Health Home services
7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary or optimizes beneficiary choice.
8. Maintains a list of CCOs and their assigned Health Home population
9. Monitors CCOs to ensure fidelity to the Health Home model
10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols.
11. Ensures person-centered and integrated Health Action Planning which includes providing high-touch care management
12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator
13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA
14. Maintains an adequate network of Care Coordination Organizations

☒ Community Mental Health Centers

Describe the Provider Qualifications and Standards

1. HIPAA-compliant data systems for enrollment, collecting and reporting encounters to HCA
2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims
3. Experience operating broad-based regional provider networks
4. Contracts directly with the state as a Qualified Health Home;
5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network
6. Subcontracts with community based CCOs to provide Health Home services
7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary or optimizes beneficiary choice.
8. Maintains a list of CCOs and their assigned Health Home population
9. Monitors CCOs to ensure fidelity to the Health Home model
10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols.
11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management
12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator
13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA
14. Maintains an adequate network of Care Coordination Organizations
15. Employs Care Coordinators to supplement CCOs in areas where qualified Care Coordinators are hard to find

☐ Home Health Agencies

☒ Case Management Agencies

Describe the Provider Qualifications and Standards

1. HIPAA compliant data systems for enrollment, collecting and reporting encounters to HCA
2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims
3. Experience operating broad-based regional provider networks

4. Contracts directly with the state as a Qualified Health Home
5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network
6. Subcontracts with community based CCOs to provide Health Home services
7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary or optimizes beneficiary choice.
8. Maintains a list of CCOs and their assigned Health Home population
9. Monitors CCOs to ensure fidelity to the Health Home model
10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols.
11. Ensures person-centered and integrated Health Action Planning, which includes providing high touch care management
12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator
13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA
14. Maintains an adequate network of Care Coordination Organizations

☒ Community/Behavioral Health Agencies

Describe the Provider Qualifications and Standards

1. HIPAA-compliant data systems for enrollment, collecting and reporting encounters to HCA
2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims
3. Experience operating broad-based regional provider networks
4. Contracts directly with the state as a Qualified Health Home
5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network
6. Subcontracts with community based CCOs to provide Health Home services
7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary or optimizes beneficiary choice
8. Maintains a list of CCOs and their assigned Health Home population
9. Monitors CCOs to ensure fidelity to the Health Home mode;
10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols.
11. Ensures person-centered and integrated Health Action Planning which includes providing high-touch care management
12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator
13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA
14. Maintains an adequate network of Care Coordination Organizations

☒ Federally Qualified Health Centers (FQHC)

Describe the Provider Qualifications and Standards

1. HIPAA-compliant data systems for enrollment, collecting and reporting encounters to HCA
2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims
3. Experience operating broad-based regional provider networks
4. Contracts directly with the state as a Qualified Health Home
5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network
6. Subcontracts with community based CCOs to provide Health Home services
7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary or optimizes beneficiary choice
8. Maintains a list of CCOs and their assigned Health Home population
9. Monitors CCOs to ensure fidelity to the Health Home model
10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols.
11. Ensures person-centered and integrated Health Action Planning. This

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includes providing high-touch care management

12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator

13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA

14. Maintains an adequate network of Care Coordination Organizations

☒ Other (Specify)

Provider Type	Description
Substance Use Disorder Treatment providers	1. HIPAA-compliant data systems for enrollment, collecting and reporting encounters to HCA 2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims 3. Experience operating broad-based regional provider networks 4. Contracts directly with the state as a Qualified Health Home 5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network 6. Subcontracts with community based CCOs to provide Health Home services 7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary or optimizes beneficiary choice 8. Maintains a list of CCOs and their assigned Health Home population 9. Monitors CCOs to ensure fidelity to the Health Home model 10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols. 11. Ensures person-centered and integrated Health Action Planning which includes providing high touch care management 12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator 13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA 14. Maintains an adequate network of Care Coordination Organizations 15. Employs Care Coordinators to supplement CCOs in areas where qualified Care Coordinators are hard to find
Hospitals	1. HIPAA-compliant data systems for enrollment, collecting and reporting encounters to HCA 2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims 3. Experience operating broad-based regional provider networks 4. Contracts directly with the state as a Qualified Health Home 5. Has capacity to provide Health

Provider Type

Description

Home services to 300 to 500 or more beneficiaries within their Health Home network

6. Subcontracts with community based CCOs to provide Health Home services
7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary or optimizes beneficiary choice.
8. Maintains a list of CCOs and their assigned Health Home population
9. Monitors CCOs to ensure fidelity to the Health Home model
10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols.
11. Ensures person-centered and integrated Health Action Planning which includes providing high-touch care management;
12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator
13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA
14. Maintains an adequate network of Care Coordination Organizations
15. Employs Care Coordinators to supplement CCOs in areas where qualified Care Coordinators are hard to find

Behavioral Health Organizations

1. HIPAA-compliant data systems for enrollment, collecting and reporting encounters to HCA
2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims
3. Experience operating broad-based regional provider networks
4. Contracts directly with the state as a Qualified Health Home
5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network
6. Subcontracts with community based CCOs to provide Health Home services
7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process uses data

Provider Type	Description
	systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary or optimizes beneficiary choice. 8. Maintains a list of CCOs and their assigned Health Home population 9. Monitors CCOs to ensure fidelity to the Health Home model 10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols. 11. Ensures person-centered and integrated Health Action Planning which includes providing high-touch care management 12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator 13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA 14. Maintains an adequate network of Care Coordination Organizations 15. Employs Care Coordinators to supplement CCOs in areas where qualified Care Coordinators are hard to find.
Managed Care Organizations	1. HIPAA-compliant data systems for enrollment, collecting and reporting encounters to HCA 2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims 3. Experience operating broad-based regional provider networks 4. Contracts directly with the state as a Qualified Health Home 5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network 6. Subcontracts with community based CCOs to provide Health Home services 7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary or optimizes beneficiary choice 8. Maintains a list of CCOs and their assigned Health Home population 9. Monitors CCOs to ensure fidelity to the Health Home model 10. Maintains Memoranda of Agreement (MOA) with the

Provider Type	Description
	organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols. 11. Ensures person-centered and integrated Health Action Planning which includes providing high-touch care management 12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator 13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA 14. Maintains an adequate network of Care Coordination Organizations 15. Employs Care Coordinators to supplement CCOs in areas where qualified Care Coordinators are hard to find
Tribal Clinics	1. HIPAA-compliant data systems for enrollment, collecting and reporting encounters to HCA 2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims 3. Experience operating broad-based regional provider networks 4. Contracts directly with the state as a Qualified Health Home 5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network 6. Subcontracts with community based CCOs to provide Health Home services 7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary or optimizes beneficiary choice. 8. Maintains a list of CCOs and their assigned Health Home population 9. Monitors CCOs to ensure fidelity to the Health Home model 10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols. 11. Ensures person-centered and

Provider Type	Description
	integrated Health Action Planning which includes providing high-touch care management 12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator 13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA 14. Maintains an adequate network of Care Coordination Organizations 15. Employs Care Coordinators to supplement CCOs in areas where qualified Care Coordinators are hard to find

Health Homes Providers

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☒ Teams of Health Care Professionals

Indicate the composition of the Health Homes Teams of Health Care Professionals the state includes in its program. For each type of provider indicate the required qualifications and standards

- ☐ Physicians
- ☒ Nurse Practitioners

Describe the Provider Qualifications and Standards

- a. Licensed Practical Nurses (LPN) must successfully complete a commission-approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice, and must pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington before practicing.
- b. Registered Nurses (RN) must successfully complete a commission approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington before practicing.
- c. Advanced Registered Nurse Practitioners (ARNP) must have formal graduate education and obtain a national specialty certification as a nurse practitioner, nurse anesthetist or nurse midwife. ARNPs must hold a registered nurse license in Washington before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.
- d. A psychiatric advanced registered nurse practitioner is a person licensed as an advanced registered nurse practitioner and is board-certified in advanced practice psychiatric and mental health nursing.
- e. Psychiatric nurses are registered nurses with a Bachelor's degree from an accredited college or university, and have, 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.

☒ Nurse Care Coordinators

Describe the Provider Qualifications and Standards

- a. Licensed Practical Nurses (LPN) must successfully complete a commission-approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice, and must pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington before practicing.
- b. Registered Nurses (RN) must successfully complete a commission-approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington before practicing.
- c. Advanced Registered Nurse Practitioners (ARNP) must have formal graduate education and obtain a national specialty certification as a nurse practitioner, nurse anesthetist or nurse midwife. ARNPs must hold a registered nurse license in Washington before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.
- d. A psychiatric advanced registered nurse practitioner is a person licensed as an advanced registered nurse practitioner and is board-certified in advanced

practice psychiatric and mental health nursing.

e. Psychiatric nurses are registered nurses with a Bachelor's degree from an accredited college or university, and have, 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.

☐ Nutritionists

☒ Social Workers

Describe the Provider Qualifications and Standards

All social workers listed below must pass either the American Association of State Social Work Board's advanced or clinical examination for licensure. The Associate social workers listed below are not required to have supervised postgraduate experience prior to becoming an associate.

a. Licensed Independent Social Worker must graduate with an MA or PhD in social work and complete a minimum of 4000 hours of supervised experience or which 1000 hours must be direct client contact, over a three-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

b. Licensed Advanced Social Worker must graduate with an MA or PhD from a social work program and complete 3200 hours with supervision. At least 90 hours are direct supervision as specified by a licensed independent clinical social worker, a licensed advanced social worker, or an equally qualified licensed mental health professional. At least 40 hours must be in one-to-one supervision and 50 hours may be in one-to-one supervision or group supervision.

c. Licensed independent clinical social worker must graduate with an MA or PhD- level from a social work program accredited by the Council on Social Work Education and successfully complete a supervised experience of at least 4000 hours of experience, of which 1000 hours must be direct client contact, over a 3-year period, supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

d. Licensed social worker associate-independent clinical must graduate with an MA or PhD-level from a social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

e. Licensed social worker associate-advanced must graduate with an MA or PhD-level from a social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

☒ Behavioral Health Professionals

Describe the Provider Qualifications and Standards

a. Psychologists must have a doctoral degree from a regionally-accredited institution, with at least 40 semester hours or 60 quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, and supervised experience consisting at least two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).

b. Child psychiatrists must be licensed as physicians and surgeons, with graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board-eligible or board-certified in child psychiatry.

c. Licensed mental health counselors must graduate with an MA or PhD-level from an educational program in mental health counseling or a related discipline, and complete 36 months of supervised full-time counseling or 3000 hours of postgraduate mental health counseling under the supervision of a qualified licensed mental health counselor. Licensed mental health counselors must pass an examination administered by the National Board of Certified Counselors. Licensed mental health counselors are not required to have supervised postgraduate experience prior to becoming an associate.

d. Licensed marriage and family therapists must have either an MA or PhD in marriage and family therapy or an MA or PhD in behavioral science with equivalent course work from an approved school. Licensed marriage and family therapists must complete a minimum of 2 years of supervised full-time marriage and family therapy. For full licensure, a licensed marriage and family therapists must take and pass the Association of Marital and Family Therapy Regulatory Boards examination. Licensed marriage and family therapist associate applicants are not required to have supervised postgraduate experience prior to becoming an associate.

☒ Other (Specify)

Provider Type	Description
Chemical Dependency Professionals	Chemical Dependency Professionals (CDPs) must pass the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination. CDPs must complete 1,000 to 2,500 hours of supervised experience that includes clinical evaluation and face-to-face counseling, dependent upon the following: associate degree, baccalaureate degree, masters or doctoral degree, licensed as an advance registered nurse practitioner, marriage and family therapists, mental health counselors, advanced social workers, independent clinical social worker or licensed as a psychologist.
Physician Assistants	Physician Assistants (PA) must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited extent under the supervision of a physician. They must be academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services. PAs must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the National Commission of Certification of Physician Assistants (NCCPA) examination. Physician assistants must have 4 clock hours of AID education and an active DEA registration.
Allied or Affiliated staff	Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator.

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☐ Health Teams

Health Homes Providers

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Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

The delivery of Washington's Health Home service model is based on an multidisciplinary array of medical care, behavioral health care, and community-based social services and supports for children and adults who meet Washington's defined chronic conditions and risk criteria. The integration of primary care, behavioral health services, and long-term care services and supports are critical when improving health outcomes and reducing costs.

Qualifying the Health Home Lead Entities/Designated Providers ensures managed care organizations (MCOs), hospitals, Federally Qualified Health Centers (FQHC), Behavioral Health Organizations, Area Agencies on Aging, Community Mental Health Agencies, Substance Use Disorder Treatment Providers, Specialty Care and Primary Care Providers, and Tribal Clinics who may apply have the necessary skills and infrastructure to provide Health Home services.

Qualified Lead Entities, through their respective networks, provide intensive Health Home care coordination services to Medicaid and Medicare/Medicaid beneficiaries with chronic conditions to ensure that services delivered are integrated and coordinated across medical, mental health, substance use disorder and long-term care services and supports. Beneficiaries who are eligible for Health Homes may receive direct services from both HCA and DSHS, but the Health Home contracts are based in HCA.

Additionally, multidisciplinary and affiliated staff are recruited to support engagement and outreach, clinical decisions and evidenced-based care. Multidisciplinary team members may be composed of willing participants who provide direct service to the beneficiary and subject matter experts, such as primary care providers, mental health professionals, chemical dependency treatment providers, social workers, nutritionists/dieticians, direct care workers, pharmacists, peer specialists, community health navigators, family members or housing representatives.

The Health Home structure is built on the following hierarchy:

1. Designated Provider/Qualified Health Home Lead Entities – Healthcare systems, providers and authorizing entities with experience developing community based service provider network relationships, such as managed care organizations (MCOs), hospitals, Federally Qualified Health Centers (FQHCs), Behavioral Health Organizations, Area Agencies on Aging (AAAs), Community Mental Health Agencies, Substance Use Disorder Treatment providers, Specialty Care, Primary Care Providers and tribal clinics. The Lead Entities contract directly with the state and are responsible for service delivery model and administration of the Health Home. Lead Entities assign Health Home eligible beneficiaries into Care Coordination Organizations (CCOs), collect and submit encounters; disburse payment to network affiliated CCOs through the collection and submission of encounters, monitor quality, sub-contract, collect, analyze and report financial, and health status to objectively determine progress towards meeting overall Health Home goals. Some Lead Entities also verify address and phone information, and engage participants through telephonic contact to determine willingness to participate. Some Lead Entities may also serve as internal CCOs as a means of reaching rural areas of the state that may not have enough non-Lead CCOs to support capacity.
2. Network Affiliated Care Coordination Organizations (CCO) – Accountable for Care Coordination staffing and oversight of direct delivery of the six Health Home services. CCOs are responsible for implementing systematic processes and protocols to assure service delivery and beneficiary access to Care Coordinators and affiliated staff. CCOs may be managed care organizations, hospitals, Federally Qualified Health Centers (FQHC), Behavioral Health Organizations, Area Agencies on Aging, Community Mental Health Agencies, Substance Use Disorder Treatment providers, Home Health, Specialty providers, such as AIDS or ESRD clinics, Specialty and Primary Care Providers, and Tribal Clinics.
3. Care Coordinators – Operate under the direction of the Care Coordination Organizations by directly interacting with participating beneficiaries. Care Coordinators provide the six defined Health Home care coordination benefits in-person by actively engaging the beneficiary in developing a Health Action Plan (HAP); reinforcing the HAP and supporting the beneficiary to attain short and long-term goals; coordinating with authorizing and prescribing entities as necessary to reinforce and support the beneficiary's health action goals; advocating, educating and supporting the beneficiary to attain and improve self-management skills; ensuring the receipt of evidence-based care; supporting beneficiaries and families during discharge from hospital and institutional settings, including providing evidence-based transition planning; and accompanying the beneficiary to critical appointments when necessary. To better support beneficiary goals and ensure quality of care, they coordinate services with authorizing entities for which the beneficiary is receiving services assistance. A Health Home Care Coordinator must provide service in the community in which the beneficiary resides so services can be provided in-person whenever needed, unless the beneficiary requests to receive their services elsewhere. Health Home Care Coordinators serve eligible beneficiaries in the setting of their choice and may not establish policies that would restrict service because a beneficiary moves from one eligible setting to another.
4. Affiliated health care staff, such as community health workers, peer counselors or other non-clinical personnel provides administrative support for the Health Home Care Coordinator, such as mailing health promotion material, arranging for beneficiary transportation to appointments, and calling the beneficiary to facilitate face-to-face Health Home visits with the Care Coordinator. Some affiliated staff may provide more direct care coordination functions under the supervision of a Care Coordinator.
5. Additional network providers who have agreed to participate in the Health Home model through the use of memorandums of agreement, subcontracts, or operational agreements. For example, a clinic may agree to provide referrals to a Lead Entity, through the use of an operational agreement.

Supports for Health Homes Providers

Describe the methods by which the state will support providers of Health Homes services in addressing the following components

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines

3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

Description

The foundation of the Health Home program is the community-based Care Coordination Organization (CCO) network, subcontracted to Lead Entities. CCOs are a wide variety of medical, behavioral health and social service providers who provide Health Home services through contracted Care Coordinators. Because many Health Home beneficiaries have existing relationships with one or more providers, broad-based CCO networks enable a smart assignment process. For example, the clinic where the beneficiary has their primary care provider may be their CCO, or an Area Agency on Aging who supports the beneficiary with their long-term services and supports may be their CCO.

Each activity defined under the six Health Home services is built into Lead Entity contracts, ensuring that coordination of services, access to services, and person-centered care is delivered to the Health Home beneficiary. For example, the beneficiary is involved in improving their health through the development of their Health Action Plan (HAP). HAPs are shared with the beneficiary during development and when they are updated on a four-month cycle. Beneficiaries may include their families and caregivers as part of their support team and may authorize the release of the HAP to their family members, caregivers and providers. The HAP is both an electronic form and a paper form.

HCA and DSHS jointly sponsor training for Health Home service. Nursing staff developed core curriculum materials to support the provision of timely, comprehensive, high-quality services with a whole-person focus. DSHS offers technical assistance training for core skills relevant topics. Webinars, community network meetings and/or collaborative learning efforts continue to foster shared learning, information sharing and problem solving.

The state provides access to PRISM, a secure web-based clinical support tool showing the beneficiary's medical risk factors, demographics, eligibility, managed care status, housing, utilization of Medicaid and Medicare health services (including inpatient services, outpatient services, emergency department visits, filled prescriptions, mental health services, long term care services and supports, filled lab orders, and dental services), provider contact information, and long term care case manager assessments. This resource complements existing clinic-specific Electronic Health Records and provides the foundation for a continuous quality improvement program.

Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes providers are as follows

Qualified Health Home Lead Entities and their networks are developed to meet the needs of the populations they serve. Care coordination is necessary across numerous service domains and therefore may include many different disciplines. The state qualifies each Lead Entity, who is responsible for the integration and coordination of primary, acute, behavioral health (mental health and substance use disorder) and long-term services and supports for persons with chronic illness across the lifespan, through contractual/operational arrangements with appropriate providers. A Care Coordinator is the central point of contact working with the managed care or Fee-for-Service beneficiary to direct person-centered health action planning and implementation, and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable Emergency Department visits; providing timely post discharge follow-up, and improving beneficiary outcomes by addressing health care needs.

Washington qualifies the designated providers as Lead Entities through both a Request for Application (RFA) process and a contracting process. For the first two phases of implementation, Washington issued an RFA and qualified eight Lead Entities to provide Health Home services through their network of Care Coordination Organizations. For the last implementation phase of the program, HCA issued an RFA for any new organizations who wished to be Qualified Lead Entities in Coverage Area 2, which consists of Snohomish County with Island, San Juan, Skagit, and Whatcom counties and Coverage Area 3, which consists of King county. Previously Qualified Health Home Lead Entities may contract for Health Home services in Coverage Area 2 and 3 without responding to an RFA if they demonstrate network adequacy.

The following are minimum requirements to become a Qualified Health Home Lead Entity:

1. Applicant is a Medicaid provider in good standing, has the ability to serve at least 300 Health Home beneficiaries, has experience operating broad-based networks, agrees to serve the entire coverage area, assures a referral system is in place, documents beneficiary consent, subcontracts with CCOs, has the ability to coordinate care and services after critical events, such as emergency department use and hospital inpatient admission and discharge, language access and interpretation capabilities, can provide links to acute and outpatient medical, mental health and substance abuse services, and community-based social services;
2. Provider networks must include a wide-variety of community-based CCOs, such as Community Mental Health Agencies (CMHAs), Substance Use Disorder treatment providers, long-term services and support providers, FQHCs, and Community Health Centers;
3. Organizational infrastructure includes the ability to provide administrative functions, customer service staff, policies on process and timelines for bringing in additional CCOs to preserve integrity of face-to-face Health Home care coordination activities, ability to track Health Home beneficiaries to CCO assignment, collecting and submitting claims and encounters, payment disbursement, taking into account movement between payment levels and/or movement between CCOs, quality monitoring, subcontracting, collecting, analyzing and reporting financial, and health status. Ability to ensure hospitals have procedures in place for referring Health Home-eligible beneficiaries for enrollment if they are seeking or need treatment in a hospital emergency room;
4. Core Health Home requirements must be met, showing the ability to provide six Health Home care coordination functions and a guarantee of non-duplication of efforts that includes:
 - a. engagement and outreach
 - b. health action planning
 - c. self-management of chronic conditions

- d. setting short and long-term goals
- e. cultural competency
- f. motivational interviewing
- g. identification of services and gaps in services
- h. evidence-based interventions
- i. information-sharing with beneficiary's treating/authorizing entities
- j. establishment of multidisciplinary teams
- k. accompanying beneficiary to visits when requested
- l. arranging for priority appointments
- m. notification systems for transitional care
- n. follow-up on medication upon discharge and follow-up with pharmacy to get scripts filled
- o. helping the beneficiary access follow-up care and referrals
- p. optimizing social supports and family
- q. use of health information technology

Before contracts are awarded through the RFA process, HCA and DSHS conduct desk audits and on-site readiness reviews to ascertain readiness to provide Health Home services. Contracts will be offered only after the readiness reviews and after any identified deficiencies are mitigated through a corrective action plan. Before contracts are awarded to previously Qualified Lead Entities, HCA and DSHS will determine if their networks are adequate to provide Health Home services.

The period of performance for a Fee-for-Service Health Home contract is an initial two years. For managed care organizations who apply to become Lead Entities, the period of performance will be based upon their managed care contract. The program will be audited during annual contract compliance audits. Based upon results of the audit, the designated provider may be put on corrective action or have their qualification status terminated.

