Medicaid State Plan – Numbered Pages

Administering Medicaid Programs

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

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IN TOC, CLICK ON SECTION 1.2 -1.3 MEDICAID STATE PLAN ADMINISTRATION FOR STATE PLAN AMENDMENT 22-0016 SEE PAGE 17.A.3 ASSURANCES FOR MEDICAL CARE ADVISORY COMMITTEE

1.4 ~~State Medical Care Advisory Committee (42 CFR 431.12(b))~~

~~There is an advisory committee to the Medicaid agency director on health and medical care services established in accordance with and meeting all the requirements of 42 CFR 431.12.~~

~~_X_ The State enrolls recipients in MCO, PIHP, PAHP, and/or PCCM programs. The State assures that it complies with 42 CFR 438.104(c) to consult with the Medical Care Advisory Committee in the review of marketing materials.~~

Tribal Consultation Requirements under the Social Security Act

Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Please describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Please include information about the frequency, inclusiveness and process for seeking such advice.

The State uses several avenues to seek advice on a regular, ongoing basis for its Medicaid, Medicaid-related, and CHIP programs. For organizations that have regularly scheduled meetings, State staff request items of interest to be added to the agenda as needed. Staff attend the bi-monthly meetings of the American Indian Health Commission for Washington State (AIHC) and participate in ad hoc workgroups created by the Commission to address policy issues. In addition, the AIHC receives notification of new SPAs and annual SPA updates are offered. The State also attends the quarterly Indian Policy Advisory Committee (IPAC) meetings and participates in subcommittee meetings regarding specific topics, as requested. (IPAC is an advisory committee created to work with the State's Department of Social and Health Services).Information is also shared with the Northwest Portland Area Indian Health Board which sends information on a weekly basis to the health board delegates – the State regularly sends information to be included in those mailings. The State also regularly sends specific program information via electronic messages (email) to tribal health administrators, tribal clinic directors, pharmacists, tribal billing staff, and tribal chemical dependency and mental health program managers. All communications offer the opportunity for participation and cooperation.

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1.4 State Medical Care Advisory Committee (cont)

In addition to the processes described above, the State has a process in place to notify its tribes, Indian Health Programs, and Urban Indian Health Organizations about specific State Plan Amendments; waiver proposals, extensions, amendments, and renewals; and demonstration projects. After the need for a SPA, waiver, or demonstration project is identified, the tribal notification process is initiated:

1) A Dear Tribal Leader notification letter is drafted and sent a minimum of 60 days prior to submitting the SPA, waiver, or project, whenever possible. In expedited circumstances (e.g., in severely time limited situations), the State sends a notification letter a minimum of 10 days in advance of the action whenever possible. The notification letter includes:
   - A description of the purpose of the SPA, waiver, or project. A review SPA or waiver is included with the letter when one is available. If a review document is not available, the letter describes the intent of the SPA, waiver, or project.
   - A description of any anticipated impact on tribes, including any tribal-specific impact. If no tribal impact is identified, an explanation of how that determination was made is included.
   - A method for providing comments with a due date at least 30 days in the future. In expedited circumstances, the State allows 7 days for response whenever possible.
   - Contact information for program- or tribal-specific questions, and for tribes to request an in-person meeting or formal consultation (for scheduling, the request must be received within 30 days of the date of the notice, or in expedited circumstances, the request must be received within the expedited response period.).
2) The notification letter is mailed hard copy to tribal chairs. Hard copies may also be mailed to other identified tribal leaders upon request.
3) Electronic notification messages are sent to the following – the notification letter is attached to the email:
   - Tribal clinic directors
   - Tribal health administrators as requested by the tribe
   - Indian Health Service Chief Executive Officer (for direct service tribes)
   - Urban Indian Health Organization directors
   - The American Indian Health Commission (AIHC)
   - The Indian Health Service (IHS), Portland area office
   - The Northwest Portland Area Indian Health Board
   - The Senior Director for the Office of Indian Policy (within the State's Department of Social and Health Services) to forward to IPAC delegates
4) All responses (verbal and written) are documented. Responses are sent to the originator. Suggested changes are reviewed and, if appropriate, are included in a revised document.
5) If requested, in-person meeting(s) are scheduled.

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1.4 State Medical Care Advisory Committee (cont)

Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

The process above is described in the single state agency's Administrative Procedure 1-15-01, which is associated with Administrative Policy 1-15 regarding State Plan Amendments (SPAs).

1) The draft Policy and Procedure were sent electronically to the American Indian Health Commission (AIHC) on June 6, 2011, as appendices to a draft Communication Protocol for the single state agency. These documents were then presented at the AIHC meeting on June 10, 2011.
2) The draft Policy and Procedure were distributed to tribal leaders at the State's Centennial Accord meeting on June 9, 2011.
3) Electronic and written notification and a review copy of this SPA (TN#11-25) was sent on July 28, 2011, as follows (a Dear Tribal Leader notification letter was attached to the email):
   - Tribal chairpersons (hard copy letter)
   - Tribal clinic directors
   - Indian Health Service Chief Executive Officer (for direct service tribes)
   - Urban Indian Health Organizations
   - The American Indian Health Commission (AIHC)
   - The Indian Health Service (IHS), Portland area office
   - The Northwest Portland Area Indian Health Board
   - Senior Director for the Office of Indian Policy (within the State's Department of Social and Health Services) to forward to IPAC delegates

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April 1994

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Citation	1.5	Pediatric Immunization Program
1928 of the Act		1. The State has implemented a program for the distribution of pediatric vaccines to program-registered providers for the immunization of federally vaccine-eligible children in accordance with section 1928 as indicated below.

a. The State program will provide each vaccine-eligible child with medically appropriate vaccines according to the schedule developed by the Advisory Committee on Immunization Practices and without charge for the vaccines.

b. The State will outreach and encourage a variety of providers to participate in the program and to administer vaccines in multiple settings, e.g., private health care providers, providers that receive funds under Title V of the Indian Health Care Improvement Act, health programs or facilities operated by Indian tribes, and maintain a list of program-registered providers.

c. With respect to any population of vaccine-eligible children a substantial portion of whose parents have limited ability to speak the English language, the State will identify program-registered providers who are able to communicate with this vaccine-eligible population in the language and cultural context which is most appropriate.

d. The State will instruct program-registered providers to determine eligibility in accordance with section 1928(b) and (h) of the Social Security Act.

e. The State will assure that no program-registered provider will charge more for the administration of the vaccine than the regional maximum established by the Secretary. The State will inform program-registered providers of the maximum fee for the administration of vaccines.

f. The State will assure that no vaccine-eligible child is denied vaccines because of an inability to pay an administration fee.

g. Except as authorized under section 1915(b) of the Social Security Act or as permitted by the Secretary to prevent fraud or abuse, the State will not impose any additional qualifications or conditions, in addition to those indicated above, in order for a provider to qualify as a program-registered provider.

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Citation	1.5	Pediatric Immunization Program (cont.)
1928 of the Act		2. The State has not modified or repealed any Immunization Law in effect as of May 1, 1993 to reduce the amount of health insurance coverage of pediatric vaccines. 3. The State Medicaid Agency has coordinated with the State Public Health Agency in the completion of this preprint page. 4. The State agency with overall responsibility for the implementation and enforcement of the provisions of section 1928 is: / / State Medicaid Agency /X/ State Public Health Agency

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Revision: HCFA-PM-91-4 (BPD)
August 1991

OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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SECTION 2 - COVERAGE AND ELIGIBILITY

Citation		
42 CFR 435.10 and Subpart J	2.1	Application, Determination of Eligibility and Furnishing Medicaid The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and Furnishing Medicaid.

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Citation 42 CFR 435.914 1902(a)(34) of the Act	2.1(b) (1)	Except as provided in items 2.1 (b) (2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in Attachment 2.6-A.

Originally superseded by SPA 19-0002. See MAGI-Based & Eligibility State Plan Amendments for current information

~~1902(e)(8) and 1905(a) of the Act~~	~~(2)~~	~~For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after The end of the month which the individual is first Determined to be a qualified Medicare beneficiary. Attachment 2.6 specifies the requirements for Determination of eligibility for this group.~~

Originally superseded by SPA 13-0030. See MAGI-Based & Eligibility State Plan Amendments for current information

~~1902(a)(47) and~~	~~(3)~~	~~Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. Attachment 2.6-A specifies the requirements for determination of eligibility for this group.~~

Removed per CMS November 2018.

~~42 CFR 438.6~~	~~(c)~~	~~The Medicaid agency elects to enter in a risk contract that complies with 42 CFR 438.6, and that is procured through an open, competitive procurement process that is consistent with 45 CFR Part 74. The risk contract is with (check all that apply):~~

~~___ Qualified under Title XIII 1310 of the Public Health Service Act~~

~~_X_ A Managed Care Organization that meets the definition of 1903(m) Of the Act and 42 CFR 438.2~~

~~_X_ A Prepaid Inpatient Health Plan that meets the definition of 42 CFR 438.2~~

~~_X_ A Prepaid Ambulatory Health Plan that meets the definition of 42 CFR 438.2~~

~~___ Not applicable.~~

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Originally superseded by SPA 13-0031.
See MAGI-Based & Eligibility State Plan Amendments for current information

~~Citation~~		
~~1902(a)(55) Of the Act~~	~~2.1 (d)~~	~~The Medicaid agency has procedures to take applications, assist applicants, and perform initial processing of Applications from those low income women, infants, and children under age 19, described in §1902(a)(10)(A)(i) (IV), (a)(10)(A)(ii) (IX), (a)(10)(A)(i)(VII), and (a)(10)(A)(ii)(IX) at locations other than those used by the title IV-A program including FQHCs and disproportionate share hospitals. Such application forms do not include the AFDC form except as permitted by HCFA instructions.~~

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Originally superseded by SPA 19-0002. See MAGI-Based & Eligibility State Plan Amendments for current information

Citation
~~42 CFR 435.10~~

2.2 Coverage and Conditions of Eligibility

~~Medicaid is available to the groups specified in ATTACHMENT 2.2-A.~~

~~___ Mandatory categorically needy and other required special groups only.~~

~~___ Mandatory categorically needy, other required special groups, and the medically needy, but no other optional groups.~~

~~___ Mandatory categorically needy, other required special groups, and specified optional groups.~~

~~_X_ Mandatory categorically needy, other required special groups, specified optional groups, and the medically needy.~~

~~The conditions of eligibility that must be met are specified in ATTACHMENT 2.6-A.~~

~~All applicable requirements of 42 CFR Part 435 and sections 1902(a)(10)(A)(ii)(XI), 1902(a)(10)(E), 1902(l) and (m), 1905(p), (q) and (s), 1920, and 1925 of the Act are met.~~

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Revision: HCFA-PM-87-4 (BERC)
March 1987

OMB No.: 0938-0193

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Originally superseded by SPA 13-0033.
See MAGI-Based & Eligibility State Plan Amendments for current information

~~Citation~~ ~~435.10 and 435.403, and 1902(b) of the Act, P.L. 99-272 (Section 9529)~~ And P.L. 99-509 (Section 9405)	~~2.3~~	~~Residence~~ ~~Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR 435.403, regardless of whether or not the individuals maintain the residence permanently or maintain it at a fixed address.~~

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March 1987

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Citation	2.4	Blindness
42 CFR 435.530(b) 42 CFR 435.531 AT-78-90 AT-79-29		All of the requirements of 42 CFR 435.530 and42 CFR 435.531 are met. The more restrictive definition of blindness in terms of ophthalmic measurement used in this plan is specified in ATTACHMENT 2.2-A.

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Citation	2.5	Disability
42 CFR 435.121, 435.540(b) 435.541		All of the requirements of 42 CFR 435.540 and 435.541 are met. The State uses the same definition of disability used under the SSI program unless a more restrictive definition of disability is specified in Item A.13.b. of ATTACHMENT 2.2-A of this plan.

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Originally superseded by SPA 19-0002.
See MAGI-Based & Eligibility State Plan Amendments for current information

Citation	2.6	Financial Eligibility
~~42 CFR 435.10 and Subparts G & H~~	~~(a)~~	~~The financial eligibility conditions for Medicaid-only eligibility groups and for persons deemed to be cash assistance recipients are described in ATTACHMENT 2.6-A.~~
~~1902(a)(10)(A)(i)(III), (IV), (V), and (VI), 1902(a)(10)(A)(ii)(IX), 1902(a)(10)(A)(ii)(X), 1902(a)(10)(C), 1902(f), 1902(l) and (m), 1905(p) and (s), 1902(r)(2), and 1920 of the Act~~		

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REVISION: HCFA-PM-86-20 (BERC) OMB No.: 0938- 0193
September 1986

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Citation		
431.52 and 1902(b) of the Act, P.L. 99-272 (Section 9529)	2.7	Medicaid Furnished Out of State Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another State, to the same extent that Medicaid is furnished to residents in the State; and An eligible individual who is a resident of the state when care is provided in Canada under the conditions specified in Attachment 2.7-A.

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SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation	3.1 Amount, Duration, and Scope of Services
42 CFR Part 440, Subpart B 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.	(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.
	(l) Categorically needy Services for the categorically needy are described below and in ATTACHMENT 3.1-A. These services include:
1902(a)(10)(A) and 1905(a) of the Act	(I) Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or, for EPSDT services, section 1905(r) and 42 CFR Part 441, Subpart B.
	(ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife if under the supervision of, or associated with, a physician or other health care provider.
	___ Not applicable. Nurse-midwives are not authorized to practice in this state.

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Citation			3.1(a) (1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)
1902(e) (5) of the Act		(iii)	Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.
	X	(iv)	Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.
1902(a) (10) (F) (VII)		(v)	Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a) (10) (A) (i) (IV) and 1902(a) (10) (A) (ii) (IX) of the Act.

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REVISION: HCFA-PM-92-7 (MB)
October 1992

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Citation	3.1(a)(1)		Amount, Duration, and Scope of Services: Categorically Needy (Continued)
		(vi)	Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan.
1902(e)(7) of the Act		(vii)	Inpatient services that are being furnished to infants and children described in section 1902(1)(1)(B) through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.
1902(e)(9) of the Act	_X_	(viii)	Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.
1902(a)(52) and 1925 of the Act		(ix)	Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan.
1905(a)(23) and 1929	___	(x)	Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

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Citation
1905(a)(26) and 1934

3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

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

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy. (Note: Other programs to be offered to Categorically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage -that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

PRA Disclosure Statement *The purpose of the PRA package is to provide a mechanism for states who voluntarily elect to provide medical assistance under Section 1934(a)(1) with respect to PACE program services to PACE program eligible individuals who are eligible for medical assistance under the State plan and who are enrolled in a PACE program under a PACE program agreement. 42 CFR 460.2 implements sections 1895, 1905(a), and 1934 of the Act, which authorizes the establishment of PACE as a State option under Medicaid to provide for Medicaid payment to, and coverage of benefits under, PACE. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1027 (Expires: 06/30/2023). The time required to complete this information collection is estimated to average 20 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

REVISION: HCFA-PM-92-7 (MB)
October 1992

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Citation	3.1	Amount, Duration, and Scope of Services (continued)
42 CFR Part 440, Subpart B	(a)(2)	Medically needy.
	_X_	This state plan covers the medically needy. The services described below and in ATTACHMENT 3.1-B are provided.
		Services for the medically needy include:
1902(a)(10)(C)(iv)(i) of the Act 42 CFR 440.220		If services in an institution for mental diseases* or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in section 1905(a)(1)through (20). The services are provided as defined in 42 CFR Part 440, Subpart A and in sections 1902, 1905, and 1915 of the Act. *(42 CFR 440.140 and 440.160).
	___	Not applicable with respect to nurse-midwife services under section 1902(a)(17). Nurse-midwives are not authorized to practice in this State.
1902(e)(5) of the Act	(ii)	Prenatal care and delivery services for pregnant women.

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Citation			
	3.1(a)(2)		Amount, Duration, and Scope of Services: Medically Needy (Continued)
		(iii)	Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.
	_X_	(iv)	Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.
		(v)	Ambulatory services, as defined in ATTACHMENT 3.1B, for recipients under age 18 and recipients entitled to institutional services.
		/ /	Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the medically needy.
		(vi)	Home health services to recipients entitled to nursing facility services as indicated in item 3.1(b) of this plan.
43 CFR 440.140,. 440.150, 440.160 Subpart B, 443.441, Subpart C	_X_	(vii)	Services in an institution for mental diseases for individuals over age 65.
	_X_	(viii)	Services in an intermediate care facility for the mentally retarded.
1902(a)(10)(C)		(ix)	Inpatient psychiatric services for individuals under age 21.

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May 1993

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Citation	3.1(a)(2)		Amount, Duration, and Scope of Services: Medically Needy (Continued)
1902(e)(9) of Act	_X_	(x)	Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.
1905(a)(23) and 1929 of the Act	___	(xi)	Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

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3.1 Amount. Duration, and Scope of Services (continued)

(a)(3) Other Required Special Groups: Qualified Medicare Beneficiaries

Medicare cost sharing for qualified Medicare beneficiaries described in section 1902(a) (10)(E)(i) and 1905(p) of the Act is provided only as indicated in item 3.2 of this plan.

(a)(4)(i) Other Required Special Groups; Qualified Disabled and Working Individuals

Medicare Part A premiums for qualified disabled and working individuals described in section 1902(a)(10)(E)(ii) of the Act are provided as indicated in item 3.2 of this plan.

(ii) Other Required Special Groups: Specified, Low-Income Medicare Beneficiaries

Medicare Part B premiums for specified low-income Medicare beneficiaries described in section 1902(a) (10) (E) (iii) and 1905(p) of the Act are provided as in indicated in item 3.2 of this plan.

(iii) Other Required Special Groups: Qualifying Individuals - 1

Medicare Part B premiums for qualifying individuals described in 1902(a)(10)(E)(iv) and 1905(p)(3)(A)(ii) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

(a)(5) Other Required Special Groups: Families Receiving Extended Medical Benefits

Extended Medicaid benefits for families described in section 1925 of the Act are provided as indicated in item 3.5 of this plan.

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REVISION: HCFA-PM-98-1 (CMSO)
April 1998

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Citation

Sec. 245A(h) of the Immigration and Nationality Act

(a)(6) Limited Coverage for Certain Aliens

(i) Aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who meet the financial and categorical eligibility requirements under the approved State Medicaid plan are provided the services covered under the plan if they--

(A) Are aged, blind, or disabled individuals as defined in section 1614(a)(1) of the Act;

(B) Are children under 18 years of age; or

(C) Are Cuban or Haitian entrants as defined in section 501(e)(1) and (2)(A) of P.L.96-422 in effect on April 1, 1983.

(ii) Except for emergency services and pregnancy-related services, as defined in 42 CFR 447.53(b) aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who are not identified in items 3.1(a)(6)(i)(A) through (C) above, and who meet the financial and categorical eligibility requirements under the approved State plan are provided services under the plan no earlier than five years from the date the alien is granted lawful temporary resident status.

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REVISION: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation		
	3.1(a) (6)	Amount, Duration, and Scope of Services: Limited Coverage for Certain Aliens (continued)
1902(a) and 1903(v) of the Act	(iii)	Aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law who meet the eligibility conditions under this plan, except for the requirement for receipt of AFDC, SSI, or a State supplementary payment, are provided Medicaid only for care and services necessary for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903(v)(3) of the Act.
1905(a)(9) of the Act	(a)(7)	Homeless Individuals. Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.
1902(a)(47) and 1920 of the Act	(a)(8)	Presumptivelv Eligible Pregnant Women Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan.
42 CFR 441.55 50 FR 43654 1902(a)(43), 1905(a)(4)(B), 1905(r) of the Act	(a)(9)	EPSDT Services. The Medicaid agency meets the requirements of sections 1902(a)(43),1905(a)(4)(B), and 1905(r) of the Act with respect to early and periodic screening, and diagnostic, and treatment (EPSDT) services.

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Citation	3.1(a)(9)	Amount, Duration, and Scope of Services: EPSDT Services (continued)
42 CFR 441.60	/ /	The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements.**
42 CFR 440.240 and 440.250 1902(a) and 1902 (a)(10), 1902(a)(52), 1903(v), 1915(g), 1925(b)(4), and 1932	(a)(10)	Comparability of Services Except for those items or services for which sections 1902(a), 1902(a)(10), 1903(v), 1915, 1925, and 1932 of the Act, 42 CFR 440.250, and section 245A of the Immigration and Nationality Act, permit exceptions:
	(i)	Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person.
	(ii)	The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.
	(iii)	Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.
/ /	(iv)	Additional coverage for pregnancy-related services and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

** Describe here

The continuing care provider submits monthly encounter data reflecting the number of examinations completed, the number of examinations where a referable condition was identified, and the number of follow-up treatment encounters. Medicaid staff make periodic on-site visits to monitor the provider's record of case management.

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May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

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Citation
42 CFR Part
440, Subpart B
42 CFR 441.15
AT-78-90
AT-80-34

3.1(b) Home health services are provided in accordance with the requirements of 42 CFR 441.15.

(1) Home health services are provided to all categorically needy individuals21 years of age or over.

(2) Home health services are provided to all categorically needy individuals under 21 years of age.