As the Health Home program matures, HCA and DSHS may allow other entities interested in applying to become a Qualified Health Home Lead Entity to submit a request to HCA and DSHS, at which point the process for contracting will take effect.

Name	Date Created	
No items available		

Health Homes Service Delivery Systems

MEDICAID | Medicaid State Plan | Health Homes | WA2018MS0006O | WA-18-0028 | Washington State Health Home Program

Package Header

Package ID	WA2018MS0006O	SPA ID	WA-18-0028
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Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

- ☒ Fee for Service
- ☐ PCCM
- ☒ Risk Based Managed Care

The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals

- ☒ Yes
- ☐ No

Provide a summary of the contract language that you will impose on the Health Plans in order to deliver the Health Homes services

Managed care contracts contain language to support the Health Home benefit for eligible beneficiaries. An MCO has two paths to choose from when providing those benefits. They may either become a qualified Health Home Lead Entity through the Request for Application process or they may provide their Health Home benefits through a delegation agreement with another qualified Health Home Lead Entity.

Contract language will contain:

1. Standards for the six Health Home services - Comprehensive Care Management, Care Coordination and Health Promotion, Transitional Care, Individual and Family Support, Referrals to the Community and Use of Health Information Technology
2. The use of clinical and non-clinical Care Coordinators and allied staff
3. Contracts, memorandums of agreement or operational agreements with hospitals for emergency department and hospitalization notification, including a referral process to refer beneficiaries to HCA for Health Home enrollment
4. Data security requirements
5. Standardized screening and assessments
6. Development of a Health Action Plan (HAP) through an in-person visit to promote self-management through the identification of the beneficiary's short and long-term goals
7. Encounter data reporting and documentation of delivered services to support encounters
8. The use of multidisciplinary care teams, that include the Care Coordinator, the beneficiary, and any other identified providers
9. Training requirements
10. Program Integrity
11. Grievances and Appeals processes
12. Access to the PRISM clinical decision support tool;
13. If the Health Home beneficiary is a Medicaid managed care enrollee, the MCO will share critical data with the Health Home Care Coordination Organization. Data may include institutional admissions and discharge readiness for transitional health care services management and facilitation, lapses in pharmaceutical payments that may indicate need for beneficiary outreach and education regarding medication use, lapses in pharmaceutical payments; and emergency department use that may suggest a need for a Care Coordinator visit or intervention to address the clinical and Health Action Plan goals.

The Apple Health MCO and IMC contracts are located online at https://www.hca.wa.gov/assets/billers-and-providers/model_contract_ahmc.pdf and the Managed Fee-for-Service (MFFS) Health Home contract at <https://www.hca.wa.gov/assets/billers-and-providers/FFScontract.pdf>

- ☒ The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.

Name	Date Created	
No items available		

Name	Date Created

The State intends to include the Health Home payments in the Health Plan capitation rate

- ☒ Yes
- ☐ No

- Assurances
- ☒ The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:

- Any program changes based on the inclusion of Health Homes services in the health plan benefits
 - Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)
 - Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)
 - Any risk adjustments made by plan that may be different than overall risk adjustments
 - How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM

☒ The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services

☒ The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found

☒ Other Service Delivery System

Describe if the providers in this other delivery system will be a designated provider or part of the Team of health care professionals and how payment will be delivered to these providers

In addition to the Managed Care Health Home delivery system, Washington also uses a Managed Fee-for-Service (MFFS) delivery system, which provides Health Home services through community-based Qualified Health Home Lead organizations. This service delivery system requires the Health Home Lead organization to pay for services to their subcontracted Care Coordination Organizations (CCOs) and report their claims payments to the state in the form of encounter data before receiving the monthly per member per month payment only for services rendered.

☒ The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.

Name	Date Created	
No items available		

Health Homes Payment Methodologies

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Payment Methodology

The State's Health Homes payment methodology will contain the following features

☒ Fee for Service

☐ Individual Rates Per Service

☒ Per Member, Per Month Rates

☒ Fee for Service Rates based on

☐ Severity of each individual's chronic conditions

☐ Capabilities of the team of health care professionals, designated provider, or health team

☒ Other

Describe below

The Managed Fee-for-Service (MFFS) system provides HH services via community-based HH Lead organizations which pay subcontracted Care Coordination Organizations & report their claims payments to as encounter data before receiving the monthly payment.

☐ Comprehensive Methodology Included in the Plan

☒ Incentive Payment Reimbursement

☒ Fee for Service Rates based on

☐ Severity of each individual's chronic conditions

☐ Capabilities of the team of health care professionals, designated provider, or health team

☒ Other

Describe below

In 2018, the Washington legislature approved an increase to the current rates established in July 2013 and added a 5% performance incentive payment in addition to the increase in rates. The state's actuary firm, Milliman, reviewed and developed the new rates to ensure the actual Health Home expenditure and cost trends support a composite rate increase of 20% for each tier level of service. The complete report on the cost data and assumptions used is available online at <https://www.hca.wa.gov/assets/billers-and-providers/HHCareCoordinationRateDevelopment.pdf>. As a result, the state implemented the new rates for each tier effective August 1, 2018, to include a 5% performance incentive payment based on increased beneficiary engagement rate. Monthly, HCA produces a report of the total number

of enrolled beneficiaries (Denominator) with the total number of encounter data (claims paid) accepted (Numerator) to determine the engagement rate of the Health Home Leads. The expectation is for the Health Home Lead to maintain at least 25% engagement of the enrolled beneficiaries per month per coverage area for the quarter in order to receive an additional 5% incentive payment above the total amount paid. The document with the specific Health Home rates, including administrative costs and the performance incentive payment is available online at <https://www.hca.wa.gov/assets/billers-and-providers/HHCareCoordinationRates.pdf>

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

Health Home (HH) rates were built for three levels of payment using a clinical and non-clinical staffing model combined with monthly service intensity. HH Lead entities pay for only one procedure code or service level encounter per beneficiary per month, regardless of the number of services the Health Home Care Coordinator provided to the beneficiary during the month. The procedure codes used to claim payment for the HH service level tiers are:

- Tier One – G9148
- Tier Two – G9149
- Tier Three – G9150

The three levels of payment are dependent upon the intensity of the service, determined by one-on-one, high-touch interactions with the beneficiary and/or caregiver. The initial care coordination (CC) stage (Tier One) encompasses three primary responsibilities: health screening and assessments, development of a person-centered health action plan for care management, and assessing the beneficiary for self-management and promoting self-management skills to improve functional or health status or prevent or slow declines in functioning. Tier One of the HH rate is a one-time payment and indicates the beneficiary is engaged in the program.

The second service level, Tier Two, is for providing Intensive, high-touch HH services. Once a month, the Care Coordination Organization (CCO) submits a claim for payment of the Tier Two procedure code or service level encounter. This rate includes face-to-face meetings with the beneficiary, pays for and signifies the documentation and intensive CC provided for the beneficiary, delivering at least one of the six defined health home services.

The third service level, Tier Three, is for Low-Level HH services to maintain the beneficiary's self-management skills and continued assessment of needs. Once per month, the CCO submits a claim for payment of the Tier Three procedure code or service level encounter. Payment for this service level includes documentation that HH services were provided to beneficiary either in person or by phone.

☐ PCCM (description included in Service Delivery section)

☐ Risk Based Managed Care (description included in Service Delivery section)

☒ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

☒ Tiered Rates based on

☐ Severity of each individual's chronic conditions

☐ Capabilities of the team of health care professionals, designated provider, or health team

☒ Other

Describe below

The Managed Fee-for-Service (MFFS) system provides HH services via community-based HH Lead organizations who pay subcontracted Care Coordination Organizations & report their claims payments to HCA as encounter data before receiving the monthly payment.

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

Provide a comprehensive description of the policies the state will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors

used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

Washington State Health Homes have designated three tiers that define the level of care coordination services provided:

1. Initial engagement and action planning = Tier One
2. Intensive level of care coordination = Tier Two
3. Low level of care coordination = Tier Three

The Tier Level of the client is intended to reflect the overall level of:

1. Engagement and activation level of the client and/or their caregivers
2. Activity in the Health Action Plan
3. Provision of at least one of the qualified Health Home Services
4. Frequency of contacts (face-to-face visits, phone calls, referrals, or care coordination).

Selecting the appropriate Tier should most closely reflect the above activities. Typically, the Tier will not change from month to month, between Tier Two and Tier Three but does change when the client and/or their caregivers consistently demonstrate an intensive or low level Health Home need. At least one of the six qualifying Health Home services must be provided within each Tier Level in order to bill and receive payment for the service.

Qualifying Health Home Services include:

- Comprehensive Care Management: The initial and ongoing assessment and care management services aimed at the integration of physical, behavioral health, long-term services and supports, and community services, using a detailed person-centered HAP which addresses all clinical and non-clinical needs.

Examples:

- o Conduct outreach and engagement activities
- o Develop the HAP setting client centered goals and action steps to achieve the goals
- o Complete comprehensive needs assessment such as the Patient Activation Measure (PAM) and other required assessments for the HAP
- o Prepare crisis intervention and resiliency plans
- o Support the client to live in the setting of their choice
- o Identify possible gaps in services and secure needed supports

- Care Coordination and Health Promotion: Facilitating access to, and monitoring of progress toward goals identified in the HAP to manage chronic conditions for optimal health and to promote wellness. Accomplished through face-to-face and collateral contacts with the client, family, caregivers, physical care, and other providers.

Examples:

- o Support to implement the HAP
- o Encourage and monitor progress towards individualized short and long term goals
- o Coordinate with service providers, case managers, and health plans
- o Conduct or participate in interdisciplinary teams
- o Assist and support the client with scheduling health appointments and accompany if needed
- o Communicate and consult with all providers and the client
- o Provide individualized educational materials according to the needs and goals of the client
- o Promote participation in community educational and support groups

- Comprehensive Transitional Care: The facilitation of services for the client, family, and caregivers when the client is transitioning between levels of care.

Examples:

- o Follow-up with hospitals/ED upon notification of admission or discharge
- o Provide post-discharge contact with client, family, and caregivers to ensure discharge orders are understood and acted upon
- o Assist with access to needed services or equipment and ensure it is received
- o Provide education to the client and providers that are located at the setting from which the person is transitioning
- o Communicate and coordinate with the client, family, caregivers, and providers to ensure smooth transitions to new settings
- o Ensure follow-up with Primary Care Provider (PCP)
- o Review and verify medication reconciliation post discharge is completed

- Individual and Family Supports: Coordination of information and services to support the client and their family or caregivers to maintain and promote quality of life, with particular focus on community living options.

Examples:

- o Provide education and support of self-advocacy including referral to Peer Support specialists
- o Identify and access resources to assist client and family supports in finding, retaining and improving self-management, socialization, and adaptive skills
- o Educate client, family or caregivers of advance directives, client rights, and health care issues
- o Communicate and share information with the client, family, and caregivers with appropriate consideration of language, activation level, literacy and cultural preferences

- Referral to Community and Social Supports: The provision of information and assistance for the purpose of referring the client and their family or caregivers to community based resources as needed.

Examples:

- o Identify, refer and facilitate access to relevant community and social services that support the client's HAP
- o Assist the client to apply for or maintain eligibility for health care services, disability benefits, housing, and legal services not provided through other case management systems
- o Monitor and follow-up with referral resources to ensure appointments and other activities were established and the client engaged in the services

- Use of Health Information Technology to link services: Determine level of service provided and update client health records and HAP according to the Health Home Qualified Lead required information systems.

Client movement between Tiers

Based on the needs and preferences of the client they may move between Tiers Two and Three; higher intensity to lower or lower intensity to higher.

Tier One:

* Minimum Contact:

>Contact is made with the client to arrange a face to face meeting to confirm the client's desire to participate in the Health Home Program.

>Care Coordinator visits the client to complete required assessments and develop the Health Action Plan (HAP) with client centered goals and action steps to achieve those goals.

* Activity Examples:

>Review PRISM and other available client records.

>Administer required screenings.

Administer optional screenings as needed.

>Together, the Care Coordinator and the client identify the client's health goals (long term and short term) and develop a Health Action Plan (HAP).

>Establish a follow up plan with the client.

>Submit Tier One Claim for payment with date of service when the HAP has been completed.

Tier Two - Intensive Health Home care coordination:

* Minimum Contact:

>At a minimum, Tier Two includes one face-to-face visit between the care coordinator and the client during the month in which qualifying health home services are provided.

>Exceptions can be approved to the monthly care coordinator's face-to-face visit by the Health Home Lead entity. A face-to-face visit with other service providers or allied staff directly related to the client's HAP goals and included in the action steps may be considered as an exception.

>Exceptions can be approved to monthly care coordinator's face-to-face visit by the Health Home Lead entity as long as there is documented evidence of other types of qualifying health home activities being provided.

>At least one qualifying Health Home service must be provided prior to submitting a Tier Two claim for payment.

* Activity Examples:

>Administration and follow up on clinical, functional, and resource use screenings.

>Continuity and coordination of care services through in-person visits, telephone calls, and team meetings, and the ability to accompany beneficiaries to health care provider appointments, as needed.

>Beneficiary assessments to determine readiness for self-management and promotion of self-management skills so the beneficiary is better able to engage with health and service providers.

>Health education and coaching designed to assist beneficiaries to increase self-management skills and improve health outcomes.

>Referrals and assessment of the use of peer supports, support groups and self-care/self-management programs.

>Medication reconciliation as part of care transitioning.

>Education and coaching of caregivers, family members, and other supports.

Tier Three - Low level Health Home care coordination:

* Minimum Contact:

>Low Level Health Home care coordination supports maintenance of the client's self-management skills with periodic home visits and/or telephone calls to reassess health care needs.

>The client expresses their preference to have fewer contacts or a lower level of engagement with the care coordinator.

>Contact may not occur every month depending on the HAP and the needs of the client.

>At least one qualifying Health Home Service must be provided prior to submitting a Tier Three claim for payment.

* Activity Examples:

>Monthly calls to the client to discuss success with maintaining health and/or behavioral changes. >Monthly call to check in on HAP progress and to identify new or changing goals.

>At Tier Three, the review of the HAP must occur at least every four months for progress towards goals, level of activation, and new or unidentified care opportunities.

The Health Care Authority publishes the Encounter Data Reporting Guide (EDRG) for MCOs, Health Home Lead Entities, and Behavioral Health Organizations. The EDRG describes the frequency of required encounter data submissions and includes the Health Home Managed Fee-for-Services (MFFS) payment process. The EDRG is available on-line at: <https://www.hca.wa.gov/assets/billers-and-providers/encounter-data-reporting-guide.pdf>

Health Homes Payment Methodologies

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Agency Rates

Describe the rates used

- ☐ FFS Rates included in plan
- ☐ Comprehensive methodology included in plan
- ☒ The agency rates are set as of the following date and are effective for services provided on or after that date

Effective Date

8/1/2018

Website where rates are displayed

<https://www.hca.wa.gov/assets/billers-and-providers/HHCareCoordinationRates.pdf>

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Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates;
2. Please identify the reimbursable unit(s) of service;
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit;
4. Please describe the state's standards and process required for service documentation, and;
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including:
 - the frequency with which the state will review the rates, and
 - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description In 2018, the Washington legislature approved an increase to the current rates established in July 2013 and added a 5% performance incentive payment in addition to the increase in rates. The state's actuary firm, Milliman, reviewed and developed the new rates to ensure the actual Health Home expenditure and cost trends support a composite rate increase of 20% for each tier level of service. The complete report on the cost data and assumptions used is available online at <https://www.hca.wa.gov/assets/billers-and-providers/HHCareCoordinationRateDevelopment.pdf>. As a result, the state implemented the new rates for each tier effective August 1, 2018, to include a 5% performance incentive payment based on increased beneficiary engagement rate. Monthly, HCA produces a report of the total number of enrolled beneficiaries (Denominator) with the total number of encounter data (claims paid) accepted (Numerator) to determine the engagement rate of the Health Home Leads. The expectation is for the Health Home Lead to maintain at least 25% engagement of the enrolled beneficiaries per month per coverage area for the quarter in order to receive an additional 5% incentive payment above the total amount paid. The document with the specific Health Home rates, including administrative costs and the performance incentive payment is available online at <https://www.hca.wa.gov/assets/billers-and-providers/HHCareCoordinationRates.pdf>.

2. Washington State has three payment tiers with specific HCPCS procedure codes that define the level of Health Home care coordination services provided. All three tiers have a mix of clinical and non-clinical staffing elements. The procedure code submitted for payment reflects the overall level of the beneficiary's:

- Engagement and activation level;
- Activity in the Health Action Plan;
- Provision of at least one of the six defined Health Home services; and
- Frequency of contacts (face-to-face visits, phone calls, referrals, or care coordination).

3. Tier One (G9148) is for initial engagement and health action planning. This is a one-time payment to initiate participation in the Health Home, conduct a face-to-face home visit, and complete the Health Action Plan (HAP). Development of the HAP may include family members, caregivers, and other social supports as appropriate.

Tier Two (G9149) is for on-going, face-to-face and telephonic visits with the beneficiary to provide one or more of the six Health Home services. Tier Two is paid once per month, per beneficiary. The minimum level for reimbursement is at least one face-to-face contact with the beneficiary during the month.

Tier Three (G9150) is low-level care coordination for beneficiaries who request less contact or face-to-face visits or have achieved a level of self-management for their chronic conditions and no longer need the intensive care coordination. Tier Three is paid once per month, per beneficiary only for months in which a Health Home service was provided.

4. Washington requires all Health Home Lead Entities to submit completed Health Action Plans (HAP) into a HAP database. The HAPs are reviewed against the Tier One claims to ensure that a payment has been made for a completed HAP. HAPs are updated every activity period, which consists of four months, or more frequently if there has been a change in circumstances, such as a hospital or Emergency Department visit. HAPs are also updated when short and long-term goals have been finalized and the beneficiary sets new goals. Washington requires all Health Home providers to document the Health Home services provided in their subcontracts with Care Coordination Organizations (CCOs). Annually, during the contract compliance reviews the state audits care management records and notes.

5. Reviewing and rebasing the rates for future updates will happen every three years or more frequently if cost trends warrant a more frequent adjustment. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers.

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | WA2018MS00060 | WA-18-0028 | Washington State Health Home Program

Package Header

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Assurances

- ☒ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.
- Describe below how non-duplication of payment will be achieved**

Case management provided under the state’s 1915(c) waivers are non-duplicative of Health Home services. The functions provided by 1915(c) case managers include determination of waiver eligibility, comprehensive assessment to determine unmet needs related to waiver services, service planning of services provided under the waiver, qualification of waiver providers, authorization of waiver services, and monitoring of service provision. This type of specialized case management for both individuals receiving long-term services and supports and individuals receiving developmental disabilities services will continue to be necessary for individuals served under waivers, and the Health Home program will not duplicate the functions provided by state and Area Agency on Aging (AAA) staff who perform these functions.

Health Homes will be responsible for review of claims and social service use history, health screening (e.g., screening for common mental health conditions associated with chronic illness such as depression, patient activation assessments), examination of current clinical conditions and treatment, and PRISM information. This assessment is used to identify care gaps, utilization patterns, where chronic care condition education and coaching may be most helpful and to assist the beneficiary in development and implementation of their Health Action Plan, including identification of self-care goals.

The Health Home will also be responsible for transitions, assessing beneficiaries at higher risk for re-institutionalization, assisting the beneficiary and their support network in gaining an understanding of discharge instructions and information, ensuring appropriate follow-up primary and specialty care and that medication reconciliation occurs, and assisting with referrals for additional services the beneficiary may need.

For Tribal PCCMs, the state will not allow an eligible Health Home enrollee to be enrolled in a Tribal PCCM and a Tribal Health Home at the same time. A Tribal member, if enrolled in a PCCM, must choose which method they wish to use for case management. If they decide to become enrolled in a Tribal Health Home, they must disenroll themselves from their Tribal PCCM.

Health Home enrollment is managed by the state and the ProviderOne enrollment and payment system which does not allow a tribal member to be enrolled in a Health Home and a PCCM at the same time.
- ☒ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).
- ☒ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.
- ☒ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
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Health Homes Services

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Package Header

Package ID	WA2018MS0006O	SPA ID	WA-18-0028
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Service Definitions

Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

Comprehensive Care Management

Definition

Care Coordinators deliver comprehensive care management, primarily in-person with periodic follow-up. Care management services include screening to assess gaps in care or establish baseline results, in-person visits to the beneficiary's home or location of their choice, and accompanying beneficiaries to health care provider appointments, as needed. Care Coordinators assess beneficiary readiness for self-management and promote self-management skills so the beneficiary is better able to engage with health and service providers and support the achievement of self-directed, individualized health goals to attain recovery, improve functional or health status or prevent or slow declines in functioning. Comprehensive care management service delivery uses the Health Action Plan (HAP) to document a beneficiary directed care management plan. The HAP is created during a face-to-face initial visit with the beneficiary, and is updated periodically on a four-month cycle, as well as when there are changes in beneficiary circumstances such as hospitalization or emergency department visits. The results of screenings and assessments are documented in the HAP and used to identify gaps in care and chart the beneficiary's progress towards meeting their short and long-term goals through active Health Home participation.

State approved clinical and functional screens identify depression, alcohol or substance use disorder, functional impairment, and pain appropriate to the age and risk profile of the individual. Screens support referrals to services when needed, e.g., referral for assessment of need for substance use disorder treatment, specialty care or long term services and supports. Other assessments that may supplement comprehensive care management are mental health treatment plans, substance use disorder treatment plans, and/or other pre-existing care plans, including assessment results.

Care Coordinators may conduct client outreach and engagement activities to assess on-going emerging needs and to promote continuity of care and improved health outcomes. This may also be done by allied or affiliated staff under the direction of the Care Coordinator.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All Health Home Lead Entities will have access to the Medicaid Management Information System called ProviderOne (P1) and the DSHS Predictive Risk Intelligence System (PRISM). Authorizers and providers of long-term services and supports have access to DSHS's Comprehensive Assessment and Reporting Evaluation (CARE) data either electronically or in paper form. Most elements of CARE are also contained in PRISM. Data sharing agreements and Release of Information consent forms will be maintained by all Health Home Lead Entities to facilitate sharing electronic health information with their Health Home network affiliates.

1. DSHS is responsible for maintenance and updates to PRISM and reporting loss of eligibility on a monthly basis.
2. ProviderOne contains Medicaid eligibility, loss of eligibility, MCO and Health Home enrollment, disenrollment, claims, per member per month (PMPM) payment to MCOs, MFFS payment for Health Home services made to community-based Health Home Lead organizations and the collection and reporting of encounter data.
3. Emergency Department Information Exchange (EDIE) notification provides Medicaid claims data to ED physicians. EDIE is HIPAA-compliant and can proactively alert care providers through a variety of methods such as fax, phone, email, or integration with a facility's current Electronic Medical Record (EMR), when high-utilizing patients enter the ED. Once notified, care providers can use EDIE to access care guidelines and crucial information on the patient from other participating facilities to better determine the patient's actual medical situation.
4. PreManage is the information exchange system that alerts Health Home providers when their beneficiary is admitted for inpatient hospital services.