/X/ Yes

/ / Not applicable. The State plan does not provide for skilled nursing facility services for such individuals.

(3) Home health services are provided to the medically needy:

/X/ Yes, to all

/ / Yes, to individuals age 21 or over; SNF services are provided

/ / Yes, to individuals under age 21; SNF services are provided

/ / No; SNF services are not provided

/ / Not applicable; the medically needy are not included under this plan

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Citation	3.1	Amount, Duration, and Scope of Services (continued)
42 CFR 431.53	(c)(1)	Assurance of Transportation Provision is made for assuring necessary providers transportation of recipients to and from providers. Methods used to assure such transportation are described in ATTACHMENT 3.1-D.
42 CFR 483.10	(c)(2)	Payment for Nursing Facility Services The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10 (C) (8) (i)

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May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

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Citation		
42 CFR 440.260 AT-78-90	3.1 (d)	Methods and Standards to Assure Quality of Services The standards established and the methods used to assure high quality care are described in ATTACHMENT 3.1-C.

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May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

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Citation	3.1(e) Family Planning Services
42 CFR 441.20 AT-78-90	The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

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April 1987

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation
42 CFR 441.30.
AT-78-90

3.1 (f) (1) Optometric Services

Optometric services (other than those provided under §§435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

/X/ Yes

/ / No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform.

/ / Not applicable. The conditions in the first sentence do not apply.

1903(i)(1)
of the Act,
P.L. 99-272
(Section 9507)

(2) Organ Transplant Procedures

Organ transplant .procedures are provided

/ / No

/X/ Yes. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described at ATTACHMENT 3.1-E.

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Citation 42 CFR 431.110(b) AT-78-90	3.1	(g)	Participation by Indian Health Service Facilities Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.
1902(e)(9) of the Act, P.L. 99-509 (Section 9408)		(h)	Respiratory Care Services for Ventilator-Dependent Individuals Respiratory care services, as defined in section 1902(e)(9)(C) of the Act, are provided under the plan to individuals who-

(1) Are medically dependent on a ventilator for life support at least six hours per day;

(2) Have been so dependent as inpatients during a single stay or a continuous stay in one or more hospitals, SNFs or ICFs for the lesser of-

/X/ 30 consecutive days;

/ / __ days (the maximum number of inpatient days allowed under the State plan);

(1) Except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, SNF, or ICF for which Medicaid payments would be made;

(4) Have adequate social support services to be cared for at home; and

(5) Wish to be cared for at home.

/X/ Yes. The requirements of section 1902(e)(9) of the Act are met.

/ / Not applicable. These services are not included in the plan.

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REVISION: HCFA-PM-93-5 (MB)
May 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation			
	3.2	Coordination of Medicaid with Medicare and Other Insurance	
		(a)	Premiums
		(1)	Medicare Part A and Part B
1902(a)(10)(E)(i) and 1905(p)(1) of the Act		(i)	Qualified Medicare Beneficiary QMB

The Medicaid agency pays Medicare Part A premiums (if applicable) and Part B premiums for individuals in the QMB group defined in Item A.25 of ATTACHMENT 2.2-A, through the group premium payment arrangement, unless the agency has a Buy-in agreement for such payment, as indicated below.

Buy-In agreement for:

/X/ Part A /X/ Part B

/ / The Medicaid agency pays premiums, for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.

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REVISION: HCFA-PM-97-3 (CMSO)
December 1997

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation		
1902(a)(10)(E)(ii) and 1905(s) of the Act	(ii)	Qualified Disabled and Working Individual (QDWI) The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement, subject to any contribution required as described in ATTACHMENT 4.18-E, for individuals in the QDWI group defined in item A.26 of ATTACHMENT 2.2-A of this plan.
1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act	(iii)	Specified Low-Income Medicare Beneficiary (SLMB) The Medicaid agency pays Medicare Part B premiums under the State buy-In process for individuals in the SLMB group defined in item A.27 of ATTACHMENT 2.2-A of this plan.
1902(a)(10)(E){iv}(I), 1905(p}(3)(A)(ii), and 1933 of the Act	(iv)	Qualifying Individual - 1 (QI-1) The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals described in 1902(a) (10) (E) (iv) (I) and subject to 1933 of the Act.
1902(a)(10)(E)(iv)(II), 1905(p)(3)(A)(ii), and 1933 of the Act	(v)	Qualifying Individual - 2 (QI-2) The Medicaid agency pays the portion of the amount of increase to the Medicare Part B premium attributable to the Home Health Provision to the individuals described in 1902(a)(10) (E}(iv)(II) and subject to 1933 of the Act.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation

1843 (b) and 1905(a) of the Act and 42 CFR 431.625

(vi) Other Medicaid Recipients

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

/X/ All individuals who are: (a) receiving benefits under titles I, IV-A, X, XIV, or XVI (AABD or SSI); b) receiving State supplements under title XVI; or c) within a group listed at 42 CFR 431.625(d)(2).

/ / Individuals receiving title II or Railroad Retirement benefits.

/X/ Medically needy individuals (FFP is not available for this group)

1902(a)(30) and 1905(a) of the Act

(2) Other Health Insurance

/X/ The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 63 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B).

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State/Territory: WASHINGTON

Citation		
(b) Deductibles/Coinsurance		
		(1) Medicare Part A and B
1902(a)(30), 1902(n), 1905(a),and 1916 of the Act		Supplement 1 to ATTACHMENT 4.19-B describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups.
Sections 1902 (a)(10)(E)(i) and 1905(p)(3) of the Act	(i)	Qualified Medicare Beneficiaries (QMBS) The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for QMBs (subject to any nominal Medicaid copayment) for all services available under Medicare.
1902(a)(10), 1902(a)(30), and 1905(a) of the Act	(ii)	Other Medicaid Recipients The Medicaid agency pays for Medicaid services also covered under Medicare and furnished to recipients entitled to Medicare (subject to any nominal Medicaid copayment). For services furnished to individuals who are described in section 3.2(a)(1)(iv), payment is made as follows:
42 CFR 431.625		/X/ For the entire range of services available under Medicare Part B. / / Only for the amount, duration, and scope of services otherwise available under this plan.
1902(a)(10), 1902(a)(30), 1905(a), and 1905(p) of the Act	(iii)	Dual Eligible -- OMB plus The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for all services available under Medicare and pays for all Medicaid services furnished to individuals eligible both as QMBs and categorically or medically needy (subject to any nominal Medicaid copayment).

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State/Territory: WASHINGTON

Citation			
1906 of the Act	(c)		Premiums, Deductibles, Coinsurance and Other Cost Sharing Obligations The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan (subject to any nominal Medicaid copayment) for eligible individuals in employer-based cost-effective group health plans.
1906A of the Act	(c)-1	/X/	The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan, as specified in the qualified employer-sponsored coverage, without regard to limitations specified in section 1916 or section 1916A of the Act, for eligible individuals under age 19 who have access to and elect to enroll in such coverage. The eligible individual is entitled to services covered by the State plan which are not included in the employer-sponsored coverage. For qualified employer-sponsored coverage, the employer must contribute at least 40 percent of the premium cost. When coverage for eligible family members under age 19 is not possible unless an ineligible parent enrolls, the Medicaid agency pays premiums for enrollment of the ineligible parent, and, at the parent's option, other ineligible family members. The agency also pays deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan for the ineligible parent.
1902(a)(10)(F) of the Act	(d)	/ /	The Medicaid agency pays premiums for individuals described in item 19 of Attachment 2.2-A.

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May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation		
42 CPR 441.101, 42 CFR 431.620 (c) and (d) AT-79-29	3.3	Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases Medicaid is provided for individuals 65 years of age or older who are patients in institutions for mental diseases. /X/ Yes. The requirements of 42 CFR Part 441, Subpart C, and 42 CFR 431.620 (c) and (d) are met. / / Not applicable. Medicaid is not provided to aged individuals in such institutions under this plan.

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May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation		
42 CFR 441.252 AT-78-99	3.4	Special Requirements Applicable to Sterilization Procedures All requirements of 42 CFR Part 441, Subpart F are met.

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August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation
1902(a)(52) and 1925 of the Act

3.5 Families Receiving Extended Medicaid Benefits

(a) Services provided to families during the first 6-month period of extended Medicaid benefits under Section 1925 of the Act are equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

(b) Services provided to families during the second 6-month period of extended Medicaid benefits under section 1925 of the Act are--

/X/ Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (o may be greater if provided through a caretaker relative employer's health insurance plan).

/ / Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients, (or may be greater if provided through a caretaker relative employer's health insurance plan) minus any one or more of the following acute services:

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

/ / Medical or remedial care provided by licensed practitioners.

/ / Home health services.

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Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

/ / Private duty nursing services.

/ / Physical therapy and related services.

/ / Other diagnostic, screening, preventive, or rehabilitation services.

/ / Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases.

/ / Intermediate care facility services for the mentally retarded.

/ / Inpatient psychiatric services for individuals under age 21.

/ / Hospice services.

/ / Respiratory care services.

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

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Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

(c) / / The agency pays the family's premiums, enrollment fees, deductibles, coinsurance, and similar costs for health plans offered by the caretaker's employer as payments for medical assistance--

/ / 1st 6 months / / 2nd 6 months

/ / The agency requires caretakers to enroll in employers' health plans as a condition of eligibility.

/ / 1st 6 mos. / / 2nd 6 mos.

(d) / / (1)The Medicaid agency provides assistance to families during the second 6-month period of extended Medicaid benefits through the following alternative methods:

/ / Enrollment in the family option of an employer's health plan.

/ / Enrollment in the family option of a State employee health plan.

/ / Enrollment in the State health plan for the uninsured.

/ / Enrollment in an eligible health maintenance organization (HMO) with a prepaid enrollment of less than 50 percent Medicaid recipients (except recipients of extended Medicaid).

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Citation

3.5 Families Receiving Extended Medicaid Benefits (Continued)

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency-

(i) Pays all premiums and enrollment fees imposed on the family for such plan(s).

/ / (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

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REVISION: HCFA-PN-87-4 (BERC) OMB No.: 0938-0193
March 1987

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation		
42 CFR 431.15 AT-79-29	4.1	Methods of Administration The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.

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State/Territory: WASHINGTON

Citation	4.2	Hearings for Applicants and Recipients
42 CFR 431.202 AT-79-29 AT-80-34		The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.
1919(e)(3)		With respect to transfers and discharges from nursing facilities, the requirements of 1919(e)(3) are met.

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State/Territory: WASHINGTON

Citation		
42 CFR 431.301	4.3	Safeguarding Information on Applicants and Recipients
AT-79-29		Under State statute which imposes legal sanctions, safeguards are provided that restrict the use of disclosure of information concerning applicants and recipients to purposed directly connected with the administration of the plan.
52 FR 5967		All other requirements of 42 CFR Part 431, Subpart F are met.

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State/Territory: WASHINGTON

Citation		
42 CFR 431.800(c) 50 FR 21839 1903(u)(1)(D) of the Act, P.L. 99-509 (Section 9407)	4.4	Medicaid Quality Control
	(a)	A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.
	(b)	The State operates a claims processing assessment system that meets the requirements of 431.800(e), (g) , (h), (j)*, and (k) . / / Yes. /X/ Not applicable. The State has an approved Medicaid Management Information System (MMIS). *pen & ink change to add “j” per PM 87-14, 10/87

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State/Territory: WASHINGTON

Citation		
42 CFR 455.12 AT-78-90 48 FR 3742 52 FR 48817	4.5	Medicaid Agency Fraud Detection and Investigation Program The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse.

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REVISION: HCFA-PM-99-9 (CMSO)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation		
Section 1902(a)(64) of the Social Security Act P.L. 105-33	4.5a	Medicaid Agency Fraud Detection and Investigation Program The Medicaid agency has established a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this title.

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4.5b Medicaid Recovery Audit Contractor Program

Citation

Section 1902(a)(42)(V)(i)
of the Social Security Act

____ The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan.

__X__ The State is seeking a time-limited exception to establishing such program for the following reasons:

Washington State is respectfully requesting an extension to its current exception to establish a Medicaid RAC program. The State released a Request for Proposal on September 14, 2022, with a due date of September 23, 2022, and once again no bids were received.

Approximately 90% of Washington State's Medicaid population is enrolled in managed care and provider network payments are not subject to recovery audit contracting. The State has not received bids from any RAC vendor during the last three RFPs issued.

Washington State maintains a robust program integrity oversight program of fee-for-service (FFS) payments and is entering into a Joint Operating Agreement with Qlarant, the UPIC for the Western Region to assist in oversight of FFS expenditures. The State will leverage audits of FFS programs and providers with Qlarant to ensure appropriate oversight of FFS expenditures continue.

4.5b Medicaid Recovery Audit Contractor Program

Section 1902(2)(42)(B)(ii)(I) of the Act	___ The State/Medicaid Agency has contracts of the type(s)) listed in section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute.

4.5b Medicaid Recovery Audit Contractor Program

Section 1902(a)(42)(B)(ii)(ll)(aa) of the Act

Place a check mark to provide assurance of the following:

___ The State will make payments to the RAC(s) only from amounts recovered.

___ The State will make payments to the RAC(s) on a contingent basis for collecting overpayments.

The following payment methodology shall be used to determine State payments to Medicaid RACs for identification and recovery of overpayments (e.g., the percentage of the contingency fee):

____ The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register.

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_____ The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate.

_____The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.

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State/Territory: WASHINGTON

4.5b Medicaid Recovery Audit Contractor Program (cont)

Section 1902 (a)(42)(B)(ii)(II)(BB) of the Act	___ The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee):
Section 1902 (a)(42)(B)(ii)(III) of the Act	____ The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).
Section 1902 (a)(42)(B)(ii)(IV)(aa) of the Act	____ The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan.
Section 1902(a)(42)(B)(ii)(IV(bb) of the Act	_____ The State assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share.
Section 1902 (a)(42)(B)(ii)(IV)(cc) of the Act	____ Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.

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REVISION: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation	4.6	Reports
42 CFR 431.16 AT-79-29		The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.

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May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation		
42 CFR 431.17 AT-79-29	4.7	Maintenance of Records The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation		
42 CFR 431.18(b) AT-79-29	4.8	Availability of Agency Program Manuals Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.

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May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation		
42 CFR 433.37 AT-78-90	4.9	Reporting Provider Payments to Internal Revenue Service There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.

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NEW: HCFA-PM-99-3
June 1999

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation	
42 CFR431.51 AT-78-90 46 FR 48524 48 FR23212 1902 (a) (23) of the Act P.L. 100-93 (section 8(f)) P.L.100-203 (Section 4113)	4.10 Free Choice of Providers (a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis. (b) Paragraph (a) does not apply to services furnished to an individual-- (1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or (2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or (3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act, or
Section 1902(a)(23) the Social Security Act P.L. 105-33	(4) By individuals or entities who have been convicted of a of felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services. (5) Under an exception allowed under 42 CFR 438.50 or 42 CFR 440.168, subject to the limitations in paragraph (c). (c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1905(t), 1915 9a), 1915(b),1), or 1932(a); or managed care organization, prepaid inpatient health plan, a prepaid ambulatory health plan, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905(a)(4)(c).

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4.11 Relations with Standard-Setting and Survey Agencies

(a) The State agencies utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients as contracted by the Centers for Medicare and Medicaid Services (CMA). These agencies are: the Department of Social and Health Services and the Department of Health.

(b) The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients are: the Legislature, State Board of Health, State Fire Marshall, the Department of Social and Health Services, and the Department of Health.

(c) Attachment 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Center for Medicare and Medicaid Services on request.

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4.11 Relations with Standard-setting and Survey Agencies – continued

(d) The Department of Social and Health Services is the state agency responsible for licensing and surveying long-term care health institutions and determines if institutions and agencies meet the requirements for participation In the Medicaid program. The requirements in 42 CFR 431.610(e)(f) and (g) are met.

(e) The Department of Social and Health Services is the state agency responsible for surveying and certifying ICF/IID facilities. The requirements in 42 CFR 483.400 through 483.480 and 42 CFR 440.150 are met.

(f) The Department of Health is the contracted survey agency for the Centers for Medicare and Medicaid (CMS) to survey non-long- term care health institutions and to make recommendations to CMS that a facility meets the federal Medicare requirements according to the State Operations Manual and the Mission and Priority document (published yearly) for participation in the Medicare program. The requirements in 42 CFR part 431.610 (e) and (f) are met.

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4.12 Consultation to Medical Facilities

(a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105(b).

(b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105 (b) .

/X/ Yes, as listed below:

Emergency medicine and trauma prevention pre-hospital system facilities and organizations.

Rural Health Clinics

Rehabilitation facilities

End Stage Renal Dialysis facilities

Ambulatory Surgery Centers

Child Birth Centers

Residential Treatment facilities

Chemical Dependency Treatment facilities

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Citation			
	4.13		Required Provider Agreement
			With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:
42 CFR 431.107		(a)	For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.
42 CFR Part 483 1919 of the Act		(b)	For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.
42 CFR Part 483 Subpart D		(c)	For providers of ICF/MR services, the requirements of participation in 42 CFR Part 483, Subpart D are also met.
1920 of the Act		(d)	For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920(b)(2) and (c) are met.
			/X/ Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

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Citation

1902(a)(58)
1902(w) 4.13

(e) For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:

(1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans (unless the PAHP excludes providers in 42 CFR 489.102), and health insuring organizations are required to do the following:

(a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

(b) Provide written information to all adult individuals on their policies concerning implementation of such rights;

(c) Document in the individual's medical records whether or not the individual has executed an advance directive;

(d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(e) Ensure compliance with requirements of State Law (whether

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statutory or recognized by the courts) concerning advance directives; and

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

(2) Providers will furnish the written information described in paragraph(1)(a) to all adult individuals at the time specified below:

(a) Hospitals at the time an individual is admitted as an inpatient.

(b) Nursing facilities when the individual is admitted as a resident.

(c) Providers of home health care personal care services before the individual comes under the care of the provider;

(d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and

(e) Managed care organizations, health insuring organizations, prepaid inpatient health plans, and prepaid ambulatory health plans (as applicable) at the time of enrollment of the individual with the organization.

(3) Attachment 4.34A describes law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives.

_____Not applicable. No State law or court decision exist regarding advance directives.

Citation

4.13 Required Provider Agreement (cont)

1902(a)(b)(27), of the Social Security Act

(f) Additional Provider requirements

42 CFR 431.107(5)

A provider must furnish its NPI (if eligible for an NPI) to the Medicaid Agency in order to obtain a provider agreement with the Agency, and include its NPI on all claims submitted to the Agency under the Medicaid program.

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Citation			
	4.14		Utilization/Quality Control
42 CFR 431.60 42 CFR 456.2 50 FR 15312 1902(a)(30)(C) and 1902(d) of the Act, P.L. 99-509 (Section 9431)	(a)		A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met:
		X	Directly
			By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO —
			(1) Meets the requirements of §434.6(a):
			(2) Includes a monitoring and evaluation plan to ensure satisfactory performance;
			(3) Identifies the services and providers subject to PRO review;
			(4) Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and
			(5) Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.
1932(c)(2) and 1902(d) of the meets ACT, P.L. 99-509 each (section 9431)		X	A qualified External Quality Review Organization performs an annual External Quality Review that the requirements of 42 CFR 438 Subpart E for managed care organization, prepaid inpatient health plan, and health insuring organizations under contract, except where exempted by the regulation

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OMB N0. 0938-0193

Citation			
42 CFR 456.2 50 PR 15322	4.14	(b)	The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services:

/X/ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CPR Part 462 that has a contract with the agency to perform those reviews.

/ / Utilization review is performed in accordance with 42 CPR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for:

/ / All hospitals (other than mental hospitals).

/ / Those specified in the waiver.

/X/ No waivers have been granted.

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Citation			
42 CFR 456.2 50 FR 15312	4.14	(c)	The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals.

/ / Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/ / Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:

/ / All mental hospitals.

/ / Those specified in the waiver.

/X/ No waivers have been granted.

/ / Not applicable. Inpatient services in mental hospitals are not provided under this plan.

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OMB N0. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 (d) The Medicaid agency meets the requirements of 42 CPR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

/ / Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/X/ Utilization review is performed in accordance with 42 CYR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart E for:

/X/ All skilled nursing facilities.

/ / Those specified in the waiver.

/ / No waivers have been granted.

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Citation
42 CFR 456.2
50 FR 15312

4.14 (e) /X/ The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through:

/ / Facility-based review.

/ / Direct review by personnel of the medical assistance unit of the State agency.

/ / Personnel under contract to the medical assistance unit of the State agency.

/ / Utilization and Quality Control Peer Review Organizations.

/ / Another method as described in ATTACHMENT 4.14-A.

/X/ Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used.

/ / Not applicable. Intermediate care facility services are not provided under this plan.

(f) The Medicaid agency meets the requirements of section 1902(a){30) of section 1902(a) (30) of the Act for control of the assurance of quality furnished by each health maintenance organization under contract with the Medicaid agency. Independent, external quality reviews are performed annually by:

/ / A Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.
/ / A private accreditation body.
/X/ An entity that meets the requirements of the Act, as determined by the Secretary.