Scope of service

The service can be provided by the following provider types

- ☒ Behavioral Health Professionals or Specialists

Description

- a. Psychologists must have a doctoral degree from a regionally-accredited institution, with at least 40 semester hours or 60 quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, and supervised experience consisting at least two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).
- b. Child psychiatrists must be licensed as physicians and surgeons, with graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board-eligible or board-certified in child psychiatry.
- c. Licensed mental health counselors must graduate with an MA or PhD-level from an educational program in mental health counseling or a related discipline, and complete 36 months of supervised full-time counseling or 3000 hours of postgraduate mental health counseling under the supervision of a qualified licensed mental health counselor. Licensed mental health counselors must pass an examination administered by the National Board of Certified Counselors. Licensed mental health counselors are not required to

- ☐ Nurse Practitioner
- ☒ Nurse Care Coordinators

- ☒ Nurses

- ☐ Medical Specialists
- ☐ Physicians
- ☒ Physician's Assistants

have supervised postgraduate experience prior to becoming an associate.

d. Licensed marriage and family therapists must have either an MA or PhD in marriage and family therapy or an MA or PhD in behavioral science with equivalent course work from an approved school. Licensed marriage and family therapists must complete a minimum of 2 years of supervised full-time marriage and family therapy. For full licensure, a licensed marriage and family therapists must take and pass the Association of Marital and Family Therapy Regulatory Boards examination. Licensed marriage and family therapist associate applicants are not required to have supervised postgraduate experience prior to becoming an associate.

Description

- a. Licensed Practical Nurses (LPN) must successfully complete a commission-approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice, and must pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington before practicing.
- b. Registered Nurses (RN) must successfully complete a commission-approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington before practicing.
- c. Advanced Registered Nurse Practitioners (ARNP) must have formal graduate education and obtain a national specialty certification as a nurse practitioner, nurse anesthetist or nurse midwife. ARNPs must hold a registered nurse license in Washington before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.
- d. A psychiatric advanced registered nurse practitioner is a person who is licensed as an advanced registered nurse practitioner and is also board-certified in advanced practice psychiatric and mental health nursing.
- e. Psychiatric nurses are registered nurses with a Bachelor's degree from an accredited college or university, and have, 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.

Description

- a. Licensed Practical Nurses (LPN) must successfully complete a commission-approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice, and must pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington before practicing.
- b. Registered Nurses (RN) must successfully complete a commission approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington before practicing.
- c. Advanced Registered Nurse Practitioners (ARNP) must have formal graduate education and obtain a national specialty certification as a nurse practitioner, nurse anesthetist or nurse midwife. ARNPs must hold a registered nurse license in Washington before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.
- d. A psychiatric advanced registered nurse practitioner is a person who is licensed as an advanced registered nurse practitioner and is also board-certified in advanced practice psychiatric and mental health nursing.
- e. Psychiatric nurses are registered nurses with a Bachelor's degree from an accredited college or university, and have, 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.

Description

Physician Assistants (PA) must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited extent under the supervision of a physician. They must be academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services. PAs must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the National Commission of Certification of Physician Assistants (NCCPA) examination. Physician assistants must have 4 clock hours of AID education and an active DEA registration.

- ☐ Pharmacists
- ☒ Social Workers

Description

All social workers listed below must pass either the American Association of State Social Work Board's advanced or clinical examination for licensure. The Associate social workers listed below are not required to have supervised postgraduate experience prior to becoming an associate.

- a. Licensed Independent Social Worker must graduate with an MA or PhD in social work and complete a minimum of 4000 hours of supervised experience or which 1000 hours must be direct client contact, over a three-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.
- b. Licensed Advanced Social Worker must graduate with an MA or PhD in a social work program and complete 3200 hours with supervision. At least 90 hours are direct supervision as specified by a licensed independent clinical social worker, a licensed advanced social worker, or an equally qualified licensed mental health professional. At least 40 hours must be in one-to-one supervision and 50 hours may be in one-to-one supervision or group supervision.
- c. Licensed independent clinical social worker must graduate with an MA or PhD-level from a social work program accredited by the Council on Social Work Education and successfully complete a supervised experience of at least 4000 hours of experience, of which 1000 hours must be direct client contact, over a 3-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.
- d. Licensed social worker associate-independent clinical must graduate with an MA or PhD-level from a social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.
- e. Licensed social worker associate-advanced must graduate with an MA or PhD-level from a social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
Chemical Dependency Professionals	Chemical Dependency Professionals (CDPs) must pass the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination. CDPs must complete 1,000 to 2,500 hours of supervised experience, dependent upon the following, associate degree, baccalaureate degree, masters or doctoral degree, licensed as an advance registered nurse practitioner, marriage and family therapists, mental health counselors, advanced social workers, independent clinical social worker or licensed as a psychologist, that include clinical evaluation and face-to-face counseling.
Indian Health Services (IHS)-Certified Community Health Representatives	The IHS-certified Community Health Representative (CHR) Program is a unique concept for providing health care, health promotion, and disease prevention services. CHRs must demonstrate how they assist and connect with the community, and their work has become essential to the spectrum of Tribal community-oriented primary health care services. CHRs come from the communities they serve and have tribal cultural competence.
Exception to Rule	Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an

Provider Type	Description exception to the policy. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills and knowledge and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and eligible for professional liability insurance as required by the hiring organization. The lead entity will provide HCA a letter of request for approval to hire a specific candidate. The letter will include the rationale for the potential care coordinator (i.e. any special skills or knowledge such as bicultural or bilingual), employee background and experience and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request: • Resume • Letters of recommendation • Educational transcripts • Documentation of courses, classes and trainings • Certifications • Licenses The state will review and score each Exception to Rule letter of request and documentation in the following areas: • Education • Experience • Skills/Knowledge • Letters of Recommendation The potential candidate must receive a score of at least 80% to qualify under the Exception to Rule
Allied or Affiliated Staff	Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator. Allied or affiliated staff may: 1. Contact the client to introduce Health Home benefits and schedule initial Care Coordinator face-to-face visit. 2. Conduct client outreach and engagement activities to assess on-going emerging needs and to promote continuity of care and improved health outcomes.

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | WA2018MS0006O | WA-18-0028 | Washington State Health Home Program

Package Header

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Care Coordination

Definition

The dedicated Health Home Care Coordinator and affiliated staff play a central and active role in development and execution of cross-system care coordination to assist the beneficiary to access and navigate needed services. The Care Coordinator assures communication is fostered between the providers of care, including the treating primary care provider and medical specialists and entities authorizing behavioral health and long-term services and supports. Care Coordination is the bridge between all the beneficiary's systems of care, including non-clinical support such as food, housing, and transportation.

When providing intensive care coordination to the beneficiary, the Care Coordinator caseload will be maintained at a level that ensures fidelity in providing required Health Home services, including interventions. Allied staff, such as community health workers, peer counselors or other non-clinical staff, may be used to facilitate the work of the assigned Health Home Care Coordinator.

Care coordination provides informed interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors impacting a beneficiary's health and health care choices. Care Coordinators and affiliated staff promote:

1. Optimal clinical outcomes, including a description of how progress toward outcomes will be measured through the Health Action Plan;
2. Outreach and engagement activities that support the beneficiary's participation in their care and promotes continuity of care;
3. Health education and coaching designed to assist beneficiaries to increase self-management skills and improve health outcomes; and
4. Use of peer supports, support groups and self-care programs to increase the beneficiary's knowledge about their health care conditions and improve adherence to prescribed treatment.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

PRISM is an information technology resource that supports the beneficiary and the Health Home Care Coordinator to identify the unmet needs, gaps in care, transitional support needs, clinical protocols required and current utilization of case management, medical and behavioral health services.

The Health Action Plan (HAP) may be shared, with beneficiary consent, via secure email or hard copy. The HAP includes:

1. Required and optional health screenings and assessments;
2. Beneficiary and Care Coordinator prioritized action items;
3. Beneficiary identified goals (short and long term);
4. Action steps for the beneficiary, the Health Home Care Coordinator and/or other direct service and medical providers; and
5. If the beneficiary has a personal care worker, action steps for them to support identified health action goals identified by the beneficiary.

The Health Home Care Coordinator updates and modifies the HAP on a four month cycle. The HAP is also updated and modified as needed to reflect:

1. A change in the beneficiary's condition;
2. New immediate goals to be addressed through the Health Home; and
3. Resolution of goals or action steps.

Scope of service

The service can be provided by the following provider types

- ☒ Behavioral Health Professionals or Specialists

Description

- a. Psychologists must have a doctoral degree from a regionally-accredited institution, with at least 40 semester hours or 60 quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, and supervised experience consisting at least two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).
- b. Child psychiatrists must be licensed as physicians and surgeons, with graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board-eligible or board-certified in child psychiatry.
- c. Licensed mental health counselors must graduate with an MA or PhD-level from an educational program in mental health counseling or a related discipline, and complete 36 months of supervised full-time counseling or 3000 hours of postgraduate mental health counseling under the supervision of a qualified licensed mental health counselor. Licensed mental health counselors must pass an examination administered by the National Board of Certified Counselors. Licensed mental health counselors are not required to have supervised postgraduate experience prior to becoming an associate.
- d. Licensed marriage and family therapists must have either an MA or PhD in marriage and family therapy or an MA or PhD in behavioral science with equivalent course work from an approved school. Licensed marriage and family therapists must complete a minimum of 2 years of supervised full-time

- ☐ Nurse Practitioner
- ☒ Nurse Care Coordinators

- ☒ Nurses

- ☐ Medical Specialists
- ☐ Physicians
- ☒ Physician's Assistants

marriage and family therapy. For full licensure, a licensed marriage and family therapists must take and pass the Association of Marital and Family Therapy Regulatory Boards examination. Licensed marriage and family therapist associate applicants are not required to have supervised postgraduate experience prior to becoming an associate.

Description

- a. Licensed Practical Nurses (LPN) must successfully complete a commission-approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice, and must pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington before practicing.
- b. Registered Nurses (RN) must successfully complete a commission-approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington before practicing.
- c. Advanced Registered Nurse Practitioners (ARNP) must have formal graduate education and obtain a national specialty certification as a nurse practitioner, nurse anesthetist or nurse midwife. ARNPs must hold a registered nurse license in Washington before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.
- d. A psychiatric advanced registered nurse practitioner is a person who is licensed as an advanced registered nurse practitioner and is also board-certified in advanced practice psychiatric and mental health nursing.
- e. Psychiatric nurses are registered nurses with a Bachelor's degree from an accredited college or university, and have, 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.

Description

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- c. Advanced Registered Nurse Practitioners (ARNP) must have formal graduate education and obtain a national specialty certification as a nurse practitioner, nurse anesthetist or nurse midwife. ARNPs must hold a registered nurse license in Washington before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.
- d. A psychiatric advanced registered nurse practitioner is a person who is licensed as an advanced registered nurse practitioner and is also board-certified in advanced practice psychiatric and mental health nursing.
- e. Psychiatric nurses are registered nurses with a Bachelor's degree from an accredited college or university, and have, 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.

Description

Physician Assistants (PA) must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited extent under the supervision of a physician. They must be academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services. PAs must have

graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the National Commission of Certification of Physician Assistants (NCCPA) examination. Physician assistants must have 4 clock hours of AID education and an active DEA registration.

- ☐ Pharmacists
- ☒ Social Workers

Description

All social workers listed below must pass either the American Association of State Social Work Board's advanced or clinical examination for licensure. The Associate social workers listed below are not required to have supervised postgraduate experience prior to becoming an associate.

- a. Licensed Independent Social Worker must graduate with a MA or PhD social work and complete a minimum of 4000 hours of supervised experience or which 1000 hours must be direct client contact, over a three-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.
- b. Licensed Advanced Social Worker must graduate with a MA or PhD social work program and complete 3200 hours with supervision. At least 90 hours are direct supervision as specified by a licensed independent clinical social worker, a licensed advanced social worker, or an equally qualified licensed mental health professional. At least 40 hours must be in one-to-one supervision and 50 hours may be in one-to-one supervision or group supervision.
- c. Licensed independent clinical social worker must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and successfully complete a supervised experience of at least 4000 hours of experience, of which 1000 hours must be direct client contact, over a 3-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.
- d. Licensed social worker associate-independent clinical must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.
- e. Licensed social worker associate-advanced must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
Allied or Affiliated Staff	Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator. Allied or Affiliated staff may: 1. Communicate with service providers and health plans as appropriate to secure necessary care and supports; 2. Link/refer client to needed services to support care plan/treatment goals, including medical/ behavioral health care; patient education, and self-help/recovery, medication adherence, health literacy, and self-management. 3. Advocate for services and assist with scheduling of needed services. 4. Assist and support client with scheduling medical and applicable appointments.
Exception to Rule	Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy/rule. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills, knowledge, and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and be eligible for professional liability insurance as required by the hiring organization. The lead entity will provide HCA a letter of request for approval to hire a specific candidate. The letter will include the rationale for the potential care

Provider Type	Description
Chemical Dependency Professionals	coordinator (e.g., any special skills or knowledge such as bicultural or bilingual), employee background and experience, and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request: • Resume • Letters of recommendation • Educational transcripts • Documentation of courses, classes and trainings • Certifications • Licenses The state will review and score each Exception to Rule letter of request and documentation in the following areas: • Education • Experience • Skills/Knowledge • Letters of Recommendation The potential candidate must receive a score of at least 80% to qualify under the Exception to Rule
Indian Health Services (IHS) Certified Community Health Representatives	Chemical Dependency Professionals (CDPs) must pass the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination. CDPs must complete 1,000 to 2,500 hours of supervised experience that includes clinical evaluation and face-to-face counseling, dependent upon the following: associate degree, baccalaureate degree, masters or doctoral degree, licensed as an advance registered nurse practitioner, marriage and family therapists, mental health counselors, advanced social workers, independent clinical social worker or licensed as a psychologist. The IHS certified Community Health Representative (CHR) Program is a unique concept for providing health care, health promotion, and disease prevention services. CHRs must demonstrate how they assist and connect with the community, and their work has become essential to the spectrum of Tribal community-oriented primary health care services. CHRs come from the communities they serve and have tribal cultural competence

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | WA2018MS0006O | WA-18-0028 | Washington State Health Home Program

Package Header

Package ID	WA2018MS0006O	SPA ID	WA-18-0028
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Health Promotion

Definition

Health promotion begins for Health Home beneficiaries with the commencement of the Health Action Plan (HAP). Each Health Home must demonstrate use of self-management, recovery and resiliency principles using beneficiary-identified supports including family members and caregivers that are paid or unpaid. The Health Home Care Coordinator will use the beneficiary's activation score and level to determine the coaching methodology appropriate for each beneficiary to be used when working with the beneficiary towards reaching their health goals. Educational materials are customized and introduced according to the beneficiary's readiness for change, progressing with the beneficiary's level of confidence and self-management abilities. Opportunities for mentoring and modeling communication with health care providers are provided through joint office visits and communications with health care providers by the beneficiary and the Health Home Care Coordinator. The Health Home provides wellness and prevention education specific to the beneficiary's chronic conditions, HAP, including assessment of need and facilitation of receipt of routine preventive care, support for improving social connections to community networks, and links to resources that support a healthier lifestyle. Linkages include but are not limited to resources for smoking prevention and cessation, substance use disorder treatment and prevention, nutritional counseling, obesity reduction and prevention, increasing physical activity, disease specific or chronic care management self-help resources, and other services, such as housing based on beneficiary needs and preferences.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Insignia Health is an information technology resource which provides calculation of the Patient Activation Measure (PAM)/Caregiver Activation Measures (CAM), Parent/Patient Activation Measure (PPAM) and the Coaching for Activation website. This site provides educational materials linked to a beneficiary's level of activation and can be sent electronically to a beneficiary or printed for review at a Health Home visit or by phone.

The Health Home Care Coordinator is able to view the medical claims, behavioral health claims, prescription claims, and LTC services utilization and selected CARE characteristics (for those beneficiaries with long-term services and supports) in PRISM so that education materials can be tailored to the individual's engagement and activation.

Scope of service

The service can be provided by the following provider types

☒ Behavioral Health Professionals or Specialists

Description

- a. Psychologists must have a doctoral degree from a regionally-accredited institution, with at least 40 semester hours or 60 quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, and supervised experience consisting at least two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).
- b. Child psychiatrists must be licensed as physicians and surgeons, with graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board-eligible or board-certified in child psychiatry.
- c. Licensed mental health counselors must graduate with a MA or PhD level educational program in mental health counseling or a related discipline, and complete 36 months of supervised full-time counseling or 3000 hours of postgraduate mental health counseling under the supervision of a qualified licensed mental health counselor. Licensed mental health counselors must pass an examination administered by the National Board of Certified Counselors. Licensed mental health counselors are not required to have supervised postgraduate experience prior to becoming an associate.
- d. Licensed marriage and family therapists must have either an MA or PhD in marriage and family therapy or an MA or PhD in behavioral science with equivalent course work from an approved school. Licensed marriage and family therapists must complete a minimum of 2 years of supervised full-time marriage and family therapy. For full licensure, a licensed marriage and family therapists must take and pass the Association of Marital and Family Therapy Regulatory Boards examination. Licensed marriage and family therapist associate applicants are not required to have supervised postgraduate experience prior to becoming an associate.

- ☐ Nurse Practitioner
- ☒ Nurse Care Coordinators

Description

- a. Licensed Practical Nurses (LPN) must successfully complete a commission-approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice, and must pass the official National

☒ Nurses

☐ Medical Specialists

☐ Physicians

☒ Physician's Assistants

☐ Pharmacists

☒ Social Workers

Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington before practicing.

b. Registered Nurses (RN) must successfully complete a commission approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington before practicing.

c. Advanced Registered Nurse Practitioners (ARNP) must have formal graduate education and obtain a national specialty certification as a nurse practitioner, nurse anesthetist or nurse midwife. ARNPs must hold a registered nurse license in Washington before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.

d. A psychiatric advanced registered nurse practitioner is a person who is licensed as an advanced registered nurse practitioner and is also board-certified in advanced practice psychiatric and mental health nursing.

e. Psychiatric nurses are registered nurses with a Bachelor's degree from an accredited college or university, and have, 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.

Description

a. Licensed Practical Nurses (LPN) must successfully complete a commission-approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice, and must pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington before practicing.

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Description

Physician Assistants (PA) must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited extent under the supervision of a physician. They must be academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services. PAs must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the National Commission of Certification of Physician Assistants (NCCPA) examination. Physician assistants must have 4 clock hours of AID education and an active DEA registration.

Description

All social workers listed below must pass either the American Association of State Social Work Board's advanced or clinical examination for licensure. The Associate Social Workers listed below are not required to have supervised

postgraduate experience prior to becoming an associate.

a. Licensed Independent Social Worker must graduate with an MA or PhD in social work and complete a minimum of 4000 hours of supervised experience or which 1000 hours must be direct client contact, over a three-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

b. Licensed Advanced Social Worker must graduate with an MA or PhD in a social work program and complete 3200 hours with supervision. At least 90 hours are direct supervision as specified by a licensed independent clinical social worker, a licensed advanced social worker, or an equally qualified licensed mental health professional. At least 40 hours must be in one-to-one supervision and 50 hours may be in one-to-one supervision or group supervision.

c. Licensed independent clinical social worker must graduate with an MA or PhD-level from a social work program accredited by the Council on Social Work Education and successfully complete a supervised experience of at least 4000 hours of experience, of which 1000 hours must be direct client contact, over a 3-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

d. Licensed social worker associate-independent clinical must graduate with an MA or PhD-level from a social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

e. Licensed social worker associate-advanced must graduate with an MA or PhD-level from a social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
Allied or Affiliated Staff	Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator. Allied or Affiliated staff may: 1. Provide customized educational materials according to the needs and goals of the client, caregiver, or other social supports as appropriate. 2. Promote participation in community educational and support groups. 3. Provide links to health care resources that support the client's goals. 4. Support the execution of cross-system care coordination activities that assist clients in accessing and navigating needed services. 5. Distribute health education and other materials. 6. Assist with follow up calls and provide appointment reminders.
Chemical Dependency Professionals	Chemical Dependency Professionals (CDPs) must pass the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination. CDPs must complete 1,000 to 2,500 hours of supervised experience, dependent upon the following, associate degree, baccalaureate degree, masters or doctoral degree, licensed as an advance registered nurse practitioner, marriage and family therapists, mental health counselors, advanced social workers, independent clinical social worker or licensed as a psychologist, that include clinical evaluation and face-to-face counseling.
Exception to Rule	Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy/rule. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills and knowledge and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and eligible for professional liability insurance as required by the hiring organization. The lead entity will provide HCA a letter of request for approval to hire a

Provider Type	Description
	specific candidate. The letter will include the rationale for the potential care coordinator (i.e. any special skills or knowledge such as bicultural or bilingual), employee background and experience and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request: • Resume • Letters of recommendation • Educational transcripts • Documentation of courses, classes and trainings • Certifications • Licenses The state will review and score each Exception to Rule letter of request and documentation in the following areas: • Education • Experience • Skills/Knowledge • Letters of Recommendation The potential candidate must receive a score of at least 80% to qualify under the Exception to Rule
Indian Health Services (IHS) Certified Community Health Representatives	The IHS certified Community Health Representative (CHR) Program is a unique concept for providing health care, health promotion, and disease prevention services. CHRs must demonstrate how they assist and connect with the community, and their work has become essential to the spectrum of Tribal community-oriented primary health care services. CHRs come from the communities they serve and have tribal cultural competence.

Health Homes Services

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Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

Comprehensive transitional care is provided to prevent beneficiary avoidable readmission after discharge from an inpatient facility to ensure proper and timely follow-up care.

The beneficiary's Health Action Plan (HAP) includes transitional care planning. Transitional care planning includes:

1. A notification system with managed care plans, hospitals, nursing homes and residential/rehabilitation facilities to provide the Health Home prompt communication of a beneficiary's admission and/or discharge from an emergency department, inpatient, nursing home or residential/rehabilitation and if proper permissions, a substance use disorder treatment setting. Progress notes or a case file documents the notification and the HAP should be updated with transition planning.
2. The use of a Health Home Care Coordinator as an active participant in all appropriate phases of care transition, including discharge planning visits during hospitalizations or nursing home stays following hospital/institutional discharge, conducted via home visits and telephone calls.
3. Beneficiary education addressing discharge care needs, including medication management, encouragement and intervention to assure follow-up appointments and self-management of their chronic or acute conditions, including information on when to seek medical care and emergency care. Involvement of family and formal or informal caregivers are facilitated when requested by the beneficiary.
4. A systematic follow-up protocol to assure timely access to follow-up care post discharge and to identify and re-engage beneficiaries that do not receive post-discharge care.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Emergency Department Information Exchange (EDIE) notifications provide Medicaid claims data to ED physicians. EDIE is HIPAA-compliant. EDIE can proactively alert care providers through a variety of methods such as fax, phone, email, or integration with facility's current electronic medical record when high utilizing beneficiaries enter the ED. Once notified, care providers can use EDIE to access care guidelines and crucial information on the beneficiary from other participating facilities to better determine the beneficiary's overall medical situation.