The Medicaid agency certifies that the entity in the preceding subcategory under 4.14(f) is not an agency of the State.

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Citation	4.14 Utilization/Quality Control (Continued)	
42 CFR 438.356(e)		For each contract, the State follows an open, competitive procurement process that is in accordance with State law and regulations and consistent with 45 CFR part 74 as it applies to State procurement of Medicaid services.
42 CFR 438.354		The State ensures that an External Quality Review Organization and its subcontractors performing the External Quality Review or External Quality Review-related activities meets the competence and independence requirements.
	___	Not applicable.

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Citation		
	4.15	Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Providing Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals
42 CFR Part 456 Subpart I, and 1902(a)(31) and 1903(g) of the Act	/ /	The State has contracted with a Peer Review Organization (PRO) to perform inspection of care for:
		/ / ICFs/MR;
		/ / Inpatient psychiatric facilities for recipients under age 21; and
		/ / Mental Hospitals.
42 CFR Part 456 Subpart A and 1902(a)(30) of the Act	/X/	All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services.
	/ /	Not applicable with respect to intermediate care facilities for the mentally retarded services; such services are not provided under this plan.
	/ /	Not applicable with respect to services for individuals age 65 or over in institutions for mental disease; such services are not provided under this plan.
	/ /	Not applicable with respect to inpatient psychiatric services for individuals under age 21; such services are not provided under this plan.

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Citation	4.16	Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees
42 CFR 431.615(c) AT-78-90		The Vocational Rehabilitation Agencies are located within the Single State Agency. The Medicaid agency has cooperative arrangements with the Title V Grantee, Department of Health, that meet the requirements of 42 CFR 431.615. ATTACHMENT 4.16-A describes the cooperative arrangement with the Title V Grantee.

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Citation
42 CFR 433.36(c)
1902(a)(18) and
1917(a) and (b) of
the Act

4.17 Liens and Adjustments or Recoveries

(a) Liens

/ / The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917(a) of the Act and regulations at 42 CFS 433.36(c) – (g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

/X/ The State imposes liens on real property on account of benefits incorrectly paid.

/X/ The State imposes TEFRA liens 1917(a)(1)(B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs except on property interests disregarded under the long-term care insurance partnership.

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (NOTE: If the State indicates in its State plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.)

/X/ The State imposes liens on both real and personal property of an individual after the individual's death.

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4.17 Liens and Adjustments or Recoveries (cont.)

(b) Adjustments or Recoveries

The State complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.36(h) – (i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

(1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

/ / Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

(2) The State determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under §1917(a)(1)(B) (even if it does not impose those liens).

(3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

/ / In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State plan as listed below:

Through December 31, 2013, all Medicaid services listed in Attachments 3.1-A and 3.1-B provided to eligible clients age 55 and over, except for Medicare cost sharing benefits identified in 4.17 (b)(3-Continued). Through Dec. 31, 2009, Medicare cost-sharing and Medicare premiums for individuals also receiving Medicaid (dual eligibles), and premium payments to managed care organizations will be included in the statement of claim.

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4.17 Liens and Adjustments or Recoveries (cont)

(b) (3) Adjustments or Recoveries (cont)

1917(b)(1) Limitations on Estate Recovery – Medicare Cost Sharing:

(i) Medical assistance for Medicare cost sharing is protected from estate recovery for the following categories of dual eligibles: QMB, SLMB, QI,
QDWI, QMB+, SLMB+. This protection extends to medical assistance for four Medicare cost sharing benefits: Part A and B premiums, deductibles, coinsurance, co-payments) with dates of service on or after January 1, 2010. The date of service for deductibles, coinsurance, and co-payments is the date the request for payment is received by the State Medicaid agency. The date of service for premiums is the date the State Medicaid agency paid the premium.

(ii) In addition to being a qualified dual eligible, the individual must also be age 55 or over. The above protection from estate recovery for Medicare cost sharing benefits (premiums, deductibles, coinsurance, and co-payments) applies to approved mandatory (i.e., nursing facility, home and community-based services, and related prescription drug and hospital services) as well as optional Medicaid services identified in the State Plan, which are applicable to the categories of dual eligibles referenced above.

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4.17 Liens and Adjustments or Recoveries (cont.)

(4) / / The State disregards assets or resources for individuals who receive or are entitled to receive benefits under a long term care insurance policy for in Attachment 2.6 – A, Supplement 8b.

/X/ The State adjusts or recovers from the individual's estate on account of all medical assistance paid for nursing facility and other long term care services provided on behalf of the individual. (States other than California, Connecticut, Indiana, Iowa and New York which provide long term care insurance policy-based asset or resource disregard must select this entry. These five States may either check this entry or one of the following entries.)

/ / The State does not adjust or recover from the individual's estate on account of any medical assistance paid for nursing facility or other long term care services provided on behalf of the individual.

/ / The State adjusts or recovers from the assets or resources on account of medical assistance paid for nursing facility or other long term care services provided on behalf of the individual to the extent described below:

/X/ If an individual covered under a long-term care insurance policy received benefits for which assets or resources were disregarded as provided for in Attachment 2.6-A, supplement 8c (State Long-Term Care Insurance Partnership), the State does not seek adjustment or recovery from the individual's estate for the amount of assets or resources disregarded.

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4.17 Liens and Adjustments or Recoveries (cont.)

(c) Adjustments or Recoveries: Limitations

The State complies with the requirements of section 1917(b)(2) of the Act and regulations at 42 CFR §433.36(h) – (i).

(1) Adjustment or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.

(2) With respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustment or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:

(a) a sibling of the individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized), or

(b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care the child provided permitted the individual to reside at home rather than become institutionalized.

(3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.

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4.17 Liens and Adjustments or Recoveries (cont.)

(d) ATTACHMENT 4.17-A

(1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36 (d).

(2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36 (f).

(3) Defines the following terms:

- estate at a minimum estate as defined under State probate law). Except for the grandfathered States listed in section 4.17 (b) (3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual has any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangement),
  - individual's home,
  - equity interest in the home,
  - residing in the home for at least 1 or 2 years on a continuous basis,
  - discharge from the medical institution and return home, and
  - lawfully residing.

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4.17.1 Liens and Adjustments or Recoveries (cont.)

(4) Defines undue hardship.

(5) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.

(6) Defines when adjustment or recovery is not cost-effective. Defines cost-effective and includes methodology or thresholds used to determine cost-effectiveness.

(7) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.

(8) Defines tribal exemptions for Estate Recovery.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Citation		4.19 Payment for Services
		Effective July 1, 2011, all references to the Department of Social and Health Services (DSHS or the Department) as the Medicaid State Agency in Attachment 4.19-A Part 1; Supplement 3 to Attachment 4.19-A Part 1; And Attachment 4.19-D Part 1 now refer to the Washington State Health Care Authority, also known as the Health Care Authority or the Agency.
42 CFR 447.252 1902(a)(13) and 1923 of the Act	(a)	The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and sections 1902(a)(13) and 1923 of the Act with respect to payment for inpatient hospital services.
1902(e)(7) of the Act		ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services.
		/X/ Inappropriate level of care days are covered and are paid under the State plan at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.
		/ / Inappropriate level of care days are not covered.

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Citation		
42 CFR 447.201 42 CFR 447.302 52 FR 28648 1902(a)(13)(E) 1903(a)(1) and (n), 1920, and 1926 of the Act	4.19(b)	In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m), the Medicaid agency meets the following requirements: (1) Section 1902(a)(13)(E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905 (a)(2)(C) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services. ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys). (2) Sections 1902 (a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan. ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.
1902(a)(10) and 1902(a)(30) of the Act		SUPPLEMENT 1 to ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance.

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REVISION: HCFA-PM-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Citation		
42 CFR 447.40 AT-78-90	4.19 (c)	Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

/X/ Yes. The State's policy is described in ATTACHMENT 4.19-C.

/ / No.

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State/Territory: WASHINGTON

Citation			4.19(d) Payment for Services
42 CFR 447.252 47 FR 47964 48 FR 56046 42 CFR 447.280 47 FR 31518 52 FR 28141	/X/	(1)	The Medicaid agency meets the requirements of42 CFR Part 447, Subpart C, with respect to payments for skilled nursing and intermediate care facility services. ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for skilled nursing and intermediate care facility services.
		(2)	The Medicaid agency provides payment for routine skilled nursing facility services furnished by a swing-bed hospital.
			/X/ At the average rate per patient day paid to SNFs for routine services furnished during the previous calendar year.
			/ / At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.
			/ / Not applicable. The agency does not provide payment for SNF services to a swing-bed hospital.
		(3)	The Medicaid agency provides payment for routine intermediate care facility services furnished by a swing-bed hospital.
			/X/ At the average rate per patient day paid to ICFs, other than ICFs for the mentally retarded, for routine services furnished during the previous calendar year.
			/ / At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.
			/ / Not applicable. The agency does not provide payment for ICF services to a swing-bed hospital.
	/ /	(4)	Section 4.19(d)(1) of this plan is not applicable with respect to intermediate care facility services; such services are not provided under this State plan.

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REVISION: HCFA-PM-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation	4.19 (e)	The Medicaid agency meets all requirements of 42 CPR 447.45 for timely payment of claims.
42 CPR 447.45 (c) AT-79-50		ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

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REVISION: HCFA-PM-87-4 (BERC)
March 1987

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation 42 CPR 447.15 AT-78-90 AT-80-34 48 FR 5730	4.19 (f)	The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15. No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.

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REVISION: HCFA-PM-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation	4.19(g)	The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials.
42 CFR 447.201 42 CFR 447.202 AT-78-90		

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REVISION: HCFA-PM-80-60 (BPP)
August 12, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation		
42 CFR 447.201 42 CFR 447.203 42 CFR 447.203 AT-78-90	4.19 (h)	The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.

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REVISION: HCFA-PM-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation	4.19(i)	
42 CFR 447.201 42 CFR 447.204 AT-78-90		The Medicaid agency's payments are Sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation	4.19	(j)	The Medicaid agency meets the requirements Of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.
42 CFR 447.201 and 447.205			
1903(v) of the Act		(k)	The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act.

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REVISION: HCFA-PM-92-7 (MB) OMB No.: 0938-
October 1992

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation		
1903(i)(14) of the Act	4.19 (l)	The Medicaid agency meets the requirements of section 1903(i)(14) of the Act with respect to payment for physician services furnished to children under 21 and pregnant women. Payment for physician services furnished by a physician to a child or a pregnant woman is made only to physicians who meet one of the requirements listed under this section of the Act.