PreManage is information exchange system alerts providers when their beneficiary is accessing inpatient hospital services.

Lead FFS Entities with access to EDIE and Pre-Manage can push real-time information on ED visits and inpatient hospital stays to their Care Coordination Organizations.

Managed care Lead Entities notify Health Home Care Coordinators of beneficiary admission to hospital and tertiary care facilities to facilitate discharge planning and care transitions. MCO Lead Entities also inform the Health Home Care Coordinators of lapses in pharmacy refills for beneficiaries with chronic conditions requiring long-term use of medications. Health Home Care Coordinators are responsible for conducting outreach activities with the beneficiary to ensure medications have been picked up and are being used according to the clinical treatment plan.

Scope of service

The service can be provided by the following provider types

- ☒ Behavioral Health Professionals or Specialists

Description

- a. Psychologists must have a doctoral degree from a regionally-accredited institution, with at least 40 semester hours or 60 quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, and supervised experience consisting at least two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).
- b. Child psychiatrists must be licensed as physicians and surgeons, with graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board-eligible or board-certified in child psychiatry.
- c. Licensed mental health counselors must graduate with an MA or PhD-level from an educational program in mental health counseling or a related discipline, and complete 36 months of supervised full-time counseling or 3000 hours of postgraduate mental health counseling under the supervision of a qualified licensed mental health counselor. Licensed mental health counselors must pass an examination administered by the National Board of Certified Counselors. Licensed mental health counselors are not required to have supervised postgraduate experience prior to becoming an associate.
- d. Licensed marriage and family therapists must have either an MA or PhD

- ☐ Nurse Practitioner
- ☒ Nurse Care Coordinators

- ☒ Nurses

- ☐ Medical Specialists
- ☐ Physicians
- ☒ Physician's Assistants

in marriage and family therapy or an MA or PhD in behavioral science with equivalent course work from an approved school. Licensed marriage and family therapists must complete a minimum of 2 years of supervised full-time marriage and family therapy. For full licensure, a licensed marriage and family therapists must take and pass the Association of Marital and Family Therapy Regulatory Boards examination. Licensed marriage and family therapist associate applicants are not required to have supervised postgraduate experience prior to becoming an associate.

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- b. Registered Nurses (RN) must successfully complete a commission approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington before practicing.
- c. Advanced Registered Nurse Practitioners (ARNP) must have formal graduate education and obtain a national specialty certification as a nurse practitioner, nurse anesthetist or nurse midwife. ARNPs must hold a registered nurse license in Washington before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.
- d. A psychiatric advanced registered nurse practitioner is a person who is licensed as an advanced registered nurse practitioner and is also board-certified in advanced practice psychiatric and mental health nursing.
- e. Psychiatric nurses are registered nurses with a Bachelor's degree from an accredited college or university, and have, 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.

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Description

Physician Assistants (PA) must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited

- ☐ Pharmacists
- ☒ Social Workers

extent under the supervision of a physician. They must be academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services. PAs must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the National Commission of Certification of Physician Assistants (NCCPA) examination. Physician assistants must have 4 clock hours of AID education and an active DEA registration.

Description

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- d. Licensed social worker associate-independent clinical must graduate with an MA or PhD-level from a social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.
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- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dietitians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
Chemical Dependency Professionals	Chemical Dependency Professionals (CDPs) must pass the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination. CDPs must complete 1,000 to 2,500 hours of supervised experience, dependent upon the following, associate degree, baccalaureate degree, masters or doctoral degree, licensed as an advance registered nurse practitioner, marriage and family therapists, mental health counselors, advanced social workers, independent clinical social worker or licensed as a psychologist, that include clinical evaluation and face-to-face counseling.
Exception to Rule	Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills and knowledge and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and eligible for professional liability insurance as required by the hiring organization. The lead entity will provide HCA a letter of request for approval to hire a

Provider Type	Description
Allied or Affiliated Staff	specific candidate. The letter will include the rationale for the potential care coordinator (i.e. any special skills or knowledge such as bicultural or bilingual), employee background and experience and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request: • Resume • Letters of recommendation • Educational transcripts • Documentation of courses, classes and trainings • Certifications • Licenses The state will review and score each Exception to Rule letter of request and documentation in the following areas: • Education • Experience • Skills/Knowledge • Letters of Recommendation The potential candidate must receive a score of at least 80% to qualify under the Exception to Rule
Indian Health Services (IHS) Certified Community Health Representatives	Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator. Allied or Affiliated staff may: 1. Support client with connecting to community supports to ensure that needed services or equipment are received.

Health Homes Services

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Individual and Family Support (which includes authorized representatives)

Definition

The Health Home Care Coordinator recognizes the unique roles the beneficiary may assign to family, identified decision makers and caregivers in assisting them with accessing and navigating health care and social service delivery systems, as well as support health action planning.

The Health Home Care Coordinator uses peer supports, support groups, and self-management programs to increase beneficiary and caregivers' knowledge of the beneficiary's chronic conditions, promote the beneficiary's engagement and self-management capabilities, and help the beneficiary improve adherence to their prescribed treatment.

The Health Home Care Coordinator, affiliated staff, and the beneficiary:

1. Identify the role that families, informal supports and paid caregivers provide to achieve self-management and optimal levels of physical and cognitive function;
2. Educate and support self-management, self-help recovery, and other resources necessary for the beneficiary, their family, and their caregivers to support the beneficiary's individualized health action goals;
3. Discuss advance directives with beneficiaries and their families; and
4. Communicate and share information with beneficiaries and their families and other caregivers with appropriate consideration of language, activation level, literacy and cultural preferences.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The PRISM software application includes the PRISM Health Report for all beneficiaries. The PRISM report is provided to the beneficiary's primary care provider and any other health care providers identified by the beneficiary and authorized by a signed release of information. This includes the Health Home Care Coordinator. The report includes:

1. Beneficiary demographics
2. Last dental appointment
3. Health conditions
4. Hospital stays
5. Emergency room visits
6. Office visits and procedures in the last 180 days, used by the Care Coordinator to assess sufficient clinical oversight of the beneficiary's chronic conditions
7. Prescriptions filled in the last 90 days
8. Prescriptions by drug class in last two years

Coaching for Activation educational materials are available electronically and are printed for beneficiary and family support.

Scope of service

The service can be provided by the following provider types

- ☒ Behavioral Health Professionals or Specialists

Description

- a. Psychologists must have a doctoral degree from a regionally-accredited institution, with at least 40 semester hours or 60 quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, and supervised experience consisting at least two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).
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- d. Licensed marriage and family therapists must have either an MA or PhD in marriage and family therapy or an MA or PhD in behavioral science with equivalent course work from an approved school. Licensed marriage and family therapists must complete a minimum of 2 years of supervised full-time marriage and family therapy. For full licensure, a licensed marriage and family therapists must take and pass the Association of Marital and Family Therapy

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a. Licensed Independent Social Worker must graduate with an MA or PhD in social work and complete a minimum of 4000 hours of supervised experience or which 1000 hours must be direct client contact, over a three-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

b. Licensed Advanced Social Worker must graduate with an MA or PhD from a social work program and complete 3200 hours with supervision. At least 90 hours are direct supervision as specified by a licensed independent clinical social worker, a licensed advanced social worker, or an equally qualified licensed mental health professional. At least 40 hours must be in one-to-one supervision and 50 hours may be in one-to-one supervision or group supervision.

c. Licensed independent clinical social worker must graduate with an MA or PhD-level from a social work program accredited by the Council on Social Work Education and successfully complete a supervised experience of at least 4000 hours of experience, of which 1000 hours must be direct client contact, over a 3-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

d. Licensed social worker associate-independent clinical must graduate with an MA or PhD-level from a social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

e. Licensed social worker associate-advanced must graduate with an MA or PhD-level from a social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
Exception to Rule	Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills and knowledge and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and eligible for professional liability insurance as required by the hiring organization. The lead entity will provide HCA a letter of request for approval to hire a specific candidate. The letter will include the rationale for the potential care coordinator (i.e. any special skills or knowledge such as bicultural or bilingual), employee background and experience and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request: • Resume • Letters of recommendation • Educational transcripts • Documentation of courses, classes and trainings • Certifications • Licenses The state will review and score each Exception to Rule letter of request and documentation in the following areas: • Education • Experience • Skills/Knowledge

Provider Type	Description
Allied or Affiliated Staff	Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator. Allied or Affiliated staff may: 1. Educate client, family, or caregiver advance directives, client rights, and health care issues, as needed. 2. Meet with client and family, inviting any other providers to facilitate needed interpretation services. 3. Refer client/family to peer supports, support groups, social services, entitlement programs as needed.
Chemical Dependency Professionals	Chemical Dependency Professionals (CDPs) must pass the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination. CDPs must complete 1,000 to 2,500 hours of supervised experience, dependent upon the following, associate degree, baccalaureate degree, masters or doctoral degree, licensed as an advance registered nurse practitioner, marriage and family therapists, mental health counselors, advanced social workers, independent clinical social worker or licensed as a psychologist, that include clinical evaluation and face-to-face counseling.
Indian Health Services (IHS) Certified Community Health Representatives	The IHS certified Community Health Representative (CHR) Program is a unique concept for providing health care, health promotion, and disease prevention services. CHRs must demonstrate how they assist and connect with the community, and their work has become essential to the spectrum of Tribal community-oriented primary health care services. CHRs come from the communities they serve and have tribal cultural competence.

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | WA2018MS0006O | WA-18-0028 | Washington State Health Home Program

Package Header

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Referral to Community and Social Support Services

Definition

The Health Home Care Coordinator and affiliated staff identify available community based resources, actively manage referrals, assist the beneficiary in advocating for access to care, and engage with community and social supports related to goal achievement documented in the Health Action Plan. When needed and not otherwise provided through other case management systems, the Health Home Care Coordinator provides assistance in obtaining and maintaining eligibility for health care services, disability benefits, housing, personal needs and legal services. These services will be coordinated with appropriate local, state and federal governments and community based organizations. Referral to community and social support services includes long-term services and supports, mental health, substance use disorder and other community and social services support providers needed to support the beneficiary in support of health action goals.

The Health Home Care Coordinator documents referrals to and access by the beneficiary of community- based and other social support services.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

PRISM and Insignia Health are information technology sources supporting the beneficiary and the Health Home Care Coordinator to identify the unmet needs, gaps in care, transitional support needs, clinical protocols required and current utilization of case management, medical and behavioral health services.

Scope of service

The service can be provided by the following provider types

☒ Behavioral Health Professionals or Specialists

Description

- a. Psychologists must have a doctoral degree from a regionally-accredited institution, with at least 40 semester hours or 60 quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, and supervised experience consisting at least two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).
- b. Child psychiatrists must be licensed as physicians and surgeons, with graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board-eligible or board-certified in child psychiatry.
- c. Licensed mental health counselors must graduate with an MA or PhD-level from an educational program in mental health counseling or a related discipline, and complete 36 months of supervised full-time counseling or 3000 hours of postgraduate mental health counseling under the supervision of a qualified licensed mental health counselor. Licensed mental health counselors must pass an examination administered by the National Board of Certified Counselors. Licensed mental health counselors are not required to have supervised postgraduate experience prior to becoming an associate.
- d. Licensed marriage and family therapists must have either an MA or PhD in marriage and family therapy or an MA or PhD in behavioral science with equivalent course work from an approved school. Licensed marriage and family therapists must complete a minimum of 2 years of supervised full-time marriage and family therapy. For full licensure, a licensed marriage and family therapists must take and pass the Association of Marital and Family Therapy Regulatory Boards examination. Licensed marriage and family therapist associate applicants are not required to have supervised postgraduate experience prior to becoming an associate.

☐ Nurse Practitioner

☒ Nurse Care Coordinators

Description

- 1. Licensed Practical Nurses (LPN) must successfully complete a commission approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice and pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington State before practicing.
- 2. Registered Nurses (RN) RNs must successfully complete a commission approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National

☒ Nurses

☐ Medical Specialists

☐ Physicians

☒ Physician's Assistants

☐ Pharmacists

☒ Social Workers

Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington State before practicing.

3. Advanced registered Nurse Practitioners (ARNP) must have formal graduate education and achieve a national specialty certification for the nurse practitioner, nurse anesthetist or nurse midwife role. ARNPs must hold a registered nurse license in Washington State before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.

4. Psychiatric advanced registered nurse practitioner" means a person who is licensed as an advanced registered nurse practitioner; and who is board certified in advanced practice psychiatric and mental health nursing.

5. Psychiatric nurses are registered nurses with a bachelor's degree from an accredited college or university, and have, 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.

Description

1. Licensed Practical Nurses (LPN) must successfully complete a commission approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice and pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington State before practicing.

2. Registered Nurses (RN) RNs must successfully complete a commission approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington State before practicing.

3. Advanced registered Nurse Practitioners (ARNP) must have formal graduate education and achieve a national specialty certification for the nurse practitioner, nurse anesthetist or nurse midwife role. ARNPs must hold a registered nurse license in Washington State before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.

4. Psychiatric advanced registered nurse practitioner" means a person who is licensed as an advanced registered nurse practitioner; and who is board certified in advanced practice psychiatric and mental health nursing.

5. Psychiatric nurses are registered nurses with a bachelor's degree from an accredited college or university, and have, 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.

Description

Physician Assistants (PA) must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited extent under the supervision of a physician. They must be academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services. PAs must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the National Commission of Certification of Physician Assistants (NCCPA) examination. Physician assistants must have 4 clock hours of AID education and an active DEA registration.

Description

All social workers listed below must pass either the American Association of State Social Work Board's advanced or clinical examination for licensure. The Associate Social Workers listed below are not required to have supervised postgraduate experience prior to becoming an associate.

a. Licensed Independent Social Worker must graduate with an MA or PhD in social work and complete a minimum of 4000 hours of supervised experience or which 1000 hours must be direct client contact, over a three-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

b. Licensed Advanced Social Worker must graduate with an MA or PhD from

a social work program and complete 3200 hours with supervision. At least 90 hours are direct supervision as specified by a licensed independent clinical social worker, a licensed advanced social worker, or an equally qualified licensed mental health professional. At least 40 hours must be in one-to-one supervision and 50 hours may be in one-to-one supervision or group supervision.

c. Licensed independent clinical social worker must graduate with an MA or PhD-level from a social work program accredited by the Council on Social Work Education and successfully complete a supervised experience of at least 4000 hours of experience, of which 1000 hours must be direct client contact, over a 3-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

d. Licensed social worker associate-independent clinical must graduate with an MA or PhD-level from a social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

e. Licensed social worker associate-advanced must graduate with an MA or PhD-level from a social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
Chemical Dependency Professionals	Chemical Dependency Professionals (CDPs) must pass the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination. CDPs must complete 1,000 to 2,500 hours of supervised experience, dependent upon the following, associate degree, baccalaureate degree, masters or doctoral degree, licensed as an advance registered nurse practitioner, marriage and family therapists, mental health counselors, advanced social workers, independent clinical social worker or licensed as a psychologist, that include clinical evaluation and face-to-face counseling.
Exception to Rule	Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy/rule. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills and knowledge and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and eligible for professional liability insurance as required by the hiring organization. The lead entity will provide HCA a letter of request for approval to hire a specific candidate. The letter will include the rationale for the potential care coordinator (i.e. any special skills or knowledge such as bicultural or bilingual), employee background and experience and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request: • Resume • Letters of recommendation • Educational transcripts • Documentation of courses, classes and trainings • Certifications • Licenses The state will review and score each Exception to Rule letter of request and documentation in the following areas: • Education • Experience • Skills/Knowledge • Letters of Recommendation The potential candidate must receive a score of at least 80% to qualify under the Exception to Rule

Provider Type	Description
Allied or Affiliated Staff	Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator. Allied or Affiliated staff may: 1. Identify, refer and facilitate access to relevant community and social support services that support the client's health action goals. 2. Assist client to apply for or maintain eligibility for health care services, disability benefits, housing, and legal services not provided through other case management systems. 3. Provide general information about upcoming community events.
Indian Health Services (IHS) Certified Community Health Representative	The IHS certified Community Health Representative (CHR) Program is a unique concept for providing health care, health promotion, and disease prevention services. CHRs must demonstrate how they assist and connect with the community, and their work has become essential to the spectrum of Tribal community-oriented primary health care services. CHRs come from the communities they serve and have tribal cultural competence.

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | WA2018MS0006O | WA-18-0028 | Washington State Health Home Program

Package Header

Package ID	WA2018MS0006O	SPA ID	WA-18-0028
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	User-Entered		

Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

Enrollment flow is dependent upon 1) whether the beneficiary is enrolled with a Managed Care Lead Entity, or 2) is not enrolled in managed care and is receiving their medical benefits in the FFS delivery system. Almost all Washington's Medicaid Health Home beneficiaries are enrolled in managed care. Those that remain in the FFS delivery system either reside in a voluntary managed care county, are a full-dual eligible, or have self-identified as American Indian/Alaska Native.

All Health Home beneficiaries, regardless of whether they receive their Medicaid benefits in managed care or in FFS, have the same eligibility criteria - one or more chronic conditions from the chronic condition list and meet the state's definition of "at risk for another."

Enrollment starts with the identification of eligibility and assignment of a clinical indicator (Y=qualifies). The indicator is loaded into ProviderOne.

1. FFS beneficiaries with "Y"clinical indicators are enrolled into one of the qualified FFS Health Home Lead Entities in the geographic region in which they reside. Health Home outreach and education information is generated automatically and sent to the beneficiary by mail. The Health Home Lead Entity receives notification of the enrollment via HIPAA 834 files and assigns the beneficiary to one of their local Health Home Care Coordination Organizations (CCOs).
2. Managed care organizations have their eligible Health Home beneficiaries identified with a "Y" clinical indicator and receive notification of eligibility via HIPAA 834 files. The MCO assigns the beneficiary to one of their local Health Home Care Coordination Organizations (CCOs). The MCO is responsible for making sure the enrollee is notified of their eligibility to receive Health Home services.
3. Any health care provider may refer beneficiaries to the Health Home program. An example is a local emergency room department who has agreed with the Health Home Lead Entity to refer potentially eligible participants to the program.

Engagement consists of the assigned CCO placing beneficiaries with a Care Coordinator, who contacts the beneficiary to offer Health Home services. Once the beneficiary has agreed to participate in a Health Home, the Care Coordinator prepopulates the Health Action Plan with PRISM claims utilization details and arranges for an in-person visit. PRISM provides episode information related to specific diagnoses or pharmacy utilization, inpatient and outpatient claims, emergency room visits, mental health claims, substance use disorder treatment claims, pharmacy claims, and long-term care assessment data.

During the home visit, the Care Coordinator:

1. Conducts the required and when needed optional brief screening;
2. Evaluates the beneficiary's support system;
3. Completes a Consent for Release of Information;
4. Administers and scores the 13-question Patient Activation (PAM) or Caregiver Activation Measure (CAM) or Parent/Patient Activation Measure (PPAM); and
5. Develops the Health Action Plan (HAP) with the beneficiary, who will work with the CCO to identify immediate and long-term goals, prioritize concerns and establish action steps.

Name	Date Created	
HH Enrollment Procedure 22-09-01 E	8/21/2018 5:02 PM EDT	
HH Beneficiary flow 06 0624	8/21/2018 5:02 PM EDT	
Update 070117 HH CC Qualification Exception worksheet	8/21/2018 5:02 PM EDT	
Guidelines-for-HH-staff	8/21/2018 5:02 PM EDT	

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | WA2018MS0006O | WA-18-0028 | Washington State Health Home Program

Package Header

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User-Entered			

Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates:

The state will calculate regional, risk-adjusted, per member per month expenses in the target population in the baseline (FY2011), apply trend factors and estimate a projected per member per month figure. Cost savings will be calculated as the difference between actual and projected risk adjusted per member/per month expenditures. Cost savings for dual eligibles will be determined by CMS.

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

The state integrates Fee-for-Service claims data, managed care encounter data, beneficiary eligibility, enrollment and claims data for medical, pharmacy, mental health, substance use disorder, long-term services and supports, and Medicaid and dual eligible Medicare covered services in a secure web-based clinical decision support tool called PRISM. PRISM also pulls from other clinical assessment data within the state such as CARE. The state uses PRISM to support the beneficiary and the Health Home Care Coordinator to identify the unmet needs, gaps in care, clinical protocols required and current utilization of case management, medical and behavioral health services. Use of these tools enables the Health Home Care Coordinator to better coordinate care and ensure that the beneficiary's complex needs are met, and will assist the state in monitoring cost and utilization data to ensure program goals are met.

The state has developed Health Information Technology (HIT) through OneHealthPort (OHP), who HCA contracts with to consult on maintaining a statewide Health Information Exchange (HIE). HCA is developing the Medicaid Health Profile clinical data repository, with clinical data passed through OneHealthPort HIE using the Continuity of Care Document (CCD) and the Admit/ Discharge/Transfer Document (ADT) transaction sets. Updates to the Medicaid clinical data repository to refine or to correct identified data collection errors occur whenever a need is identified.

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | WA2018MS0006O | WA-18-0028 | Washington State Health Home Program

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Quality Measurement and Evaluation

- ☒ The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state.
- ☒ The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.
- ☒ The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.
- ☒ The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report.