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REVISION: HCFA-PM-94-6 (MB)
OCTOBER 1994

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation

4.19 (m) Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program

1928(c)(2)(C)(ii) of the Act

(i) A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in1928(c) (2) (C) (ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows.

(ii) The State:

/ / sets a payment rate at the level of the regional maximum established by the DHHS Secretary.

/ / is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.

/ / sets a payment rate below the level of the regional maximum established by the DHHS Secretary.

/X/ is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.

The State pays the following rate for the administration of a vaccine:

- Managed Care Plans:
  Administration rates for vaccines are factored in as part of administrative costs to the plan.
- Non-Managed Care Plan providers will be paid based on fee-for-service.

1926 of the Act

(iii) Medicaid beneficiary access to immunizations is assured through the following methodology:

- State will maintain a list of Medicaid program registered providers.
- Medicaid program-registered providers who can communicate in a language and cultural context which is most appropriate will be identified.
- Vaccines will be distributed through the Managed Care Plans and other Medicaid registered providers.
- Quality Assurance program is performing outcome studies and will continue to work with Managed Care Plans to increase immunization rates.
- Children covered under Managed Care Plans may receive immunization at the Health Department, so access is not limited.

REVISION: HCFA-PM-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation
42 CFR 447.25 (b)
AT-78-90

4.20 Direct Payments to Certain Recipients for Physicians' or Dentists' Services

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25.

/ / Yes, for / / physician's services

/ / dentists' services

ATTACHMENT 4.20-A specifies the conditions under which such payments are made.

/X/ Not applicable. No direct payments are made to recipients.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation	4.21	Prohibition Against Reassignment of Provider Claims
42 CFR 447.10 (c) AT-78-90 46 FR 42699		Payment for Medicaid services furnished by any provider under this plan is made only in accordance with the requirements of 42 CFR 447.10

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REVISION: HCFA-PM-94-1 (MB)
February 1994

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation		4.22 Third Party Liability
42 CFR 433.137	(a)	The Medicaid agency meets all requirements of: (1) 42 CFR 433.138 and 433.139. (2) 42 CFR 433.145 through 433.148. (3) 42 CFR 433.151 through 433.154. (4) Sections 1902 (a) (25) (H) and (I) of the Act.
1902 (a) (25) (H) and (I) of the Act.		
42 CFR 433.138 (f)	(b)	ATTACHMENT 4.22-A --
		(1) Specifies the frequency with which the data exchanges required in §433.138 (d) (1), (d) (3) and (d) (4) and the diagnosis and trauma code edits required in §433,137 (e) are conducted;
42 CFR 433.138 (g) (1) (ii)		(2) Describes the methods the agency uses for meeting the following requirements continued in §433.138 (g) (1) (i) and (g) (2) (i);
42 CFR 433.138 (g) (3) (i) and (iii)		(3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138 (d) (4) (ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow up that identifies legally liable third party resources; and
42 CFR 433.138 (g) (4) (I) through (iii)		(4) Describes the methods the agency uses for following up on paid claims identified under §433.138 (e) (methods include a procedure for periodically identifying these trauma code that yield the highest third party collections and giving priority to following up on these codes) and specifies the time frames for incorporation into the eligibility case file and into its third party date base and third party recovery unit of all information obtained through the follow up that identifies legally liable third party resources.

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REVISION: HCFA-PM-94-1 (MB)
February 1994

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation			
42 CFR 433.139 (b) (3) (ii)(A)	/X/	(c)	Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.
	(d)	ATTACHMENT 4.22-B specifies the following:	
42 CFR 433.139 (b) (3) (ii) (c)		(1)	The method used in determining a provider's compliance with the third party billing requirements at §433.139 (b) (ii) (C).
42 CFR 433.139 (f) (2)		(2)	The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.
42 CFR 433.139 (f) (3)		(3)	The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.
42 CFR 447.20	(e)	The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.	

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REVISION: HCFA-PM-94-1 (MB)
February 1994

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation	4.22	Third Party Liability (cont.)
42 CFR 433.151 (a)	(f)	The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.) / / State title IV-D agency. The requirements of 42 CFR 433.152 (b) are met. /X / Other appropriate State agency(s)— Department of Social and Health Services' Office of Financial Recovery / / Other appropriate agency(s) of another State-- _____ _____ / / Courts and law enforcement officials.
42 CFR 433.140 and 433.154		
1902 (a) (60) of the Act	(g)	The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.
1906 of the Act	(h)	The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following. / / The Secretary's method as provided in the State Medicaid Manual, Section 3910. /X/ The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C.

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REVISION: HCFA-PM-84-2 (BERC) OMB No.: 0938-0193
01-84

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation		
42 CFR Part 434.4 48 FR 54013	4.23	Use of Contracts The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434. / / Not applicable. The State has no such contracts.

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REVISION: HCFA-PM-94-2 (BPD)
April 1994

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation		
42 CFR 442.10 and 442.100 AT-78-90 AT-79-18 AT-80-25 AT-80-34 52 FR 32544 P.L. 100-203 (Sec. 4211) 54 FR 5316 56 FR 48826	4.24	Standards for Payments for Nursing Facility and Intermediate Care Facility for the Mentally Retarded Services With respect to nursing facilities and intermediate care facilities for the mentally retarded, all applicable requirements of 42 CFR Part 442, Subparts B and C are met. / / Not applicable to intermediate care facilities for the mentally retarded; such services are not provided under this plan.

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REVISION: HCFA-PM-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation		
42 CFR 431.702 AT-78-90	4.25	Program for Licensing Administrators of Nursing Homes The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.

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REVISION: HCFA-PM-93-3 (MB)
March 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation		4.26 Drug Utilization Review Program
1927g 1902(a)(85) 42 CFR 456.700	A. 1.	The Medicaid agency meets the Drug Utilization Review (DUR) requirements of Section 1927(g) and 1902(a)(83)(oo) of the Act for outpatient drug claims.
1927(g)(1)(A)	2.	The DUR program assures that prescriptions for outpatient drugs are: -Appropriate -Medically necessary -Not likely to result in adverse medical results
1902(a)(83)(oo)(1)(C) 42 USC 1396(oo)(1)(C)	3.	The DUR program has established a process that identifies potential fraud or abuse of controlled substances by enrolled individuals, health care provider, and pharmacies.
42 CFR 456.714		The DUR program does not include fraud or abuse detection and monitoring which is duplicative of the agency's Surveillance and Utilization Review (SUR) program.
1927(g)(1)(a) 42 CFR 456. 705(b) and 456.709(b)	B.	The DUR program is designed to educate physicians and pharmacists to identify and reduce the following: -The frequency of fraud, abuse, gross overuse, excessive utilization, or inappropriate or medically unnecessary care -Prescribing or billing practices that indicate abuse or excessive utilization among physicians, pharmacists, and patients, or -Potential and actual adverse drug reactions, and -Provide education related to: -Therapeutic appropriateness -Overutilization and underutilization -Appropriate use of generic products -Therapeutic duplication -Drug disease contraindications -Drug-drug interactions -Incorrect drug dosage or duration of drug treatment -Drug-allergy interactions -Clinical abuse/misuse
1927(g)(1)(B) 42 CFR 456.703 (d) and (f)	C.	The DUR program assesses data on drug use against predetermined standards based on peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia or their successor publications: -American Hospital Formulary Service Drug Information -United State Pharmacopeia-Drug Information -The DRUGDEX Information System

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REVISION: HCFA-PM-93-3 (MB)
March 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation		4.26 Drug Utilization Review Program (cont)
1927(g)(1)(D) 42 CFR 456.703(b)	D.	DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. The State has never–the-less chosen to include nursing home drugs in: / / Prospective DUR /X/ Retrospective DUR
1927(g)(2)(A) 42 CFR 456.705(b)	E.1.	The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid recipient.
1927(g)(2)(A)(i) 42 CFR 456.705(b) (1)-(7)	2.	Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to: -Overutilization and underutilization -Therapeutic duplication -Drug-disease contraindications -Drug-drug interactions -Drug-interactions with non-prescription or over-the-counter drugs Incorrect drug dosage or duration of drug treatment -Drug allergy interactions -Clinical abuse/misuse
1927(g)(2)(A)(ii) 42 CFR 456.705 (c) and (d)	3.	Prospective DUR includes counseling for Medicaid recipients based on standards established in State law for counseling and maintenance of patient profiles.
1903(a)(83)(oo)(1)(B)	4.	Prospective DUR includes safety edits approved by the State DUR Board for opioid prescriptions that: -Address acute and chronic use, days' supply, early refills, duplicate fills, quantity limits, and -Set the maximum daily morphine equivalent dose of opioids that can be prescribed to a patient.
1902(a)(83)(oo)(1)(B)	5.	Prospective DUR includes safety edits for antipsychotic medications Prescribed to individuals under the age of 18, including foster children

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March 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation		4.26 Drug Utilization Review Program (cont.)
1927(g)(2)(B) 42 CFR 456.709(a) 42 USC 1396(oo)(1)(C)	F.1.	The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify: -Patterns of fraud and abuse -Gross overuse - Excessive utilization -Inappropriate or medically unnecessary care - Prescribing or billing practices that indicate abuse or excessive utilization among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs.
1902(a)(83)(oo)(1)(A)(i) 1902(a)(83)(oo)(1)(B)	2.	The retrospective DUR program includes but is not limited to claims review automated processes that indicate when a patient is prescribed: - Opioids which exceed limitations on an ongoing basis for acute or chronic use, days' supply, early refills, duplicate fills, and quantity limits. -A daily morphine equivalent dose exceeding established limits for the patient's diagnosis or situation on an ongoing basis; and -Concurrent use of opioids and benzodiazepines, or opioids and antipsychotics on an ongoing basis. -An antipsychotic medication and the patient is under the age of 18 years of age, including foster children.
1927(g)(2)(C) 42 CFR 456.709(b)	3.	The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for: -Therapeutic appropriateness -Overutilization and underutilization -Appropriate use of generic products -Therapeutic duplication -Drug-disease contraindications -Drug-drug interactions -Incorrect drug dosage/duration of drug treatment -Clinical abuse/misuse
1927(g)(2)(D) 42 CFR 456.71 1	4.	The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.