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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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WA - Submission Package - WA2020MS0002O - (WA-20-0031) - Health Homes

Summary Reviewable Units Versions Correspondence Log Approval Letter News Related Actions

CMS-10434 OMB 0938-1188

Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | WA2020MS0002O | WA-20-0031 | Washington State Health Home Program

Package Header

Package ID	WA2020MS0002O	SPA ID	WA-20-0031
Submission Type	Official	Initial Submission Date	9/30/2020
Approval Date	11/20/2020	Effective Date	7/1/2020
Superseded SPA ID	WA-18-0028		
	User-Entered		

Program Authority

1945 of the Social Security Act
The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

Washington State Health Home Program

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

Washington’s original Health Homes SPAs were WA 13-0008 (approved June 28, 2013) and WA 13-17 (approved December 11, 2013). WA 15-0011 (approved June 11, 2015) superseded both of these SPAs. SPA 16-006 (approved March 31, 2017) superseded 15-0011, added a 20% performance incentive payment to increase beneficiary engagement rates, and expanded the Health Home program statewide, adding King and Snohomish counties. SPA WA 18-0028 supersedes WA 16-0026, adds a 20% rate increase, and reduces the performance incentive payment to 5%. SPA WA 20-0031 supersedes WA 18-0028: This SPA adds updated payment methodology based on actuarial analysis completed in June 2020 and will end the incentive payment December 31, 2020. These changes are being requested during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof). The revised rate methodology is different than what is otherwise applied under the Medicaid state plan for use during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof) and is time limited to no later than the termination of the national public health emergency, including any extensions. The state will work with CMS to revert back to the rate methodology used prior to the national public health emergency as circumstances allow. Washington State requests an effective date of July 1, 2020, for these changes. The termination date for the rate methodology will be determined by the end of the emergency declaration, including any potential extensions, while the incentive payment will expire on December 31, 2020 (before the end of the national public health emergency).

Under Washington’s approach, Health Homes are the bridge to integrate care within existing delivery systems for both managed care and Fee-for-Service beneficiaries. Washington’s Medicaid delivery systems are undergoing a great deal of change as the Health Care Authority (HCA) integrates physical and behavioral health services through its managed care program. As HCA phases in statewide integration, Washington’s Health Home program will become more managed care focused while continuing to serve beneficiaries who remain in the Fee-for-Service delivery system, such as full-dual eligibles and American Indian/Alaska Natives.

Washington has three high level goals to assess the effectiveness of its Health Home program: 1) Building care coordination capacity in all areas of the state; 2) Improve the beneficiary’s self-management abilities; and 3) Reduce future cost trends or at the very least attain cost neutrality with improved outcomes.

The Health Home program is designed as the central point for directing person-centered care through one-on-one interactions between the Health Home Care Coordinators and their assigned beneficiaries. Beneficiaries are identified as having one or more of the chronic conditions on the chronic condition list and at risk for a 2nd chronic condition using a tool that identifies those clients expected to have high costs in the future due to all their chronic conditions .

The Department of Social and Health Services (DSHS) generates and submits a list of eligible Health Homes beneficiaries to HCA, who enrolls them into a Managed Fee for Service Health Home Lead Entity (designated provider) or notifies the Managed Care Organization (designated provider) that one of their enrollees is eligible for Health Home services with a Health Home indicator on the 834 file. Lead Entities are permitted to provide Health Home services internally but must also subcontract with a wide-range of community-based Care Coordination Organizations (CCOs) to effectively manage the full breadth of beneficiary needs, increasing Washington’s capacity to provide statewide Health Home services, especially in rural areas of the state.

Lead Entities are qualified by HCA and DSHS through both a contracting process and

General Assurances

☒ The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.

- ☒ The state provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- ☒ The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- ☒ The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- ☒ The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- ☒ The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | WA2020MS0002O | WA-20-0031 | Washington State Health Home Program

Package Header

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Payment Methodology

The State's Health Homes payment methodology will contain the following features

☒ Fee for Service

☐ Individual Rates Per Service

☒ Per Member, Per Month Rates

☒ Fee for Service Rates based on

☐ Severity of each individual's chronic conditions

☐ Capabilities of the team of health care professionals, designated provider, or health team

☒ Other

Describe below

The Managed Fee-for-Service (MFFS) system provides HH services via community-based HH Lead organizations which pay subcontracted Care Coordination Organizations & report their claims payments to as encounter data before receiving the monthly payment.

☐ Comprehensive Methodology Included in the Plan

☒ Incentive Payment Reimbursement

☒ Fee for Service Rates based on

☐ Severity of each individual's chronic conditions

☐ Capabilities of the team of health care professionals, designated provider, or health team

☒ Other

Describe below

The Washington state legislature approved a second rate increase for the Health Home program in 2020. Through analysis rates were developed based on actual costs of the program. Based on the actuarial analysis, a 26% aggregate rate increase is required to adequately fund the continuation of the Health Home program. The increase included two components:

- 20% increase required to align the rates with CY 2019 expenditures.
- 3.5% annual unit cost trend used to trend rates 1.5 years from CY 2019 to SFY 2021 based on a review of inflation indicators, historical and projected Medicare trends, and trends per capita GDP.

Rates were redistributed among the tiers to realign payment rates with estimated cost allocations. The complete report on cost data and assumptions used is available online at

<https://hca.wa.gov/assets/billers-and-providers/HHCareCoordinationRates.pdf>.

As a result, the state implemented new rates for each tier effective July 1, 2020. These rates are being requested during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof). The revised rate methodology is different than what is otherwise applied under the Medicaid state plan for use during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof) and is time limited to no later than the termination of the national public health emergency, including any extensions.

The 5% incentive payment established in August 2018 will continue through December 31, 2020. Lead Organizations will continue to be eligible to receive the incentive payment through December 2020 for meeting an engagement standard.

To receive the incentive payment each quarter, HCA produces a report of the total number of enrolled beneficiaries (denominator) with the total number of accepted encounters (numerator) to determine the engagement rate of the Health Home Leads. In order to receive the 5% incentive payment in addition to the regular encounter payments, Leads must meet the engagement rate.

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

Health Home (HH) rates were built for three levels of payment using a clinical and non-clinical staffing model combined with monthly service intensity. HH Lead entities pay for only one procedure code or service level encounter per beneficiary per month, regardless of the number of services the Health Home Care Coordinator provided to the beneficiary during the month. The procedure codes used to claim payment for the HH service level tiers are:

- Tier One – G9148
- Tier Two – G9149
- Tier Three – G9150

The three levels of payment are dependent upon the intensity of the service, determined by one-on-one, high-touch interactions with the beneficiary and/or caregiver. The initial care coordination (CC) stage (Tier One) encompasses three primary responsibilities: health screening and assessments, development of a person-centered health action plan for care management, and assessing the beneficiary for self-management and promoting self-management skills to improve functional or health status or prevent or slow declines in functioning. Tier One of the HH rate is a one-time payment and indicates the beneficiary is engaged in the program.

The second service level, Tier Two, is for providing Intensive, high-touch HH services. Once a month, the Care Coordination Organization (CCO) submits a claim for payment of the Tier Two procedure code or service level encounter. This rate includes face-to-face meetings with the beneficiary, pays for and signifies the documentation and intensive CC provided for the beneficiary, delivering at least one of the six defined health home services.

The third service level, Tier Three, is for Low-Level HH services to maintain the beneficiary's self-management skills and continued assessment of needs. Once per month, the CCO submits a claim for payment of the Tier Three procedure code or service level encounter. Payment for this service level includes documentation that HH services were provided to beneficiary either in person or by phone.

☐ PCCM (description included in Service Delivery section)

☐ Risk Based Managed Care (description included in Service Delivery section)

☒ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

☒ Tiered Rates based on

☐ Severity of each individual's chronic conditions

☐ Capabilities of the team of health care professionals, designated provider, or health team

☒ Other

Describe below

The Managed Fee-for-Service (MFFS) system provides HH services via

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

community-based HH Lead organizations who pay subcontracted Care Coordination Organizations & report their claims payments to HCA as encounter data before receiving the monthly payment.

Variations in payment is based on the level of care coordination provided, as noted in the tiers.

Tier 1 (G9148) - initial engagement and action planning
Tier 2 (G9149) - intensive level of care coordination
Tier 3 (G9159) - low level of care coordination

Provide a comprehensive description of the policies the state will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

Washington State Health Homes have designated three tiers that define the level of care coordination services provided:

1. Initial engagement and action planning = Tier One
2. Intensive level of care coordination = Tier Two
3. Low level of care coordination = Tier Three

The Tier Level of the client is intended to reflect the overall level of:

1. Engagement and activation level of the client and/or their caregivers
2. Activity in the Health Action Plan
3. Provision of at least one of the qualified Health Home Services
4. Frequency of contacts (face-to-face visits, phone calls, referrals, or care coordination).

Selecting the appropriate Tier should most closely reflect the above activities. Typically, the Tier will not change from month to month, between Tier Two and Tier Three but does change when the client and/or their caregivers consistently demonstrate an intensive or low level Health Home need. At least one of the six qualifying Health Home services must be provided within each Tier Level in order to bill and receive payment for the service.

Qualifying Health Home Services include:

- Comprehensive Care Management: The initial and ongoing assessment and care management services aimed at the integration of physical, behavioral health, long-term services and supports, and community services, using a detailed person-centered HAP which addresses all clinical and non-clinical needs.

Examples:

- o Conduct outreach and engagement activities
- o Develop the HAP setting client centered goals and action steps to achieve the goals
- o Complete comprehensive needs assessment such as the Patient Activation Measure (PAM) and other required assessments for the HAP
- o Prepare crisis intervention and resiliency plans
- o Support the client to live in the setting of their choice
- o Identify possible gaps in services and secure needed supports

- Care Coordination and Health Promotion: Facilitating access to, and monitoring of progress toward goals identified in the HAP to manage chronic conditions for optimal health and to promote wellness. Accomplished through face-to-face and collateral contacts with the client, family, caregivers, physical care, and other providers.

Examples:

- o Support to implement the HAP
- o Encourage and monitor progress towards individualized short and long term goals
- o Coordinate with service providers, case managers, and health plans
- o Conduct or participate in interdisciplinary teams
- o Assist and support the client with scheduling health appointments and accompany if needed
- o Communicate and consult with all providers and the client
- o Provide individualized educational materials according to the needs and

goals of the client

- o Promote participation in community educational and support groups

- Comprehensive Transitional Care: The facilitation of services for the client, family, and caregivers when the client is transitioning between levels of care.

Examples:

- o Follow-up with hospitals/ED upon notification of admission or discharge
- o Provide post-discharge contact with client, family, and caregivers to ensure discharge orders are understood and acted upon
- o Assist with access to needed services or equipment and ensure it is received
- o Provide education to the client and providers that are located at the setting from which the person is transitioning
- o Communicate and coordinate with the client, family, caregivers, and providers to ensure smooth transitions to new settings
- o Ensure follow-up with Primary Care Provider (PCP)
- o Review and verify medication reconciliation post discharge is completed

- Individual and Family Supports: Coordination of information and services to support the client and their family or caregivers to maintain and promote quality of life, with particular focus on community living options.

Examples:

- o Provide education and support of self-advocacy including referral to Peer Support specialists
- o Identify and access resources to assist client and family supports in finding, retaining and improving self-management, socialization, and adaptive skills
- o Educate client, family or caregivers of advance directives, client rights, and health care issues
- o Communicate and share information with the client, family, and caregivers with appropriate consideration of language, activation level, literacy and cultural preferences

- Referral to Community and Social Supports: The provision of information and assistance for the purpose of referring the client and their family or caregivers to community based resources as needed.

Examples:

- o Identify, refer and facilitate access to relevant community and social services that support the client's HAP
- o Assist the client to apply for or maintain eligibility for health care services, disability benefits, housing, and legal services not provided through other case management systems
- o Monitor and follow-up with referral resources to ensure appointments and other activities were established and the client engaged in the services

- Use of Health Information Technology to link services: Determine level of service provided and update client health records and HAP according to the Health Home Qualified Lead required information systems.

Client movement between Tiers

Based on the needs and preferences of the client they may move between Tiers Two and Three; higher intensity to lower or lower intensity to higher.

Tier One:

* Minimum Contact:

>Contact is made with the client to arrange a face to face meeting to confirm the client's desire to participate in the Health Home Program.

>Care Coordinator visits the client to complete required assessments and develop the Health Action Plan (HAP) with client centered goals and action steps to achieve those goals.

* Activity Examples:

>Review PRISM and other available client records.

>Administer required screenings.

Administer optional screenings as needed.

>Together, the Care Coordinator and the client identify the client's health goals (long term and short term) and develop a Health Action Plan (HAP).

>Establish a follow up plan with the client.

>Submit Tier One Claim for payment with date of service when the HAP has been completed.

Tier Two - Intensive Health Home care coordination:

* Minimum Contact:

>At a minimum, Tier Two includes one face-to-face visit between the care coordinator and the client during the month in which qualifying health home services are provided.

>Exceptions can be approved to the monthly care coordinator's face-to-face

visit by the Health Home Lead entity. A face-to-face visit with other service providers or allied staff directly related to the client's HAP goals and included in the action steps may be considered as an exception.

>Exceptions can be approved to monthly care coordinator's face-to-face visit by the Health Home Lead entity as long as there is documented evidence of other types of qualifying health home activities being provided.

>At least one qualifying Health Home service must be provided prior to submitting a Tier Two claim for payment.

* Activity Examples:

>Administration and follow up on clinical, functional, and resource use screenings.

>Continuity and coordination of care services through in-person visits, telephone calls, and team meetings, and the ability to accompany beneficiaries to health care provider appointments, as needed.

>Beneficiary assessments to determine readiness for self-management and promotion of self-management skills so the beneficiary is better able to engage with health and service providers.

>Health education and coaching designed to assist beneficiaries to increase self-management skills and improve health outcomes.

>Referrals and assessment of the use of peer supports, support groups and self-care/self-management programs.

>Medication reconciliation as part of care transitioning.

>Education and coaching of caregivers, family members, and other supports.

Tier Three - Low level Health Home care coordination:

* Minimum Contact:

>Low Level Health Home care coordination supports maintenance of the client's self-management skills with periodic home visits and/or telephone calls to reassess health care needs.

>The client expresses their preference to have fewer contacts or a lower level of engagement with the care coordinator.

>Contact may not occur every month depending on the HAP and the needs of the client.

>At least one qualifying Health Home Service must be provided prior to submitting a Tier Three claim for payment.

* Activity Examples:

>Monthly calls to the client to discuss success with maintaining health and/or behavioral changes. >Monthly call to check in on HAP progress and to identify new or changing goals.

>At Tier Three, the review of the HAP must occur at least every four months for progress towards goals, level of activation, and new or unidentified care opportunities.

The Health Care Authority publishes the Encounter Data Reporting Guide (EDRG) for MCOs, Health Home Lead Entities, and Behavioral Health Organizations. The EDRG describes the frequency of required encounter data submissions and includes the Health Home Managed Fee-for-Services (MFFS) payment process. The EDRG is available on-line at: <https://www.hca.wa.gov/assets/billers-and-providers/encounter-data-reporting-guide.pdf>

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | WA2020MS00020 | WA-20-0031 | Washington State Health Home Program

Package Header

Package ID	WA2020MS00020	SPA ID	WA-20-0031
Submission Type	Official	Initial Submission Date	9/30/2020
Approval Date	11/20/2020	Effective Date	7/1/2020
Superseded SPA ID	WA-18-0028		
	User-Entered		

Agency Rates

Describe the rates used

- ☐ FFS Rates included in plan
- ☐ Comprehensive methodology included in plan
- ☒ The agency rates are set as of the following date and are effective for services provided on or after that date

Effective Date

7/1/2020

Website where rates are displayed

<https://www.hca.wa.gov/assets/billers-and-providers/HHCareCoordinationRates.pdf>

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Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates;
2. Please identify the reimbursable unit(s) of service;
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit;
4. Please describe the state's standards and process required for service documentation, and;
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including:
 - the frequency with which the state will review the rates, and
 - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description

1. The Washington state legislature approved a second rate increase for the Health Home program in 2020. Through analysis rates were developed based on actual costs of the program. Based on the actuarial analysis, a 26% aggregate rate increase is required to adequately fund the continuation of the Health Home program. The increase included two components:

- 20% increase required to align the rates with CY 2019 expenditures.
- 3.5% annual unit cost trend used to trend rates 1.5 years from CY 2019 to SFY 2021 based on a review of inflation indicators, historical and projected Medicare trends, and trends per capita GDP.

Rates are redistributed among the tiers to realign payment rates with estimated cost allocations. The complete report on cost data and assumptions used is available online at <https://hca.wa.gov/assets/billers-and-providers/HHCareCoordinationRates.pdf>.

As a result, the state implemented new rates for each tier effective July 1, 2020. These rates are being requested during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof). The revised rate methodology is different than what is otherwise applied under the Medicaid state plan for use during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof) and is time limited to no later than the termination of the national public health emergency, including any extensions.

The 5% incentive payment established in August 2018 will continue through December 31, 2020. Lead Organizations will continue to be eligible to receive the incentive payment through December 2020 for meeting an engagement standard. To receive the incentive payment each quarter, HCA produces a report of the total number of enrolled beneficiaries (denominator) with the total number of accepted encounters (numerator) to determine the engagement rate of the Health Home Leads. In order to receive the 5% incentive payment in addition to the regular encounter payments, Leads must meet the engagement rate.

Washington State has three payment tiers with specific HCPCS procedure codes defining the level of Health Home care coordination service provided. All three tiers have a combination of clinical and non-clinical staffing elements. The procedure code submitted for payment reflects the overall level of the beneficiary's engagement and activation level; activity in the Health Action Plan; provision of at least one of the six defined Health Home services; and frequency of contacts.

Tier One (G9148) is for initial engagement and health action planning. This is a one-time payment to initiate participation in the Health Home, conduct a face-to-face home visit, and complete the Health Action Plan (HAP). Development of the HAP may include family members, caregivers, and other social supports as appropriate.

Tier Two (G9149) is for on-going, face-to-face and telephonic visits by exception with the beneficiary to provide one or more of the six Health Home services.

Tier Three (G9150) is low level care coordination for beneficiaries who request less contact or fewer face-to-face visits or have achieved a level of self-management their chronic conditions where intensive care coordination is no longer needed. Tier One is paid once in a beneficiary's lifetime in the program and is submitted once the initial Health Action Plan is completed. Tiers Two and Three are submitted subsequent months after the Tier One and only one encounter (tier) is accepted per beneficiary per month.

2. Washington requires all Health Home Lead Entities to submit completed Health Action Plans (HAP) into a HAP database. HAPs are reviewed against Tier One encounters to ensure payment has been made for a completed HAP. HAPs are updated every activity period, which consists of four months or more frequently if there has been a change in circumstances. HAPs are also updated when short and long-term goals have been completed and the beneficiary sets new goals.

Washington requires all Health Home providers to document the Health Home services provided in their subcontracts with Care Coordination Organizations (CCOs). Annually, during contract compliance reviews, the state audits HAPs, care management records, and notes.

3. Rates are reviewed and rebased for future updates every three years or more frequently if cost trends warrant a more frequent adjustment. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers.

Health Homes Payment Methodologies

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Assurances

- ☒ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.
- Describe below how non-duplication of payment will be achieved**

Case management provided under the state’s 1915(c) waivers are non-duplicative of Health Home services. The functions provided by 1915(c) case managers include determination of waiver eligibility, comprehensive assessment to determine unmet needs related to waiver services, service planning of services provided under the waiver, qualification of waiver providers, authorization of waiver services, and monitoring of service provision. This type of specialized case management for both individuals receiving long-term services and supports and individuals receiving developmental disabilities services will continue to be necessary for individuals served under waivers, and the Health Home program will not duplicate the functions provided by state and Area Agency on Aging (AAA) staff who perform these functions.

Health Homes will be responsible for review of claims and social service use history, health screening (e.g., screening for common mental health conditions associated with chronic illness such as depression, patient activation assessments), examination of current clinical conditions and treatment, and PRISM information. This assessment is used to identify care gaps, utilization patterns, where chronic care condition education and coaching may be most helpful and to assist the beneficiary in development and implementation of their Health Action Plan, including identification of self-care goals.

The Health Home will also be responsible for transitions, assessing beneficiaries at higher risk for re-institutionalization, assisting the beneficiary and their support network in gaining an understanding of discharge instructions and information, ensuring appropriate follow-up primary and specialty care and that medication reconciliation occurs, and assisting with referrals for additional services the beneficiary may need.

For Tribal PCCMs, the state will not allow an eligible Health Home enrollee to be enrolled in a Tribal PCCM and a Tribal Health Home at the same time. A Tribal member, if enrolled in a PCCM, must choose which method they wish to use for case management. If they decide to become enrolled in a Tribal Health Home, they must disenroll themselves from their Tribal PCCM.

Health Home enrollment is managed by the state and the ProviderOne enrollment and payment system which does not allow a tribal member to be enrolled in a Health Home and a PCCM at the same time.
- ☒ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).
- ☒ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.
- ☒ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
No items available		

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WA - Submission Package - WA2023MS0004O - (WA-23-0027) - Health Homes

Summary Reviewable Units Versions Correspondence Log Approval Letter News Related Actions

CMS-10434 OMB 0938-1188

Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | WA2023MS0004O | WA-23-0027 | Washington State Health Home Program

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Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

Washington State Health Home Program

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

Under Washington's approach, the Health Home program is the bridge to integrate care within existing delivery systems for both managed care and fee-for-service beneficiaries. Washington's Medicaid delivery system integrates physical and behavioral health services statewide through its managed care program. Washington's Health Home program now serves managed care beneficiaries and beneficiaries who remain in the fee-for-service delivery system, such as a full-dual eligibles and American Indian/Alaska Native population.

Washington has three high level goals to assess the effectiveness of its Health Home program: 1) building care coordination capacity in all areas of the state; 2) improve the beneficiary's self-management abilities; and 3) reduce future cost trends or at the very least, attain cost neutrality with improved outcomes.

The Health Home program is designed as the central point for directing person-centered care through one-on-one interactions between the Health Home Care Coordinators and their beneficiaries.

Beneficiaries are identified as having one or more of the chronic conditions on the chronic condition list and are at risk for a second chronic condition using a tool that identifies clients expected to have high future costs due to all their chronic conditions.

The Department of Social and Health Services (DSHS) generates and submits a list of eligible Health Home beneficiaries to HCA. Then HCA enrolls them into a Managed Fee-For-Service Health Home Lead Entity (designated provider) or notifies the Managed Care Organization (designated provider) that one of their enrollees is eligible for Health Home services with a Health Home indicator on the 834 file. Lead Entities are permitted to serve as a Care Coordination Organization (CCO) and must also subcontract with a wide-range of community-based Care Coordination Organizations to effectively manage the full breadth of beneficiary needs, increasing Washington's capacity to provide statewide Health Home services, especially in rural areas of the state.

There are six defined Health Home services, with each individual service fully defined by embedded activities to make up the composition of the service.

Washington's previous Health Home SPAs were WA-13-0008, approved June 28, 2013, and WA-13-0017, approved December 11, 2013. SPA WA-15-0011, approved June 11, 2015, superseded previous SPA versions. SPA WA-16-0026, approved March 31, 2017, superseded previous versions; it added a 20% performance incentive payment to increase beneficiary engagement rates and expand the Health Home program statewide. SPA WA-18-0028 superseded previous SPAs; it added a 20% rate increase and reduced the performance incentive payment to 5%. SPA WA-20-0031 supersedes previous SPAs; it updated payment methodology and added a 26% rate increase across all tiers.

SPA WA-23-0027 supersedes previous Health Home SPA versions. The following updates were made to SPA WA-23-0027:

- 1) The payment methodology was updated. The administrative rate increased from 8.5% to 10% and Health Home rates were updated based on legislature approval and Lead Entity (designated provider) feedback.
- 2) SPA language was updated to align with current definitions of face-to-face (includes both in person and telemedicine) and clarified areas that required an in person visit, like Tier 1 visits (initial HAP).
- 3) Based on CMS technical assistance, we removed Designated Providers prepopulated in MACPro and added Community-Based Organizations in the other designated provider section. Community-Based Organizations are defined in this section. The functions of a designated provider remain unchanged.
- 4) Based on CMS technical assistance, we removed prepopulated Provider Types and added Care Coordination Organization (CCO) to the "other" section. The

CCO is responsible for providing Health Home services and the state Health Home program will determine guidance and protocols, using the expertise of clinical staff (physical a

General Assurances

- ☒ The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- ☒ The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- ☒ The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- ☒ The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- ☒ The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- ☒ The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Homes Geographic Limitations

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- ☒ Health Homes services will be available statewide
- ☐ Health Homes services will be limited to the following geographic areas
- ☐ Health Homes services will be provided in a geographic phased-in approach

Health Homes Population and Enrollment Criteria

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Categories of Individuals and Populations Provided Health Home Services

The state will make Health Home services available to the following categories of Medicaid participants

- ☒ Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
- ☐ Medically Needy Eligibility Groups

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | WA2023MS00040 | WA-23-0027 | Washington State Health Home Program

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Population Criteria

The state elects to offer Health Homes services to individuals with:

- ☐ Two or more chronic conditions
- ☒ One chronic condition and the risk of developing another

Specify the conditions included:

- ☒ Mental Health Condition
- ☒ Substance Use Disorder
- ☒ Asthma
- ☒ Diabetes
- ☒ Heart Disease
- ☐ BMI over 25
- ☒ Other (specify):

Name	Description
hematological	As defined by UC San Diego CDPS and Medicaid RX disease categories.
musculoskeletal	As defined by UC San Diego CDPS and Medicaid RX disease categories.
cancer	As defined by UC San Diego CDPS and Medicaid RX disease categories.
cerebrovascular disease	As defined by UC San Diego CDPS and Medicaid RX disease categories.
coronary artery disease	As defined by UC San Diego CDPS and Medicaid RX disease categories.
HIV/AIDS	As defined by UC San Diego CDPS and Medicaid RX disease categories.
renal failure	As defined by UC San Diego CDPS and Medicaid RX disease categories.
chronic respiratory conditions	As defined by UC San Diego CDPS and Medicaid RX disease categories.
neurological disease	As defined by UC San Diego CDPS and Medicaid RX disease categories.
dementia or Alzheimer's disease	As defined by UC San Diego CDPS and Medicaid RX disease categories.

Name	Description
intellectual disability or disease	As defined by UC San Diego CDPS and Medicaid RX disease categories.
gastrointestinal	As defined by UC San Diego CDPS and Medicaid RX disease categories.

Specify the criteria for at risk of developing another chronic condition:

At-risk for a second condition is a minimum predictive risk score of 1.5, which means a beneficiary's expected future medical expenditures is expected to be 50% greater than the base reference group (the Washington SSI-disabled population). The Washington risk score is based on the Chronic Illness & Disability Payment System (CDPS) and Medicaid-Rx risk groupers developed by Rick Kronick and Todd Gilmer at the University of California-San Diego, with risk weights normalized for the Washington Medicaid population. Diagnoses, prescriptions, age and gender indicated in a beneficiary's medical claims and eligibility history for the past 15 months (24 months for children) produce a risk score, with chronic conditions checked across all categorically needy populations, and a clinical indicator (Y=qualifies, N=does not qualify) is loaded into Washington's Medicaid Management System (MMIS).

Potentially eligible beneficiaries with insufficient claims history may be referred to the program by contacting HCA. A tool has been developed to manually calculate risk. This tool is on the Health Home website and distributed to the Lead Entities. Once a provider has determined a potentially beneficiary is eligible by manually calculating their risk, that information is sent to HCA for further analysis. If the beneficiary is eligible and not receiving other Medicaid care coordination services, they will be enrolled into a Health Home.

☐ One serious and persistent mental health condition

Health Homes Population and Enrollment Criteria

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Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home:

- ☐ Opt-In to Health Homes provider
- ☒ Referral and assignment to Health Homes provider with opt-out
- ☐ Other (describe)

Describe the process used:

The state identifies Fee-for-Service beneficiaries who are eligible for the Health Home program based on their chronic condition and risk score, then enrolls them into a Managed Fee-for-Service Lead Entity/Designated Provider. Enrollment is based on zip code, amount of available beneficiaries within each zip code, and capacity to provide Health Home services. The Lead Entity assigns Health Home beneficiaries to one of their network affiliated Care Coordination Organizations (CCO), who, in turn, assigns the beneficiary to a Care Coordinator. Beneficiaries have the ability to opt out of the assigned Health Home or change enrollment to another Health Home provider within the Health Home network. Eligible beneficiaries who opt out of participation and retain their 1.5 or higher risk score have the option of re-enrolling the Health Home program at any time by contacting HCA's customer service line.

Managed care beneficiaries are auto-enrolled into a Medicaid managed care organization (MCO). The state identifies MCO beneficiaries who are eligible for Health Homes based upon their chronic condition and risk score and sends the information to their MCO. MCOs that are qualified to be Lead Entities, assign their Health Home beneficiaries to one of their network-affiliated Care Coordination Organizations (CCOs), who, in turn, assign the beneficiary to a Care Coordinator. MCOs that are not qualified as a Lead Entity/designated provider must delegate Health Home services to a qualified Lead Entity and assign their eligible/identified beneficiaries to their delegated Lead Entity. The delegated Lead Entity, in turn, will assign the beneficiary to one of their network affiliated CCOs and a Care Coordinator. Beneficiaries have the ability to opt-out of the Health Home or change enrollment to another MCO or subcontracted Health Home CCO within the Health Home program.

- Beneficiaries lose Health Home eligibility when their risk score drops below 1.0 for at least six continual months and they have not participated or engaged in the program during those months. Beneficiaries who actively participate and are engaged do not lose eligibility if their risk scores drops below 1.0.
- ☒ The state provides assurance that it will clearly communicate the individual's right to opt out of the Health Home benefit or to change Health Home providers at any time and agrees to submit to CMS a copy of any letter or communication used to inform the individual of the Health Home benefit and their rights to choose or change Health Home providers or to elect not to receive the benefit.

Name	Date Created	
Health Homes Client Notice Letter-2018	8/21/2018 4:56 PM EDT	
Your WA State HH Booklet 22-851	8/21/2018 4:56 PM EDT	

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | WA2023MS0004O | WA-23-0027 | Washington State Health Home Program

Package Header

Package ID	WA2023MS0004O	SPA ID	WA-23-0027
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Types of Health Homes Providers

☒ Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

- ☐ Physicians
- ☐ Clinical Practices or Clinical Group Practices
- ☐ Rural Health Clinics
- ☐ Community Health Centers
- ☐ Community Mental Health Centers
- ☐ Home Health Agencies
- ☐ Case Management Agencies
- ☐ Community/Behavioral Health Agencies
- ☐ Federally Qualified Health Centers (FQHC)
- ☒ Other (Specify)

Provider Type	Description
Managed Care Organizations	1. HIPAA-compliant data systems for enrollment, collecting and reporting encounters to HCA 2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims 3. Experience operating broad-based regional provider networks 4. Contracts directly with the state as a Qualified Health Home 5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network 6. Subcontracts with community based CCOs to provide Health Home services 7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary or optimizes beneficiary choice. 8. Maintains a list of CCOs and their assigned Health Home population 9. Monitors CCOs to ensure fidelity to the Health Home model 10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the

Provider Type	Description
	Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols. 11. Ensures person-centered and integrated Health Action Planning which includes providing high-touch care management; 12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator 13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA 14. Maintains an adequate network of Care Coordination Organizations 15. Employs Care Coordinators to supplement CCOs in areas where qualified Care Coordinators are hard to find
Tribal Clinics	1. HIPAA-compliant data systems for enrollment, collecting and reporting encounters to HCA 2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims 3. Experience operating broad-based regional provider networks 4. Contracts directly with the state as a Qualified Health Home 5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network 6. Subcontracts with community based CCOs to provide Health Home services 7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary or optimizes beneficiary choice 8. Maintains a list of CCOs and their assigned Health Home population 9. Monitors CCOs to ensure fidelity to the Health Home model 10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols. 11. Ensures person-centered and integrated Health Action Planning

Provider Type	Description
	which includes providing high touch care management 12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator 13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA 14. Maintains an adequate network of Care Coordination Organizations 15. Employs Care Coordinators to supplement CCOs in areas where qualified Care Coordinators are hard to find
Community-Based Organizations (i.e., Area Agencies on Aging, FQHCs, Hospitals, Social Service Organizations, and Behavioral Health Agencies)	1. HIPAA-compliant data systems for enrollment, collecting and reporting encounters to HCA 2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims 3. Experience operating broad-based regional provider networks 4. Contracts directly with the state as a Qualified Health Home 5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network 6. Subcontracts with community based CCOs to provide Health Home services 7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary or optimizes beneficiary choice. 8. Maintains a list of CCOs and their assigned Health Home population 9. Monitors CCOs to ensure fidelity to the Health Home model 10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols. 11. Ensures person-centered and integrated Health Action Planning which includes providing high-touch care management 12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator 13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA 14. Maintains an adequate network of Care Coordination

Provider Type	Description
	Organizations 15. Employs Care Coordinators to supplement CCOs in areas where qualified Care Coordinators are hard to find.

Health Homes Providers

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☒ Teams of Health Care Professionals

Indicate the composition of the Health Homes Teams of Health Care Professionals the state includes in its program. For each type of provider indicate the required qualifications and standards

- ☐ Physicians
- ☐ Nurse Practitioners
- ☐ Nurse Care Coordinators
- ☐ Nutritionists
- ☐ Social Workers
- ☐ Behavioral Health Professionals
- ☒ Other (Specify)

Provider Type	Description
Care Coordination Organization	Care coordination services are provided through Care Coordination Organizations. Services may be provided by any member of the Health Home team (i.e., Care Coordinator or Affiliated Staff), but are driven by administrative protocols and clinical guidelines developed by appropriate health care professionals (i.e., nurses, mental health professionals, substance use disorder professionals).

Health Homes Providers

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☐ Health Teams

Health Homes Providers

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Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

The delivery of Washington's Health Home service model is based on a multidisciplinary array of medical care, behavioral health care, and community-based social services and supports for children and adults who meet Washington's defined chronic conditions and risk criteria. The integration of primary care, behavioral health services, and long-term care services and supports are critical when improving health outcomes and reducing costs.

Qualifying the Health Home Lead Entities (Designated Providers) ensures managed care organizations (MCOs): community-based organizations such as hospitals, FQHCs, Behavioral Health Agencies, Area Agencies on Aging, social service organizations; and tribal clinics, who may apply have the necessary skills and infrastructure to provide Health Home services.

Qualified Lead Entities, through their respective networks, provide intensive Health Home care coordination services to Medicaid and Medicaid/Medicare beneficiaries with chronic conditions to ensure that services delivered are integrated and coordinated across medical, mental health, substance use disorder, and long-term care services and supports. Beneficiaries who are eligible for Health Homes may receive direct services from both HCA and DSHS, but the Health Home contracts are based in HCA.

- The Health Homes structure is built on the following hierarchy:
1. Designated Provider/Qualified Health Home Lead Entity - Healthcare systems, providers, and authorizing entities with experience developing community-based service provider network relationships, such as managed care organizations (MCOs), community-based organizations (i.e., hospitals, federally qualified health centers or FQHCs, Area Agencies on Aging, Behavioral Health agencies, and social service organizations), and Tribal Clinics. The Lead Entities contract directly with the state and are responsible for service delivery model and administration of the Health Home. Lead Entities assign Health Home eligible beneficiaries into Care Coordination Organizations (CCOs), collect and submit encounters, disburse payment to network affiliated CCOs through the collection and submission of encounters, monitor quality, subcontract, collect, analyze, and report financial and health status to objectively determine progress towards meeting overall Health Home goals. Some Lead Entities also verify address and phone information and engage beneficiaries through telephonic contact to determine willingness to participate. Some Lead Entities may also serve as internal CCOs as a means of reaching rural areas of the state that may not have enough non-Lead CCOs to support capacity.
 2. Network Affiliated Care Coordination Organizations (CCO) - Accountable for Care Coordination staffing and oversight of direct delivery of the six Health Home services. CCOs are responsible for implementing systematic processes and protocols to assure service delivery and beneficiary access to Care Coordinators and affiliated staff. CCOs may be managed care organizations, community-based organizations (i.e., hospitals, FQHCs, Area Agencies on Aging, Behavioral Health Agencies, Behavioral Health Agencies, and social service organizations), and Tribal Clinics.
 3. Care Coordinators - Operate under the direction of the Care Coordination Organizations by directly interacting with participating beneficiaries. Care Coordinators provide the six defined Health Home care coordination benefits by actively engaging the beneficiary in developing a Health Action Plan (HAP); reinforcing the HAP and supporting the beneficiary to attain short and long-term goals; coordinating with authorizing and prescribing entities as necessary to reinforce and support the beneficiary's health action goals; advocating, educating, and supporting the beneficiary to attain and improve self-management skills; ensuring the receipt of evidence-based care; supporting beneficiaries and families during discharge from hospital and institutional settings, including providing evidence-based transition planning; and accompanying the beneficiary to critical appointments when necessary. To better support beneficiary goals and ensure quality of care, they coordinate services with authorizing entities, for which the beneficiary is receiving service assistance. A Health Home Care Coordinator must provide service in the community in which the beneficiary resides to ensure services are provided in-person whenever needs, unless the beneficiary requests to receive their services elsewhere. Health Home Care Coordinators serve eligible beneficiaries in the setting of their choice and may not establish policies that would restrict service because a beneficiary moves from one eligible setting to another.
 4. Affiliated Health Care Staff, such as community health workers, peer counselors, or other non-clinical personnel administrative support for the Health Home Care Coordinator, that includes mailing health promotion material, arranging for beneficiary transportation to appointments, and calling the beneficiary to facilitate face-to-face Health Home visits with the Care Coordinator. Some affiliated staff may provide more direct care coordination functions under the supervision of a Care Coordinator.

5. Additional network providers who have agreed to participate in the Health Home model through the use of memorandums of agreement, subcontracts, or operational agreements. For example, a clinic may agree to provide referrals to a Lead Entity, through the use of an operational agreement.

Supports for Health Homes Providers

Describe the methods by which the state will support providers of Health Homes services in addressing the following components

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services

8. Coordinate and provide access to long-term care supports and services
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

Description

The foundation of the Health Home program is the community-based Care Coordination Organization (CCO) network, subcontracted to Lead Entities. CCOs are a wide variety of medical, behavioral health and social service providers who provide Health Home services through contracted Care Coordinators. Because many Health Home beneficiaries have existing relationships with one or more providers, broad-based CCO networks enable a smart assignment process. For example, the clinic where the beneficiary has their primary care provider may be their CCO, or an Area Agency on Aging who supports the beneficiary with their long-term services and supports may be their CCO.

Each activity defined under the six Health Home services is built into Lead Entity contracts, ensuring that coordination of services, access to services, and person-centered care is delivered to the Health Home beneficiary. For example, the beneficiary is involved in improving their health through the development of their Health Action Plan (HAP). HAPs are shared with the beneficiary during development and as they are updated, usually on a four-month cycle. Beneficiaries may include their families and caregivers as part of their support team and may authorize the release of the HAP to their family members, caregivers and providers. The HAP is both an electronic form and a paper form.

HCA and DSHS jointly sponsor training for Health Home service. Nursing staff developed core curriculum materials to support the provision of timely, comprehensive, high-quality services with a whole-person focus. DSHS offers technical assistance training for core skills relevant topics. Webinars, community network meetings and/or collaborative learning efforts continue to foster shared learning, information sharing and problem solving.

The state provides access to PRISM, a secure web-based clinical support tool showing the beneficiary's medical risk factors, demographics, eligibility, managed care status, housing, utilization of Medicaid and Medicare health services (including inpatient services, outpatient services, emergency department visits, filled prescriptions, mental health services, long term care services and supports, filled lab orders, and dental services), provider contact information, and long term care case manager assessments. This resource complements existing clinic-specific Electronic Health Records and provides the foundation for a continuous quality improvement program.

Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes providers are as follows

Qualified Health Home Lead Entities and their networks are developed to meet the needs of the populations they serve. Care coordination is necessary across numerous service domains and therefore may include many different disciplines. The state qualifies each Lead Entity, who is responsible for the integration and coordination of primary, acute, behavioral health (mental health and substance use disorder) and long-term services and supports for persons with chronic illness across the lifespan, through contractual/operational arrangements with appropriate providers. A Care Coordinator is the central point of contact working with the managed care or Fee-for-Service beneficiary to direct person-centered health action planning and implementation, and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable Emergency Department visits; providing timely post discharge follow-up, and improving beneficiary outcomes by addressing health care needs.

For the first two phases of implementation, Washington issues an RFA (Request for Application) and qualified eight Lead Entities to provide Health Home services through their network of Care Coordination. Now the program is statewide, new organizations interested in being a Lead Entity will go through a contracting process after the state team determines need, provider readiness, and viability of the potential Lead Entity before approved to provide Health Home services.

The following minimum requirements to become a Qualified Health Home Lead Entity:

1. Applicant is a Medicaid provider in good standing, has the ability to serve at least 300 Health Home beneficiaries, has experience operating broad-based networks, agrees to serve the entire coverage area, assures a referral system is in place, documents beneficiary consent, subcontracts with CCOs, has the ability to coordinate care and services after critical events, such as emergency department use and hospital inpatient admission and discharge, language access and interpretation capabilities, can provide links to acute and outpatient medical, mental health and substance use services, and community-based social services.
2. Provider networks must include a wide variety of community-based CCOs.
3. Organizational infrastructure includes the ability to provide administrative functions, customer service staff, policies on process and timelines for bringing in additional CCOs to preserve integrity of face-to-face Health Home care coordination activities, ability to track Health Home beneficiaries to CCO assignment, collecting and submitting claims and encounters, payment disbursement, taking into account movement between payment levels and/or movement between CCOs, quality monitoring, subcontracting, collecting, analyzing and reporting financial and health status. Ability to ensure hospitals have procedures in place for referring Health Home eligible beneficiaries for enrollment if they are seeking or need treatment in a hospital emergency room.
4. Core Health Home requirements must be met, showing the ability to provide six Health Home care coordination functions and a guarantee of non-duplication of efforts that includes: engagement and outreach; health action planning; self-management of chronic conditions; setting short and long-term goals; cultural competency; motivational interviewing; identification of services and gaps in services; evidence-based interventions; information sharing with beneficiary's treating/authorizing entities; establishment of multidisciplinary teams; accompanying beneficiary to visits when requested; arranging for priority appointments; notification systems for transitional care; follow-up on medications upon discharge and follow-up with pharmacy to get prescriptions filled; helping the beneficiary access follow-up care and referrals; optimizing social supports and family; and use of health information technology.

Before contracts are awarded, HCA and DSHS will conduct desk audits and on-site readiness reviews to ascertain readiness to provide Health Home services. Contracts will be offered only after the readiness reviews and after any identified deficiencies are mitigated through a corrective action plan. Before contracts are awarded to previously Qualified Lead Entities, HCA and DSHS will determine if their networks are adequate to provide Health Home services. MCOs who apply to become Lead Entities must also maintain an integrated managed care (IMC) contract with HCA.

The Health Home program will be audited during annual contract compliance audits. Based upon results of the audit, the Lead Entity may be put on corrective action or have their qualification status terminated.

Name	Date Created	
No items available		

Health Homes Service Delivery Systems

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Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

- ☒ Fee for Service
- ☐ PCCM
- ☒ Risk Based Managed Care

The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals

- ☒ Yes
- ☐ No

Provide a summary of the contract language that you will impose on the Health Plans in order to deliver the Health Homes services

Managed care contracts contain language to support the Health Home benefit for eligible beneficiaries. An MCO has two paths to choose from when providing those benefits. They may either become a qualified Health Home Lead Entity through the Request for Application process or they may provide their Health Home benefits through a delegation agreement with another qualified Health Home Lead Entity.

Contract language will contain:

1. Standards for the six Health Home services - Comprehensive Care Management, Care Coordination and Health Promotion, Transitional Care, Individual and Family Support, Referrals to the Community and Use of Health Information Technology
2. The use of clinical and non-clinical Care Coordinators and allied staff
3. Contracts, memorandums of agreement or operational agreements with hospitals for emergency department and hospitalization notification, including a referral process to refer beneficiaries to HCA for Health Home enrollment
4. Data security requirements
5. Standardized screening and assessments
6. Development of a Health Action Plan (HAP) through an in-person visit to promote self-management through the identification of the beneficiary's short and long-term goals
7. Encounter data reporting and documentation of delivered services to support encounters
8. The use of multidisciplinary care teams, that include the Care Coordinator, the beneficiary, and any other identified providers
9. Training requirements
10. Program Integrity
11. Grievances and Appeals processes
12. Access to the PRISM clinical decision support tool;
13. If the Health Home beneficiary is a Medicaid managed care enrollee, the MCO will share critical data with the Health Home Care Coordination Organization. Data may include institutional admissions and discharge readiness for transitional health care services management and facilitation, lapses in pharmaceutical payments that may indicate need for beneficiary outreach and education regarding medication use, lapses in pharmaceutical payments; and emergency department use that may suggest a need for a Care Coordinator visit or intervention to address the clinical and Health Action Plan goals.

The Apple Health MCO and IMC contracts are located online at <https://www.hca.wa.gov/billers-providers-partners/program-information-providers/health-home-resources>.

☒ The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.

Name	Date Created	
No items available		

The State intends to include the Health Home payments in the Health Plan capitation rate

- ☒ Yes
- ☐ No

- Assurances**
- ☒ The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:
 - Any program changes based on the inclusion of Health Homes services in the health plan benefits
 - Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)
 - Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)
 - Any risk adjustments made by plan that may be different than overall risk adjustments
 - How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM
 - ☒ The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services
 - ☒ The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found

☒ Other Service Delivery System

Describe if the providers in this other delivery system will be a designated provider or part of the Team of health care professionals and how payment will be delivered to these providers

In addition to the Managed Care Health Home delivery system, Washington also uses a Managed Fee-for-Service (MFFS) delivery system, which provides Health Home services through community-based Qualified Health Home Lead organizations. This service delivery system requires the Health Home Lead organization to pay for services to their subcontracted Care Coordination Organizations (CCOs) and report their claims payments to the state in the form of encounter data before receiving the monthly per member per month payment only for services rendered.