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REVISION: HCFA-PM-93-3 (MB)
March 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation		4.26 Drug Utilization Review Program (cont.)
1927(g)(3)(A) 42 CFR 456.716(a)	G.1.	The DUR program has established a State DUR Board either: /X/ Directly, or / / Under contract with a private organization
1927(g)(3)(B) 42 CFR 456.716 (A) and (B)	2.	The DUR Board membership includes health professionals (one-third licensed actively practicing pharmacists and one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in one or more of the following: -Clinically appropriate prescribing of covered outpatient drugs -Clinically appropriate dispensing and monitoring of covered outpatient drugs -Drug use review, evaluation and intervention -Medical quality assurance
1927(g)(3)(C) 42 CFR 456.716(d)	3.	The activities of the DUR Board include: -Retrospective DUR, -Application of Standards as defined in section 1927(g)(2)(C) -Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR
927(g)(3)(C) 42 CFR 456.711 (a)-(d)	4.	The interventions include in appropriate instances. -Information dissemination -Written, oral and electronic reminders -Face-to-face discussions -Intensified monitoring/review of prescribers/dispensers
1927(g)(3)(D) 42 CFR 456.712 (A) and (B)	H.	The State assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the State will adhere to the plans, steps, procedures as described in the report.
1902(a)(83)(oo)(1)(D)		The report will contain all data, reports, and information required by the Secretary for submission.
1902(a)(83)(oo)(1)(A)(ii)	I.	The State requires each managed care entity contracted with the State to provide care for medical assistance clients, to have in place the same DUR safety edits as described in this section, and to provide data from claims review automated processes which allow the state to perform retrospective DUR on a population-wide basis. At the state's discretion, a managed care entity may be required to use an identical claims review automated process independently or in addition to providing data for the state performance of such retrospective DUR.

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REVISION: HCFA-PM-93-3 (MB)
March 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation			4.26 Drug Utilization Review Program (cont.)
1927(h)(1) 42 CFR 456.722	/X /	J.1.	The State establishes, as its principal means of processing claims for covered outpatient drugs under this title; a point-of-sale electronic claims management system to perform on-line: -Real time eligibility verification -Claims data capture -Adjudication of claims -Assistance to pharmacists, etc. applying for and receiving payment
1927(g)(2)(A)(i) 42 CFR 456.705(b)		2.	Prospective DUR is performed using an electronic point-of-sale drug claims processing system.
1927(j)(2) 42 CFR 456.703 (c)		K.	Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this section when facilities are drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such covered outpatient drugs

REVISION: HCFA-PM-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation	4.27	Disclosure of Survey Information and Provider or Contractor Evaluation
42 CFR 431.115 (c) AT-78-90 AT-79-74		The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.

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REVISION

STATE PLAN UNDER TITLE XIXI OF THE SOCIAL SECURITY ACT

State WASHINGTON

Citation	4.28	Appeals Process
42 CFR 431.152 42 CFR 431.220 42 CFR 442.118 42 U.S.C. 1302 42 U.S.C. 1396r (e) And (7)	(a)	The Medicaid agency has established appeals procedures for NFs and ICFs/MR as specified in 42 CFR 431.153 and 431.154.
	(b)	The State provides an appeals system that meets the requirements of 42 CFR 431 Subpart E, 42 CFR 483.12, and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the preadmission and annual resident review requirements of 42 CFR 483 Subpart C.
	(c)	The Medicaid agency has established an appeals process for denials of payments for new Admissions to ICFs/MR as specified in 42 CFR 442.118.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation	4.29	Conflict of Interest Provisions
1902(a)(4)(C) of the Social Security Act P.L. 105-33		The Medicaid agency meets the requirements of section 1902(a)(4)(C) of the Act concerning the prohibition against acts, with respect to any activity under the plan, that is prohibited by section 207 or 208 of title 18, United States Code.
1902(a)(4)(D) of the Social Security Act P.L. 105-33 1932(d)(3) 42 CFR 438.58		The Medicaid agency meets the requirements of section 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

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REVISION: HCFA-PM-87-14 (BERC) OMB No.: 0938-0193
October 1987

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation		
CFR 1002.203 AT-79-54 48 FR 3742 51 FR 34772	4.30	Exclusion of Providers and Suspension of Practitioners and Other Individuals 42 (a) All requirements of 42 CFR Part 1002, Subpart B are met. / / The agency, under the authority of State law, imposes broader sanctions.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation	(b) The Medicaid agency meets the requirements of --
1902(p) of the Act	(1) Section 1902(p) of the Act by excluding from participation --
	(A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).
42 CFR 438.808	(B) Any HMO (as defined in section 1903(m) of the Act) or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that --
	(i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or
	(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B) of the Act.
1932(d)(1) 42 CFR 438.610	(2) An MCO, PIHP, or PCCM may not have prohibited affiliations with individuals (as defined in 42 CFR 438.610(b)) suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. If the State finds that an MCO, PCCM, PIPH, or PAHP is not in compliance, the State will comply with the requirements of 42 CFR 438.61.(c).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation

1902(a)(39) of the Act
P.L. 100-93
(sec. 8(f))

(2) Section 1902(a)(39) of the Act by—

(A) Excluding an individual or entity from Participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with Sections 1128 or 1128A of the Act; and

(B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.

(c) The Medicaid agency meets the requirements of –

1902(a)(41)
Of the Act
P.L. 96-272
(sec. 308(c))

(1) Section 1902(a)(41) of the Act with respect to prompt notification to HCFA whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this State plan; and

1902(a)(49) of the Act
P.L. 100-93
(sec. 5(a)(4))

(2) Section 1902(a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation		
455.103 44 FR 41644 1902(a)(38) of the Act P.L. 100-93 (sec. 8(f))	4.31	Disclosure of Information by Providers and Fiscal Agents The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106 and sections 1128(b)(9) and 1902(a)(38) of the Act.
435.940 through 435.960 52 FR 5967	4.32	Income and Eligibility Verification System (a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960. (b) ATTACHMENT 4.32-A describes, in accordance with 42 CFR 435.948(a)(6), the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested. (c) The State has an eligibility determination system that Provides for data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including matching with medical information that is requested will be exchanged with States and other entities legally entitled to verify Title XIX applicants and individuals eligible for covered Title XIX services consistent with applicable PARIS agreements.

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REVISION: HCFA-PM-87-14 (BERC) OMB No.: 0938-0193
October 1987

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation
1902(a)(48)
of the Act,
P.L. 99-570
(Section 11005)
P.L 100-93

4.33 Medicaid Eligibility Cards for Homeless Individuals

(a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State's approved plan who does not (sec. 5(a)(3)) reside in a permanent dwelling or does not have a fixed home or mailing address.

(b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless individuals.

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Revision: HCFA-PM-88-10 (BERC) OMB No.: 0938-0193
SEPTEMBER 1988

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Citation		
	4.34	Systematic Alien Verification for Entitlements
1137 of The Act P.L. 99-603 (sec. 121)		The State Medicaid agency has established procedures for the verification of alien status through the Immigration & Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1988.

/ / The State Medicaid agency has elected to participate in the option period of October 1, 1987 to September 30, 1988 to verify alien Status through the INS designated system (SAVE).

/x/ The State Medicaid agency has received the following type(s) of waiver from participation in SAVE.

/x/ Total waiver

/ / Alternative system

/ / Partial implementation

Washington will use approved verification procedures, e.g., reviewing documents that the client holds.

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REVISION: HCFA-PM-90-2 (BPD) OMB No.: 0938-0193
January 1990

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation

4.35 Remedies for Skilled Nursing and Intermediate Care Facilities that do not Meet Requirements of Participation

1919(h)(1) and (2) of the Act, P.L. 100-203

(a) The Medicaid agency meets the requirements of Section 1919(h)(2)(A) through (D) of the Act concerning remedies for skilled nursing and intermediate care facilities that do not meet one or more requirements of participation. ATTACHMENT 4.35-A describes the criteria for applying the remedies specified in section1919(h)(2)(A)(i) through (iv) of the Act.

/ / Not applicable to intermediate care facilities; these services are not furnished under this plan.

/X/ (b) The agency uses the following remedy(ies):

(1) Denial of payment for new admissions.

(2) Civil money penalty.

(3) Appointment of temporary management.

(4) In emergency cases, closure of the facility and/or transfer of residents.

/X/ (c) The agency establishes alternative State remedies to the specified Federal remedies(except for termination of participation).ATTACHMENT 4.35-H describes these alternative remedies and specifies the basis for their use.

/ / (d) The agency uses one of the following incentive programs to reward skilled nursing or intermediate care facilities that furnish the highest quality care to Medicaid residents:

/ / (1) Public recognition

/ / (2) Incentive payments.

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REVISION: HCFA-PM-95-4 (HSQB)
June 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation		
	4.35	Enforcement of Compliance for Nursing Facilities
42 CFR §488.402(f)	(a)	Notification of Enforcement Remedies When taking an enforcement action against a non-State operated NF, the State provides notification in accordance with 42 CFR 488.402(f).
	(i)	The notice (except for civil money penalties and State monitoring) specifies the: (1) nature of compliance, (2) which remedy is imposed, (3) effective date of the remedy, and (4) right to appeal the determination leading to the remedy.
42 CFR §488.434	(ii)	The notice for civil money penalties is in writing and contains the information specified in 42 CFR 488.434.
42 CFR §488.402(f)(2)	(iii)	Except for civil money penalties and State monitoring, notice is given at least2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.
42 CFR §488.546(c)(d)	(iv)	Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.
	(b)	Factors to be Considered in Selecting Remedies
42 CFR §488.488.404(b)(i)	(i)	In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR 488.404(b)(1) & (2). / / The State considers additional factors. Attachment 4.35-A describes the State's other factors.

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REVISION: HCFA-PM-95-4 (HSQB)
June 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation		
	(c)	Application of Remedies
42 CFR §488.410	(i)	If there is immediate jeopardy to resident health or safety, the State terminates the NF's provider Agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within 23 days.
42 CFR §488.417 (b) §1919 (h)(2)(C) of the Act.	(ii)	The State imposes the denial of payment (or its approved alternative) with respect to any individual admitted to an NF that has not come into substantial compliance within 3 months after the last day of the survey.
42 CFR §488.414 §1919 (h)(2)(D) of the Act.	(iii)	The State imposes the denial of payment for new admissions remedy as specified in §488.422, when a facility has been found to have provided substandard care on the last three consecutive standard surveys.
42 CFR §488.408 1919 (h)(2)(A) of the Act.	(iv)	The State follows the criteria specified at 42 CFR §488.408 (c)(2), §488.408 (d)(2), and §488.408 (e)(2) when it imposes remedies in place of or in addition to termination.
42 CFR §488.412(a)	(v)	When immediate jeopardy does not exist, the State terminates an NF's provider agreement no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR 488.412 (a) are not met.
	(d)	Available Remedies
42 CFR §488.406(b) §1919 (h)(2)(A) of the Act.	(i)	The State has established the remedies defined in 42 CFR 488.406 (b).