☒ The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.

Name	Date Created	
No items available		

Health Homes Payment Methodologies

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Payment Methodology

The State's Health Homes payment methodology will contain the following features

☒ Fee for Service

☐ Individual Rates Per Service

☒ Per Member, Per Month Rates

☒ Fee for Service Rates based on

☐ Severity of each individual's chronic conditions

☐ Capabilities of the team of health care professionals, designated provider, or health team

☒ Other

Describe below

The Managed Fee-for-Service (MFFS) system provides HH services via community-based HH Lead organizations which pay subcontracted Care Coordination Organizations & report their claims payments to as encounter data before receiving the monthly payment.

☐ Comprehensive Methodology Included in the Plan

☐ Incentive Payment Reimbursement

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

Health Home (HH) rates were built for three levels of payment using a clinical and non-clinical staffing model combined with monthly service intensity. HH Lead entities pay for only one procedure code or service level encounter per beneficiary per month, regardless of the number of services the Health Home Care Coordinator provided to the beneficiary during the month. The procedure codes used to claim payment for the HH service level tiers are:

- Tier One – G9148
- Tier Two – G9149
- Tier Three – G9150

The three levels of payment are dependent upon the intensity of the service, determined by one-on-one, high-touch interactions with the beneficiary and/or caregiver. The initial care coordination (CC) stage (Tier One) encompasses three primary responsibilities: health screening and assessments, development of a person-centered health action plan for care management, and assessing the beneficiary for self-management and promoting self-management skills to improve functional or health status or prevent or slow declines in functioning. Tier One of the HH rate is a one-time payment and indicates the beneficiary is engaged in the program.

The second service level, Tier Two, is for providing Intensive, high-touch HH services. Once a month, the Care Coordination Organization (CCO) submits a claim for payment of the Tier Two procedure code or service level encounter. This rate includes face to face meetings with the beneficiary, pays for and signifies the documentation and intensive CC provided for the beneficiary, delivering at least one of the six defined health home services.

The third service level, Tier Three, is for Low-Level HH services to maintain the beneficiary's self-management skills and continued assessment of needs. Once per month, the CCO submits a claim for payment of the Tier Three procedure code or service level encounter. Payment for this service level includes documentation that HH services were provided to beneficiary either face to face or by phone.

☐ PCCM (description included in Service Delivery section)

☐ Risk Based Managed Care (description included in Service Delivery section)

☒ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

☒ Tiered Rates based on

☐ Severity of each individual's chronic conditions

☐ Capabilities of the team of health care professionals, designated provider, or health team

☒ Other

Describe below

The Managed Fee-for-Service (MFFS) system provides HH services via community-based HH Lead organizations who pay subcontracted Care Coordination Organizations & report their claims payments to HCA as encounter data before receiving the monthly payment.

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

Variations in payment is based on the level of care coordination provided, as noted in the tiers.

Tier 1 (G9148) - initial engagement and action planning
Tier 2 (G9149) - intensive level of care coordination
Tier 3 (G9159) - low level of care coordination

Provide a comprehensive description of the policies the state will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

Washington State Health Homes have designated three tiers that define the level of care coordination services provided:

1. Initial engagement and action planning = Tier One
2. Intensive level of care coordination = Tier Two
3. Low level of care coordination = Tier Three

The Tier Level of the client is intended to reflect the overall level of:

1. Engagement and activation level of the client and/or their caregivers
2. Activity in the Health Action Plan
3. Provision of at least one of the qualified Health Home Services
4. Frequency of contacts (face-to-face visits, phone calls, referrals, or care coordination).

Selecting the appropriate Tier should most closely reflect the above activities. Typically, the Tier will not change from month to month, between Tier Two and Tier Three but does change when the client and/or their caregivers consistently demonstrate an intensive or low level Health Home need. At least one of the six qualifying Health Home services must be provided within each Tier Level in order to bill and receive payment for the service.

Qualifying Health Home Services include:

- Comprehensive Care Management: The initial and ongoing assessment and care management services aimed at the integration of physical, behavioral health, long-term services and supports, and community services, using a detailed person-centered HAP which addresses all clinical and non-clinical needs.

Examples:

- o Conduct outreach and engagement activities
- o Develop the HAP setting client centered goals and action steps to achieve the goals
- o Complete comprehensive needs assessment such as the Patient Activation Measure (PAM) and other required assessments for the HAP
- o Prepare crisis intervention and resiliency plans
- o Support the client to live in the setting of their choice
- o Identify possible gaps in services and secure needed supports

- Care Coordination and Health Promotion: Facilitating access to, and monitoring of progress toward goals identified in the HAP to manage chronic conditions for optimal health and to promote wellness. Accomplished through face-to-face and collateral contacts with the client, family, caregivers, physical care, and other providers.

Examples:

- o Support to implement the HAP

- o Encourage and monitor progress towards individualized short and long term goals
- o Coordinate with service providers, case managers, and health plans
- o Conduct or participate in interdisciplinary teams
- o Assist and support the client with scheduling health appointments and accompany if needed
- o Communicate and consult with all providers and the client
- o Provide individualized educational materials according to the needs and goals of the client
- o Promote participation in community educational and support groups

- Comprehensive Transitional Care: The facilitation of services for the client, family, and caregivers when the client is transitioning between levels of care.

Examples:

- o Follow-up with hospitals/ED upon notification of admission or discharge
- o Provide post-discharge contact with client, family, and caregivers to ensure discharge orders are understood and acted upon
- o Assist with access to needed services or equipment and ensure it is received
- o Provide education to the client and providers that are located at the setting from which the person is transitioning
- o Communicate and coordinate with the client, family, caregivers, and providers to ensure smooth transitions to new settings
- o Ensure follow-up with Primary Care Provider (PCP)
- o Review and verify medication reconciliation post discharge is completed

- Individual and Family Supports: Coordination of information and services to support the client and their family or caregivers to maintain and promote quality of life, with particular focus on community living options.

Examples:

- o Provide education and support of self-advocacy including referral to Peer Support specialists
- o Identify and access resources to assist client and family supports in finding, retaining and improving self-management, socialization, and adaptive skills
- o Educate client, family or caregivers of advance directives, client rights, and health care issues
- o Communicate and share information with the client, family, and caregivers with appropriate consideration of language, activation level, literacy and cultural preferences

- Referral to Community and Social Supports: The provision of information and assistance for the purpose of referring the client and their family or caregivers to community based resources as needed.

Examples:

- o Identify, refer and facilitate access to relevant community and social services that support the client's HAP
- o Assist the client to apply for or maintain eligibility for health care services, disability benefits, housing, and legal services not provided through other case management systems
- o Monitor and follow-up with referral resources to ensure appointments and other activities were established and the client engaged in the services

- Use of Health Information Technology to link services: Determine level of service provided and update client health records and HAP according to the Health Home Qualified Lead required information systems.

Client movement between Tiers

Based on the needs and preferences of the client they may move between Tiers Two and Three; higher intensity to lower or lower intensity to higher.

Tier One:

* Minimum Contact:

>Contact is made with the client to arrange a face to face meeting to confirm the client's desire to participate in the Health Home Program.

>Care Coordinator visits the client to complete required assessments and develop the Health Action Plan (HAP) with client centered goals and action steps to achieve those goals.

* Activity Examples:

>Review PRISM and other available client records.

>Administer required screenings.

Administer optional screenings as needed.

>Together, the Care Coordinator and the client identify the client's health goals (long term and short term) and develop a Health Action Plan (HAP).

>Establish a follow up plan with the client.

>Submit Tier One Claim for payment with date of service when the HAP has

been completed.

Tier Two - Intensive Health Home care coordination:

* Minimum Contact:

>At a minimum, Tier Two includes one face-to-face visit between the care coordinator and the client during the month in which qualifying health home services are provided.

>Exceptions can be approved to the monthly care coordinator's face-to-face visit by the Health Home Lead entity. A face-to-face visit with other service providers or allied staff directly related to the client's HAP goals and included in the action steps may be considered as an exception.

>Exceptions can be approved to monthly care coordinator's face-to-face visit by the Health Home Lead entity as long as there is documented evidence of other types of qualifying health home activities being provided.

>At least one qualifying Health Home service must be provided prior to submitting a Tier Two claim for payment.

* Activity Examples:

>Administration and follow up on clinical, functional, and resource use screenings.

>Continuity and coordination of care services through in-person visits, telephone calls, and team meetings, and the ability to accompany beneficiaries to health care provider appointments, as needed.

>Beneficiary assessments to determine readiness for self-management and promotion of self-management skills so the beneficiary is better able to engage with health and service providers.

>Health education and coaching designed to assist beneficiaries to increase self-management skills and improve health outcomes.

>Referrals and assessment of the use of peer supports, support groups and self-care/self-management programs.

>Medication reconciliation as part of care transitioning.

>Education and coaching of caregivers, family members, and other supports.

Tier Three - Low level Health Home care coordination:

* Minimum Contact:

>Low Level Health Home care coordination supports maintenance of the client's self-management skills with periodic home visits and/or telephone calls to reassess health care needs.

>The client expresses their preference to have fewer contacts or a lower level of engagement with the care coordinator.

>Contact may not occur every month depending on the HAP and the needs of the client.

>At least one qualifying Health Home Service must be provided prior to submitting a Tier Three claim for payment.

* Activity Examples:

>Monthly calls to the client to discuss success with maintaining health and/or behavioral changes. >Monthly call to check in on HAP progress and to identify new or changing goals.

>At Tier Three, the review of the HAP must occur at least every four months for progress towards goals, level of activation, and new or unidentified care opportunities.

The Health Care Authority publishes the Encounter Data Reporting Guide (EDRG) for MCOs, Health Home Lead Entities, and Behavioral Health Organizations. The EDRG describes the frequency of required encounter data submissions and includes the Health Home Managed Fee-for-Services (MFFS) payment process. The EDRG is available on-line at: <https://www.hca.wa.gov/assets/billers-and-providers/encounter-data-reporting-guide.pdf>.

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | WA2023MS00040 | WA-23-0027 | Washington State Health Home Program

Package Header

Package ID	WA2023MS00040	SPA ID	WA-23-0027
Submission Type	Official	Initial Submission Date	9/8/2023
Approval Date	10/30/2023	Effective Date	7/1/2023
Superseded SPA ID	20-0031		
	User-Entered		

Agency Rates

Describe the rates used

- ☐ FFS Rates included in plan
- ☐ Comprehensive methodology included in plan
- ☒ The agency rates are set as of the following date and are effective for services provided on or after that date

Effective Date

7/1/2023

Website where rates are displayed

<https://www.hca.wa.gov/assets/billers-and-providers/HHCareCoordinationRates.pdf>

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Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates;
2. Please identify the reimbursable unit(s) of service;
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit;
4. Please describe the state's standards and process required for service documentation, and;
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including:
 - the frequency with which the state will review the rates, and
 - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description

1. The Washington State Legislature approved a rate increase for the FFS Health Home population. The fee-for-service (FFS) Health Home Leads made a request to the Legislature for an amount that would enable the FFS Health Home Lead Entities to be made whole financially. An additional rate increase was approved for the state fiscal year 2025. FFS Health Home Lead Entities requested an increase to the administrative rate: from 8.5% to 10% for each tier and the remaining proviso funds were used to increase the Tier 2 rate. In fiscal year 2024, the Tier 2 rate increased by 23% and an additional 5% rate increase will be added to the Tier 2 rate in fiscal year 2025.

2. Washington State has three payment tiers with specific HCPCS procedure codes that define the level of Health Home care coordination services provided. All three tiers have a mix of clinical and non-clinical staffing elements. The procedure code submitted for payment reflects the overall level of the beneficiary's engagement and activation level; activity in the Health Action Plan; provision of at least one of the six defined Health Home services; and frequency of contacts (face to face visits, phone calls, referrals, or care coordination).

3. 2.3. Tier One (G9148) is for initial engagement and health action planning. This is a one-time payment to initiate participation in the Health Home, conduct a face-to-face home visit, and complete the Health Action Plan (HAP). Development of the HAP may include family members, caregivers, and other social supports as appropriate.

Tier Two (G9149) is for on-going, face-to-face and telephonic visits with the beneficiary to provide one or more of the six Health Home services. Tier Two is paid once per month, per beneficiary. The minimum level for reimbursement is at least one face-to-face contact with the beneficiary during the month.

Tier Three (G9150) is low-level care coordination for beneficiaries who request less contact or face-to-face visits or have achieved a level of self-management for their chronic conditions and no longer need the intensive care coordination. Tier Three is paid once per month, per beneficiary only for months in which a Health Home service was provided.

4. 3.4. Washington requires all Health Home Lead Entities to submit completed Health Action Plans (HAP) into a HAP database. The HAPs are reviewed against the Tier One claims to ensure that a payment has been made for a completed HAP. HAPs are updated every activity period, which consists of four months, or more frequently if there has been a change in circumstances, such as a hospital or Emergency Department visit. HAPs are also updated when short and long-term goals have been finalized and the beneficiary sets new goals. Washington requires all Health Home providers to document the Health Home services provided in their subcontracts with Care Coordination Organizations (CCOs). Annually, during the contract compliance reviews the state audits care management records and notes.

5. Reviewing and rebasing the rates for future updates will happen every three years or more frequently if cost trends warrant a more frequent adjustment. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers.

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Assurances

- ☒ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.
- Describe below how non-duplication of payment will be achieved

Case management provided under the state’s 1915(c) waivers are non-duplicative of Health Home services. The functions provided by 1915(c) case managers include determination of waiver eligibility, comprehensive assessment to determine unmet needs related to waiver services, service planning of services provided under the waiver, qualification of waiver providers, authorization of waiver services, and monitoring of service provision. This type of specialized case management for both individuals receiving long-term services and supports and individuals receiving developmental disabilities services will continue to be necessary for individuals served under waivers, and the Health Home program will not duplicate the functions provided by state and Area Agency on Aging (AAA) staff who perform these functions.

Health Homes will be responsible for review of claims and social service use history, health screening (e.g., screening for common mental health conditions associated with chronic illness such as depression, patient activation assessments), examination of current clinical conditions and treatment, and PRISM information. This assessment is used to identify care gaps, utilization patterns, where chronic care condition education and coaching may be most helpful and to assist the beneficiary in development and implementation of their Health Action Plan, including identification of self-care goals.

The Health Home will also be responsible for transitions, assessing beneficiaries at higher risk for re-institutionalization, assisting the beneficiary and their support network in gaining an understanding of discharge instructions and information, ensuring appropriate follow-up primary and specialty care and that medication reconciliation occurs, and assisting with referrals for additional services the beneficiary may need.

For Tribal PCCMs, the state will not allow an eligible Health Home enrollee to be enrolled in a Tribal PCCM and a Tribal Health Home at the same time. A Tribal member, if enrolled in a PCCM, must choose which method they wish to use for case management. If they decide to become enrolled in a Tribal Health Home, they must disenroll themselves from their Tribal PCCM.

Health Home enrollment is managed by the state and the ProviderOne enrollment and payment system which does not allow a tribal member to be enrolled in a Health Home and a PCCM at the same time.
- ☒ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).
- ☒ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.
- ☒ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
No items available		

Health Homes Services

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Service Definitions

Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

Comprehensive Care Management

Definition

Care Coordinators deliver comprehensive care management, primarily in-person with periodic follow-up. Care management services include screening to assess gaps in care or establish baseline results, in-person visits to the beneficiary's home or location of their choice, and accompanying beneficiaries to health care provider appointments, as needed. Care Coordinators assess beneficiary readiness for self-management and promote self-management skills so the beneficiary is better able to engage with health and service providers and support the achievement of self-directed, individualized health goals to attain recovery, improve functional or health status or prevent or slow declines in functioning. Comprehensive care management service delivery uses the Health Action Plan (HAP) to document a beneficiary directed care management plan. The HAP is created during a face-to-face initial visit with the beneficiary, and is updated periodically on a four-month cycle, as well as when there are changes in beneficiary circumstances such as hospitalization or emergency department visits. The results of screenings and assessments are documented in the HAP and used to identify gaps in care and chart the beneficiary's progress towards meeting their short and long-term goals through active Health Home participation.

State approved clinical and functional screens identify depression, alcohol or substance use disorder, functional impairment, and pain appropriate to the age and risk profile of the individual. Screens support referrals to services when needed, e.g., referral for assessment of need for substance use disorder treatment, specialty care or long term services and supports. Other assessments that may supplement comprehensive care management are mental health treatment plans, substance use disorder treatment plans, and/or other pre-existing care plans, including assessment results.

Care Coordinators may conduct client outreach and engagement activities to assess on-going emerging needs and to promote continuity of care and improved health outcomes. This may also be done by allied or affiliated staff under the direction of the Care Coordinator.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All Health Home Lead Entities will have access to the Medicaid Management Information System called ProviderOne (P1) and the DSHS Predictive Risk Intelligence System (PRISM). Authorizers and providers of long-term services and supports have access to DSHS's Comprehensive Assessment and Reporting Evaluation (CARE) data either electronically or in paper form. Most elements of CARE are also contained in PRISM. Data sharing agreements and Release of Information consent forms will be maintained by all Health Home Lead Entities to facilitate sharing electronic health information with their Health Home network affiliates.

1. DSHS is responsible for maintenance and updates to PRISM and reporting loss of eligibility on a monthly basis.
2. ProviderOne contains Medicaid eligibility, loss of eligibility, MCO and Health Home enrollment, disenrollment, claims, per member per month (PMPM) payment to MCOs, MFFS payment for Health Home services made to community-based Health Home Lead organizations and the collection and reporting of encounter data.
3. Emergency Department Information Exchange (EDIE) notification provides Medicaid claims data to ED physicians. EDIE is HIPAA-compliant and can proactively alert care providers through a variety of methods such as fax, phone, email, or integration with a facility's current Electronic Medical Record (EMR), when high-utilizing patients enter the ED. Once notified, care providers can use EDIE to access care guidelines and crucial information on the patient from other participating facilities to better determine the patient's actual medical situation.
4. PreManage is the information exchange system that alerts Health Home providers when their beneficiary is admitted for inpatient hospital services.

Scope of service

The service can be provided by the following provider types

- ☐ Behavioral Health Professionals or Specialists
- ☐ Nurse Practitioner
- ☐ Nurse Care Coordinators
- ☐ Nurses
- ☐ Medical Specialists
- ☐ Physicians
- ☐ Physician's Assistants
- ☐ Pharmacists
- ☐ Social Workers
- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners

- ☐ Dieticians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
Care Coordination Organization	Care coordination services are provided through Care Coordination Organizations. Services may be provided by any member of the Health Home team but are driven by administrative protocols and clinical guidelines developed by appropriate health care professionals (i.e., nurses, mental health professionals, substance use disorder professionals).
Indian Health Services (IHS)-Certified Community Health Representatives	The IHS-certified Community Health Representative (CHR) Program is a unique concept for providing health care, health promotion, and disease prevention services. CHRs must demonstrate how they assist and connect with the community, and their work has become essential to the spectrum of Tribal community-oriented primary health care services. CHRs come from the communities they serve and have tribal cultural competence.
Exception to Rule	Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills and knowledge and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and eligible for professional liability insurance as required by the hiring organization. The lead entity will provide HCA a letter of request for approval to hire a specific candidate. The letter will include the rationale for the potential care coordinator (i.e. any special skills or knowledge such as bicultural or bilingual), employee background and experience and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request: • Resume • Letters of recommendation • Educational transcripts • Documentation of courses, classes and trainings • Certifications • Licenses The state will review and score each Exception to Rule letter of request and documentation in the following areas: • Education • Experience • Skills/Knowledge • Letters of Recommendation The potential candidate must receive a score of at least 80% to qualify under the Exception to Rule
Allied or Affiliated Staff	Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator. Allied or affiliated staff may: 1. Contact the client to introduce Health Home benefits and schedule initial Care Coordinator face-to-face visit. 2. Conduct client outreach and engagement activities to assess on-going emerging needs and to promote continuity of care and improved health outcomes.

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | WA2023MS00040 | WA-23-0027 | Washington State Health Home Program

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Care Coordination

Definition

The dedicated Health Home Care Coordinator and affiliated staff play a central and active role in development and execution of cross-system care coordination to assist the beneficiary to access and navigate needed services. The Care Coordinator assures communication is fostered between the providers of care, including the treating primary care provider and medical specialists and entities authorizing behavioral health and long-term services and supports. Care Coordination is the bridge between all the beneficiary's systems of care, including non-clinical support such as food, housing, and transportation.

When providing intensive care coordination to the beneficiary, the Care Coordinator caseload will be maintained at a level that ensures fidelity in providing required Health Home services, including interventions. Allied staff, such as community health workers, peer counselors or other non-clinical staff, may be used to facilitate the work of the assigned Health Home Care Coordinator.

Care coordination provides informed interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors impacting a beneficiary's health and health care choices. Care Coordinators and affiliated staff promote:

1. Optimal clinical outcomes, including a description of how progress toward outcomes will be measured through the Health Action Plan;
2. Outreach and engagement activities that support the beneficiary's participation in their care and promotes continuity of care;
3. Health education and coaching designed to assist beneficiaries to increase self-management skills and improve health outcomes; and
4. Use of peer supports, support groups and self-care programs to increase the beneficiary's knowledge about their health care conditions and improve adherence to prescribed treatment.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

PRISM is an information technology resource that supports the beneficiary and the Health Home Care Coordinator to identify the unmet needs, gaps in care, transitional support needs, clinical protocols required and current utilization of case management, medical and behavioral health services.

The Health Action Plan (HAP) may be shared, with beneficiary consent, via secure email or hard copy. The HAP includes:

1. Required and optional health screenings and assessments;
2. Beneficiary and Care Coordinator prioritized action items;
3. Beneficiary identified goals (short and long term);
4. Action steps for the beneficiary, the Health Home Care Coordinator and/or other direct service and medical providers; and
5. If the beneficiary has a personal care worker, action steps for them to support identified health action goals identified by the beneficiary.

The Health Home Care Coordinator updates and modifies the HAP on a four month cycle. The HAP is also updated and modified as needed to reflect:

1. A change in the beneficiary's condition;
2. New immediate goals to be addressed through the Health Home; and
3. Resolution of goals or action steps.

Scope of service

The service can be provided by the following provider types

- ☐ Behavioral Health Professionals or Specialists
- ☐ Nurse Practitioner
- ☐ Nurse Care Coordinators
- ☐ Nurses
- ☐ Medical Specialists
- ☐ Physicians
- ☐ Physician's Assistants
- ☐ Pharmacists
- ☐ Social Workers
- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
Care Coordination Organizations	Care coordination services are provided through Care Coordination Organizations. Services may be provided by any member of the Health Home team but are driven by administrative protocols and clinical guidelines developed by appropriate health care professionals (i.e., nurses, mental health professionals, substance use disorder professionals).
Exception to Rule	Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy/rule. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills, knowledge, and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and be eligible for professional liability insurance as required by the hiring organization. The lead entity will provide HCA a letter of request for approval to hire a specific candidate. The letter will include the rationale for the potential care coordinator (e.g., any special skills or knowledge such as bicultural or bilingual), employee background and experience, and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request: • Resume • Letters of recommendation • Educational transcripts • Documentation of courses, classes and trainings • Certifications • Licenses The state will review and score each Exception to Rule letter of request and documentation in the following areas: • Education • Experience • Skills/Knowledge • Letters of Recommendation The potential candidate must receive a score of at least 80% to qualify under the Exception to Rule
Indian Health Services (IHS) Certified Community Health Representatives	The IHS certified Community Health Representative (CHR) Program is a unique concept for providing health care, health promotion, and disease prevention services. CHRs must demonstrate how they assist and connect with the community, and their work has become essential to the spectrum of Tribal community-oriented primary health care services. CHRs come from the communities they serve and have tribal cultural competence
Allied or Affiliated Staff	Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator. Allied or Affiliated staff may: 1. Communicate with service providers and health plans as appropriate to secure necessary care and supports; 2. Link/refer client to needed services to support care plan/treatment goals, including medical/ behavioral health care; patient education, and self-help/recovery, medication adherence, health literacy, and self-management. 3. Advocate for services and assist with scheduling of needed services. 4. Assist and support client with scheduling medical and applicable appointments.

Health Homes Services

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Health Promotion

Definition

Health promotion begins for Health Home beneficiaries with the commencement of the Health Action Plan (HAP). Each Health Home must demonstrate use of self-management, recovery and resiliency principles using beneficiary-identified supports including family members and caregivers that are paid or unpaid. The Health Home Care Coordinator will use the beneficiary's activation score and level to determine the coaching methodology appropriate for each beneficiary to be used when working with the beneficiary towards reaching their health goals. Educational materials are customized and introduced according to the beneficiary's readiness for change, progressing with the beneficiary's level of confidence and self-management abilities. Opportunities for mentoring and modeling communication with health care providers are provided through joint office visits and communications with health care providers by the beneficiary and the Health Home Care Coordinator. The Health Home provides wellness and prevention education specific to the beneficiary's chronic conditions, HAP, including assessment of need and facilitation of receipt of routine preventive care, support for improving social connections to community networks, and links to resources that support a healthier lifestyle. Linkages include but are not limited to resources for smoking prevention and cessation, substance use disorder treatment and prevention, nutritional counseling, obesity reduction and prevention, increasing physical activity, disease specific or chronic care management self-help resources, and other services, such as housing based on beneficiary needs and preferences.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Insignia Health is an information technology resource which provides calculation of the Patient Activation Measure (PAM)/Caregiver Activation Measures (CAM), Parent/Patient Activation Measure (PPAM) and the Coaching for Activation website. This site provides educational materials linked to a beneficiary's level of activation and can be sent electronically to a beneficiary or printed for review at a Health Home visit or by phone.

The Health Home Care Coordinator is able to view the medical claims, behavioral health claims, prescription claims, and LTC services utilization and selected CARE characteristics (for those beneficiaries with long-term services and supports) in PRISM so that education materials can be tailored to the individual's engagement and activation.

Scope of service

The service can be provided by the following provider types

- ☐ Behavioral Health Professionals or Specialists
- ☐ Nurse Practitioner
- ☐ Nurse Care Coordinators
- ☐ Nurses
- ☐ Medical Specialists
- ☐ Physicians
- ☐ Physician's Assistants
- ☐ Pharmacists
- ☐ Social Workers
- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
Exception to Rule	Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy/rule. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills and knowledge and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and eligible for professional liability insurance as

Provider Type	Description
Indian Health Services (IHS) Certified Community Health Representatives	required by the hiring organization. The lead entity will provide HCA a letter of request for approval to hire a specific candidate. The letter will include the rationale for the potential care coordinator (i.e. any special skills or knowledge such as bicultural or bilingual), employee background and experience and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request: • Resume • Letters of recommendation • Educational transcripts • Documentation of courses, classes and trainings • Certifications • Licenses The state will review and score each Exception to Rule letter of request and documentation in the following areas: • Education • Experience • Skills/Knowledge • Letters of Recommendation The potential candidate must receive a score of at least 80% to qualify under the Exception to Rule
Allied or Affiliated Staff	Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator. Allied or Affiliated staff may: 1. Provide customized educational materials according to the needs and goals of the client, caregiver, or other social supports as appropriate. 2. Promote participation in community educational and support groups. 3. Provide links to health care resources that support the client's goals. 4. Support the execution of cross-system care coordination activities that assist clients in accessing and navigating needed services. 5. Distribute health education and other materials. 6. Assist with follow up calls and provide appointment reminders.
Care Coordination Organizations	Care coordination services are provided through Care Coordination Organizations. Services may be provided by any member of the Health Home team but are driven by administrative protocols and clinical guidelines developed by appropriate health care professionals (i.e., nurses, mental health professionals, substance use disorder professionals).

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Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

Comprehensive transitional care is provided to prevent beneficiary avoidable readmission after discharge from an inpatient facility to ensure proper and timely follow-up care.

The beneficiary's Health Action Plan (HAP) includes transitional care planning. Transitional care planning includes:

1. A notification system with managed care plans, hospitals, nursing homes and residential/rehabilitation facilities to provide the Health Home prompt communication of a beneficiary's admission and/or discharge from an emergency department, inpatient, nursing home or residential/rehabilitation and if proper permissions, a substance use disorder treatment setting. Progress notes or a case file documents the notification and the HAP should be updated with transition planning.
2. The use of a Health Home Care Coordinator as an active participant in all appropriate phases of care transition, including discharge planning visits during hospitalizations or nursing home stays following hospital/institutional discharge, conducted via home visits and telephone calls.
3. Beneficiary education addressing discharge care needs, including medication management, encouragement and intervention to assure follow-up appointments and self-management of their chronic or acute conditions, including information on when to seek medical care and emergency care. Involvement of family and formal or informal caregivers are facilitated when requested by the beneficiary.
4. A systematic follow-up protocol to assure timely access to follow-up care post discharge and to identify and re-engage beneficiaries that do not receive post-discharge care.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Emergency Department Information Exchange (EDIE) notifications provide Medicaid claims data to ED physicians. EDIE is HIPAA-compliant. EDIE can proactively alert care providers through a variety of methods such as fax, phone, email, or integration with facility's current electronic medical record when high utilizing beneficiaries enter the ED. Once notified, care providers can use EDIE to access care guidelines and crucial information on the beneficiary from other participating facilities to better determine the beneficiary's overall medical situation.

PreManage is information exchange system alerts providers when their beneficiary is accessing inpatient hospital services.

Lead FFS Entities with access to EDIE and Pre-Manage can push real-time information on ED visits and inpatient hospital stays to their Care Coordination Organizations.

Managed care Lead Entities notify Health Home Care Coordinators of beneficiary admission to hospital and tertiary care facilities to facilitate discharge planning and care transitions. MCO Lead Entities also inform the Health Home Care Coordinators of lapses in pharmacy refills for beneficiaries with chronic conditions requiring long-term use of medications. Health Home Care Coordinators are responsible for conducting outreach activities with the beneficiary to ensure medications have been picked up and are being used according to the clinical treatment plan.

Scope of service

The service can be provided by the following provider types

- ☐ Behavioral Health Professionals or Specialists
- ☐ Nurse Practitioner
- ☐ Nurse Care Coordinators
- ☐ Nurses
- ☐ Medical Specialists
- ☐ Physicians
- ☐ Physician's Assistants
- ☐ Pharmacists
- ☐ Social Workers
- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians

☐ Nutritionists

☒ Other (specify)

Provider Type	Description
Care Coordination Organizations	Care coordination services are provided through Care Coordination Organizations. Services may be provided by any member of the Health Home team but are driven by administrative protocols and clinical guidelines developed by appropriate health care professionals (i.e., nurses, mental health professionals, substance use disorder professionals).
Exception to Rule	Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills and knowledge and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and eligible for professional liability insurance as required by the hiring organization. The lead entity will provide HCA a letter of request for approval to hire a specific candidate. The letter will include the rationale for the potential care coordinator (i.e. any special skills or knowledge such as bicultural or bilingual), employee background and experience and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request: • Resume • Letters of recommendation • Educational transcripts • Documentation of courses, classes and trainings • Certifications • Licenses The state will review and score each Exception to Rule letter of request and documentation in the following areas: • Education • Experience • Skills/Knowledge • Letters of Recommendation The potential candidate must receive a score of at least 80% to qualify under the Exception to Rule
Allied or Affiliated Staff	Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator. Allied or Affiliated staff may: 1. Support client with connecting to community supports to ensure that needed services or equipment are received.
Indian Health Services (IHS) Certified Community Health Representatives	The IHS certified Community Health Representative (CHR) Program is a unique concept for providing health care, health promotion, and disease prevention services. CHRs must demonstrate how they assist and connect with the community, and their work has become essential to the spectrum of Tribal community-oriented primary health care services. CHRs come from the communities they serve and have tribal cultural competence.

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | WA2023MS00040 | WA-23-0027 | Washington State Health Home Program

Package Header

Package ID	WA2023MS00040	SPA ID	WA-23-0027
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Individual and Family Support (which includes authorized representatives)

Definition

The Health Home Care Coordinator recognizes the unique roles the beneficiary may assign to family, identified decision makers and caregivers in assisting them with accessing and navigating health care and social service delivery systems, as well as support health action planning.

The Health Home Care Coordinator uses peer supports, support groups, and self-management programs to increase beneficiary and caregivers' knowledge of the beneficiary's chronic conditions, promote the beneficiary's engagement and self-management capabilities, and help the beneficiary improve adherence to their prescribed treatment.

The Health Home Care Coordinator, affiliated staff, and the beneficiary:

1. Identify the role that families, informal supports and paid caregivers provide to achieve self-management and optimal levels of physical and cognitive function;
2. Educate and support self-management, self-help recovery, and other resources necessary for the beneficiary, their family, and their caregivers to support the beneficiary's individualized health action goals;
3. Discuss advance directives with beneficiaries and their families; and
4. Communicate and share information with beneficiaries and their families and other caregivers with appropriate consideration of language, activation level, literacy and cultural preferences.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The PRISM software application includes the PRISM Health Report for all beneficiaries. The PRISM report is provided to the beneficiary's primary care provider and any other health care providers identified by the beneficiary and authorized by a signed release of information. This includes the Health Home Care Coordinator. The report includes:

1. Beneficiary demographics
2. Last dental appointment
3. Health conditions
4. Hospital stays
5. Emergency room visits
6. Office visits and procedures in the last 180 days, used by the Care Coordinator to assess sufficient clinical oversight of the beneficiary's chronic conditions
7. Prescriptions filled in the last 90 days
8. Prescriptions by drug class in last two years

Coaching for Activation educational materials are available electronically and are printed for beneficiary and family support.

Scope of service

The service can be provided by the following provider types

- ☐ Behavioral Health Professionals or Specialists
- ☐ Nurse Practitioner
- ☐ Nurse Care Coordinators
- ☐ Nurses
- ☐ Medical Specialists
- ☐ Physicians
- ☐ Physician's Assistants
- ☐ Pharmacists
- ☐ Social Workers
- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
Care Coordination Organizations	Care coordination services are provided through Care Coordination Organizations. Services may be provided by any member of the Health Home team but are driven by administrative protocols and clinical guidelines developed by appropriate health care professionals (i.e., nurses, mental health professionals, substance use disorder professionals).
Exception to Rule	Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills and knowledge and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and eligible for professional liability insurance as required by the hiring organization. The lead entity will provide HCA a letter of request for approval to hire a specific candidate. The letter will include the rationale for the potential care coordinator (i.e. any special skills or knowledge such as bicultural or bilingual), employee background and experience and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request: • Resume • Letters of recommendation • Educational transcripts • Documentation of courses, classes and trainings • Certifications • Licenses The state will review and score each Exception to Rule letter of request and documentation in the following areas: • Education • Experience • Skills/Knowledge • Letters of Recommendation The potential candidate must receive a score of at least 80% to qualify under the Exception to Rule
Allied or Affiliated Staff	Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator. Allied or Affiliated staff may: 1. Educate client, family, or caregiver advance directives, client rights, and health care issues, as needed. 2. Meet with client and family, inviting any other providers to facilitate needed interpretation services. 3. Refer client/family to peer supports, support groups, social services, entitlement programs as needed.
Indian Health Services (IHS) Certified Community Health Representatives	The IHS certified Community Health Representative (CHR) Program is a unique concept for providing health care, health promotion, and disease prevention services. CHRs must demonstrate how they assist and connect with the community, and their work has become essential to the spectrum of Tribal community-oriented primary health care services. CHRs come from the communities they serve and have tribal cultural competence.

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Referral to Community and Social Support Services

Definition

The Health Home Care Coordinator and affiliated staff identify available community based resources, actively manage referrals, assist the beneficiary in advocating for access to care, and engage with community and social supports related to goal achievement documented in the Health Action Plan. When needed and not otherwise provided through other case management systems, the Health Home Care Coordinator provides assistance in obtaining and maintaining eligibility for health care services, disability benefits, housing, personal needs and legal services. These services will be coordinated with appropriate local, state and federal governments and community based organizations. Referral to community and social support services includes long-term services and supports, mental health, substance use disorder and other community and social services support providers needed to support the beneficiary in support of health action goals.

The Health Home Care Coordinator documents referrals to and access by the beneficiary of community- based and other social support services.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

PRISM and Insignia Health are information technology sources supporting the beneficiary and the Health Home Care Coordinator to identify the unmet needs, gaps in care, transitional support needs, clinical protocols required and current utilization of case management, medical and behavioral health services.

Scope of service

The service can be provided by the following provider types

- ☐ Behavioral Health Professionals or Specialists
- ☐ Nurse Practitioner
- ☐ Nurse Care Coordinators
- ☐ Nurses
- ☐ Medical Specialists
- ☐ Physicians
- ☐ Physician's Assistants
- ☐ Pharmacists
- ☐ Social Workers
- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dietitians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
Care Coordination Organizations	Care coordination services are provided through Care Coordination Organizations. Services may be provided by any member of the Health Home team but are driven by administrative protocols and clinical guidelines developed by appropriate health care professionals (i.e., nurses, mental health professionals, substance use disorder professionals).
Exception to Rule	Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy/rule. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills and knowledge and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and eligible for professional liability insurance as required by the hiring organization.

Provider Type	Description
	The lead entity will provide HCA a letter of request for approval to hire a specific candidate. The letter will include the rationale for the potential care coordinator (i.e. any special skills or knowledge such as bicultural or bilingual), employee background and experience and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request: • Resume • Letters of recommendation • Educational transcripts • Documentation of courses, classes and trainings • Certifications • Licenses The state will review and score each Exception to Rule letter of request and documentation in the following areas: • Education • Experience • Skills/Knowledge • Letters of Recommendation The potential candidate must receive a score of at least 80% to qualify under the Exception to Rule
Allied or Affiliated Staff	Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator. Allied or Affiliated staff may: 1. Identify, refer and facilitate access to relevant community and social support services that support the client's health action goals. 2. Assist client to apply for or maintain eligibility for health care services, disability benefits, housing, and legal services not provided through other case management systems. 3. Provide general information about upcoming community events.
Indian Health Services (IHS) Certified Community Health Representative	The IHS certified Community Health Representative (CHR) Program is a unique concept for providing health care, health promotion, and disease prevention services. CHRs must demonstrate how they assist and connect with the community, and their work has become essential to the spectrum of Tribal community-oriented primary health care services. CHRs come from the communities they serve and have tribal cultural competence.

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Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

Enrollment flow is dependent upon 1) whether the beneficiary is enrolled with a Managed Care Lead Entity, or 2) is not enrolled in managed care and is receiving their medical benefits in the FFS delivery system. Almost all Washington's Medicaid Health Home beneficiaries are enrolled in managed care. Those that remain in the FFS delivery system either reside in a voluntary managed care county, are a full-dual eligible, or have self-identified as American Indian/Alaska Native.

All Health Home beneficiaries, regardless of whether they receive their Medicaid benefits in managed care or in FFS, have the same eligibility criteria - one or more chronic conditions from the chronic condition list and meet the state's definition of "at risk for another."

Enrollment starts with the identification of eligibility and assignment of a clinical indicator (Y=qualifies). The indicator is loaded into ProviderOne.

1. FFS beneficiaries with "Y"clinical indicators are enrolled into one of the qualified FFS Health Home Lead Entities in the geographic region in which they reside. Health Home outreach and education information is generated automatically and sent to the beneficiary by mail. The Health Home Lead Entity receives notification of the enrollment via HIPAA 834 files and assigns the beneficiary to one of their local Health Home Care Coordination Organizations (CCOs).
2. Managed care organizations have their eligible Health Home beneficiaries identified with a "Y" clinical indicator and receive notification of eligibility via HIPAA 834 files. The MCO assigns the beneficiary to one of their local Health Home Care Coordination Organizations (CCOs). The MCO is responsible for making sure the enrollee is notified of their eligibility to receive Health Home services.
3. Any health care provider may refer beneficiaries to the Health Home program. An example is a local emergency room department who has agreed with the Health Home Lead Entity to refer potentially eligible participants to the program.

Engagement consists of the assigned CCO placing beneficiaries with a Care Coordinator, who contacts the beneficiary to offer Health Home services. Once the beneficiary has agreed to participate in a Health Home, the Care Coordinator prepopulates the Health Action Plan with PRISM claims utilization details and arranges for an in-person visit. PRISM provides episode information related to specific diagnoses or pharmacy utilization, inpatient and outpatient claims, emergency room visits, mental health claims, substance use disorder treatment claims, pharmacy claims, and long-term care assessment data.

During the home visit, the Care Coordinator:

1. Conducts the required and when needed optional brief screening;
2. Evaluates the beneficiary's support system;
3. Completes a Consent for Release of Information;
4. Administers and scores the 13-question Patient Activation (PAM) or Caregiver Activation Measure (CAM) or Parent/Patient Activation Measure (PPAM); and
5. Develops the Health Action Plan (HAP) with the beneficiary, who will work with the CCO to identify immediate and long-term goals, prioritize concerns and establish action steps.

Name	Date Created	
HH Enrollment Procedure 22-09-01 E	8/21/2018 5:02 PM EDT	
HH Beneficiary flow 06 0624	8/21/2018 5:02 PM EDT	
Update 070117 HH CC Qualification Exception worksheet	8/21/2018 5:02 PM EDT	
Guidelines-for-HH-staff	8/21/2018 5:02 PM EDT	

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | WA2023MS0004O | WA-23-0027 | Washington State Health Home Program

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Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates:

The state will calculate regional, risk-adjusted, per member per month expenses in the target population in the baseline (FY2011), apply trend factors and estimate a projected per member per month figure. Cost savings will be calculated as the difference between actual and projected risk adjusted per member/per month expenditures. Cost savings for dual eligibles will be determined by CMS.

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

The state integrates Fee-for-Service claims data, managed care encounter data, beneficiary eligibility, enrollment and claims data for medical, pharmacy, mental health, substance use disorder, long-term services and supports, and Medicaid and dual eligible Medicare covered services in a secure web-based clinical decision support tool called PRISM. PRISM also pulls from other clinical assessment data within the state such as CARE. The state uses PRISM to support the beneficiary and the Health Home Care Coordinator to identify the unmet needs, gaps in care, clinical protocols required and current utilization of case management, medical and behavioral health services. Use of these tools enables the Health Home Care Coordinator to better coordinate care and ensure that the beneficiary's complex needs are met, and will assist the state in monitoring cost and utilization data to ensure program goals are met.

The state has developed Health Information Technology (HIT) through OneHealthPort (OHP), who HCA contracts with to consult on maintaining a statewide Health Information Exchange (HIE). HCA is developing the Medicaid Health Profile clinical data repository, with clinical data passed through OneHealthPort HIE using the Continuity of Care Document (CCD) and the Admit/ Discharge/Transfer Document (ADT) transaction sets. Updates to the Medicaid clinical data repository to refine or to correct identified data collection errors occur whenever a need is identified.

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | WA2023MS00040 | WA-23-0027 | Washington State Health Home Program

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Quality Measurement and Evaluation

- ☒ The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state.
- ☒ The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.
- ☒ The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.
- ☒ The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report.

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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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WA - Submission Package - WA2024MS0008O - (WA-24-0023) - Health Homes

Summary Reviewable Units Approval Letter News Related Actions

CMS-10434 OMB 0938-1188

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | WA2024MS0008O | WA-24-0023 | Washington State Health Home Program

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Package ID	WA2024MS0008O	SPA ID	WA-24-0023
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Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates:

The state will calculate regional, risk-adjusted, per member per month expenses in the target population in the baseline (FY2011), apply trend factors and estimate a projected per member per month figure. Cost savings will be calculated as the difference between actual and projected risk adjusted per member/per month expenditures. Cost savings for dual eligibles will be determined by CMS.

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

The state integrates Fee-for-Service claims data, managed care encounter data, beneficiary eligibility, enrollment and claims data for medical, pharmacy, mental health, substance use disorder, long-term services and supports, and Medicaid and dual eligible Medicare covered services in a secure web-based clinical decision support tool called PRISM. PRISM also pulls from other clinical assessment data within the state such as CARE. The state uses PRISM to support the beneficiary and the Health Home Care Coordinator to identify the unmet needs, gaps in care, clinical protocols required and current utilization of case management, medical and behavioral health services. Use of these tools enables the Health Home Care Coordinator to better coordinate care and ensure that the beneficiary's complex needs are met, and will assist the state in monitoring cost and utilization data to ensure program goals are met.

The state has developed Health Information Technology (HIT) through OneHealthPort (OHP), who HCA contracts with to consult on maintaining a statewide Health Information Exchange (HIE). HCA is developing the Medicaid Health Profile clinical data repository, with clinical data passed through OneHealthPort HIE using the Continuity of Care Document (CCD) and the Admit/ Discharge/Transfer Document (ADT) transaction sets. Updates to the Medicaid clinical data repository to refine or to correct identified data collection errors occur whenever a need is identified.

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | WA2024MS00080 | WA-24-0023 | Washington State Health Home Program

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Quality Measurement and Evaluation

- ☒ The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state.
- ☒ The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.
- ☒ The state provides assurance that it will report to CMS information to include applicable mandatory Core Set measures submitted by Health Home providers in accordance with all requirements in 42 CFR §§ 437.10 through 437.15 no later than state reporting on the 2024 Core Sets, which must be submitted and certified by December 31, 2024 to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS. In subsequent years, states must report annually, by December 31st, on all measures on the applicable mandatory Core Set measures that are identified by the Secretary.
- ☒ The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report.

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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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