/X/	(1)	Termination
/X/	(2)	Temporary Management
/X/	(3)	Denial of Payment for New Admissions
/X/	(4)	Civil Money Penalties
/X/	(5)	Transfer of Residents; Transfer of Residents with Closure of Facility
/X/	(6)	State Monitoring

Attachments 4.35-H through 4.35-G describe the criteria for applying above remedies.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Citation

42 CFR §488.406(b) §1919 (h)(2)(B)(ii) of the Act.		(ii)	/ /	The State uses alternative remedies. The State has established alternative remedies that the State will impose in place of a remedy specified in 42 CFR 488.406(b).
		/ /	(1)	Temporary Management
		/ /	(2)	Denial of Payment for New Admissions
		/ /	(3)	Civil Money Penalties
		/ /	(4)	Transfer of Residents

Attachments 4.35-B through 4.35-G describe the alternative remedies and the criteria for applying them.

42 CFR §488.303 (b) 1910(h)(2)(F) of the Act.	(e)	/ /		State Incentive Programs
		/ /	(1)	Public Recognition
		/ /	(2)	Incentive Payments

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REVISION: HCFA-PM-91-4 (BPD) OMB: No.: 0938-
August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation	4.36	Required Coordination Between the Medicaid and WIC Programs
1902 (a)(11)(C) and 1902(a)(53) of the Act.		The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely referral to WIC in accordance with section 1902 (a)(53) of the Act.

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REVISION:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation	4.36	Prescribed Drug Reimbursement
1927(a)(2)		The State will meet all reporting and provision of information requirements as specified in Section 1927(a)(2).

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NOTE: Handwritten notes on CMS's original page:

"Washington has this pg labeled as 79e Section 1927(a)(2)"

"This should be pg 79e per request from 91-22 (P+I). However, citation 4.36 will need to be changed to a different citation #. Preprint…*unreadable* "

* See Attachment 4.19-B (IV)

There are no pages 79f through 79m

Revision: HCFA-PM-91-10 (BPD)
DECEMBER 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Citation
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2) And 1919(f)(2) P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

4.38 Nurse Aide Training and Competency Evaluation for Nursing Facilities

(a) The State assures that the requirements of 42 CFR 483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.

/ / (b) The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b)(1).

/X/ (c) The State deems individuals who meet the requirements of 42 CFR 483.150(b)(2) to have met the nurse aide training and competency evaluation requirements.

(d) The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFRE 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154.

/ / (e) The State offers a nurse aide training and competency Evaluation program that meets the requirements of 42 CFR \ 483.152.

/X/ (f) The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154.

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DECEMBER 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Citation		
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508	(g)	If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency evaluation program, the State reviews all nurse aide training and competency evaluation programs and competency evaluation programs upon request.
	(h)	The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met.
	(i)	Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met.
	(j)	Before approving a nurse aide competency evaluation Program, the State determines whether the requirements of 42 CFR 483.154 are met.
	(k)	For program reviews other than the initial review, the State visits the entity providing the program
	(l)	The State does not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in certain facilities as described in 42 CFR 483.151(b)(2) and (3).

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DECEMBER 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Citation			
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3): P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).		(m)	The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requestor whether or not the program has been approved or requests additional information from the requestor.
		(n)	The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years.
		(o)	The State reviews programs when notified of substantive Changes (e.g., extensive curriculum modification).
		(p)	The State withdraws approval from nurse aide training and competency evaluation programs and competency evaluation programs when the program is described in 42 CFR 483.151(b)(2) or (3).
	/X/	(q)	The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR 483.152 and the competency evaluation programs that cease to meet the requirements of 42 CFR 483.154.
		(r)	The State withdraws approval of nurse aide training and competency evaluation programs and competency evaluation programs that do not permit unannounced visits by the State.

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DECEMBER 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Citation			
42 CFR 483.75; 42 CFR 483 Subpart D; Sec. 1902(a)(28), 1919(e)(1) and (2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901 (b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).		(s)	When the State withdraws approval from a nurse aide training and competency evaluation program or competency evaluation program, the State notifies the program in writing indicating the reasons for withdrawal of approval.
		(t)	The State permits students who have started a training and competency evaluation program from which approval is withdrawn to finish the program.
		(u)	The State provides for the reimbursement of costs incurred in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program.
		(v)	The State provides advance notice that a record of successful completion of competency evaluation will be included in the State nurse aide registry.
		(w)	Competency evaluation programs are administered by the State or by a State-approved entity which is neither a skilled nursing facility participating in Medicaid nor a nursing facility participating in Medicaid.
	/X/	(x)	The State permits proctoring of the competency evaluation In accordance with 42 CFR 483.154(d).
		(y)	The State has a standard for successful completion of Competency evaluation programs.

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DECEMBER 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Citation			
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28); 1919(e)(1) and (2); and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3); P.L. 101-239 (Secs. 6901(b)(3) and (4)): P.L. 101-508 (Sec. 4801(a)).		(z)	The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.
	/X/	(aa)	The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).
		(bb)	The State maintains a nurse aide registry that meets the requirements in 42 CFR 483.156.
	/ /	(cc)	The State includes home health aides on the registry.
	/ /	(dd)	The State contracts the operation of the registry to a non-State entity.
	/X/	(ee)	ATTACHMENT 4.38 contains the State's description of registry information to be disclosed in addition to that required in 42 CFR 483.156(c)(1)(iii) and (iv).
	/X/	(ff)	ATTACHMENT 4.38-A contains the State's description of information included on the registry in addition to the information required by 42 CFR 4583.156(c).

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Revision: HCFA-PM-93-1 (BPD)
January 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Citation Secs. 1902(a)(28)(D)(i) and 1919(e)(7) of the Act; P.L. 100-203 (Sec. 4211(c)); P.L. 101-508 (Sec. 4801(b)).

4.39 Preadmission Screening and Annual Resident Review In Nursing Facilities

(a) The Medicaid agency has in effect a written agreement with the State mental health and mental retardation authorities that meet the requirements of 42 CFR 431.621(c).

(b) The State operates a preadmission and annual resident Review program that meets the requirements of 42 CFR 483.100-138.

(c) The State does not claim as “medical assistance under the State Plan” the cost of services to individual who should receive preadmission screening or annual resident review until such individuals are screened or reviewed.

(d) With the exception of NF services furnished to certain NF residents defined in 42 CFR 483.118(c)(1), the State does not claim as “medical assistance under the State Plan” the cost of NF services to individuals who are found not to require NF services.

/X/ (e) ATTACHMENT 4.39 specifies the State’s definition of specialized services.

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January 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

/X/ (f) Except for residents identified in 42 CFR 483.118(c)(1), the State mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most, if not all, NFs and that a more appropriate placement should be utilized.

/g/ The State describes any categorical determinations it Applies in ATTACHMENT 4.39-A.

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Revision: HCFA-PM-92-3 (HSQB) OMB No.:
April 1992

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Citation	4.40	Survey and Certification Process
Sections1919 (g)(1) through (2) and1919(g)(4) through (5) of the Act P.L.100-203 (Sec. 4212(a)).	(a)	The State assures that the requirements of 1919(g)(1)(A) through (C) and section 1919(g)(2)(A) through (E)(iii) of the Act which relate to the survey and certification of non-State owned facilities based on the requirements of section 1919(b), (c), and (d) of the Act, are met.
1919(g)(1) (B) of the Act	(b)	The State conducts periodic evaluation programs for staff and residents (and their representatives). ATTACHMENT 4.40-A describes the survey and certification educational Program.
1919(g)(1) (C) of the Act	(c)	The State provides for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility. ATTACHMENT 4.40-B describes the State's process.
1919(g)(1) (C) of the Act	(d)	The State agency responsible for surveys and certification of of nursing facilities or an agency delegated by the State survey agency conducts the process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property. If not the State survey agency, what agency? Department of Social and Health Services
1919(g)(1) (C) of the Act	(e)	The State assures that a nurse aide, found to have neglected or abused a resident or misappropriated resident property in a facility, is notified of the finding. The name and finding is placed on the nurse aide registry.
1919(g)(1) (C) of the Act	(f)	The State notified the appropriate licensure authority of any licensed individual found to have neglected or abused a resident or misappropriated resident property in a facility.

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April 1992

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

1919(g)(2) (A)(i) of the Act	(g)	The State has procedures, as provided for at section 1919 (g)(2)(i), for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice through the scheduling procedures and the conduct of the surveys themselves. ATTACHMENT 4.40-C describes the State's procedures.
1919(g)(2) (A)(ii) of the Act	(h)	The State assures that each facility shall have a standard survey which includes (for a case-mix stratified sample of Residents) a survey of the quality of care furnished, as measured by indicators of medical, nursing and rehabilitative care, dietary and nutritional services, activities and social participation, and sanitation, infection control, and the physical environment, written plans of care and audit of resident's assessments, and a review of compliance with resident's rights not later than 15 months after the previous standard survey.
1919(g)(2) (A)(iii)(I) of the Act	(i)	The State assures that the Statewide average interval between standard surveys of nursing facilities does not exceed 12 months
1919(g)((2) (A)(iii)(II) of the Act	(j)	The State may conduct a special standard or special abbreviated survey within 2 months of any change of ownership, administration, management, or director of nursing of the nursing facility to determine whether the change has resulted in any decline in the quality of care furnished in the facility.
1919(g)(2) (B) of the Act	(k)	The State conducts extended surveys immediately or, if not practicable, not later than 2 weeks following a completed standard survey in a nursing facility which is found to have provided substandard care or in any other facility at the Secretary's or State's discretion.
1919(g)(2) (C) of the Act	(l)	The State conducts standard and extended surveys based upon a protocol, i.e., survey forms, methods, procedures and guidelines developed by HCFA, using individuals in the survey team who meet minimum qualifications established by the Secretary.

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Revision: HCFA-PM-92-3 (HSQB) OMB No.:
April 1992

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

1919(g)(2) (D) of the Act	(m)	The State provides for programs to measure and reduce inconsistency in the application of survey results among surveyors. ATTACHMENT 4.40-D describes the State's programs.
1919(g)(2) (E)(i) of the Act	(n)	The State uses a multidisciplinary team of professionals including a registered professional nurse.
1919(g)(2) (E)(ii) of the Act	(o)	The State assures that members of a survey team do not serve (or have not served within the previous two years) as a member of the staff or consultant to the nursing facility or has no personal or familial financial interest in the facility being surveyed.
1919(g)(2) (E)(iii) of the Act	(p)	The State assures that no individual shall serve as a member of any survey team unless the individual has successfully completed a training and test program in survey and certification techniques approved by the Secretary.
1919(g)(4) of the Act	(q)	The State maintains procedures and adequate staff to investigate the complaints of violations of requirements by nursing facilities and onsite monitoring. ATTACHMENT 4.40-E describes the State's complaint procedures.
1919(g)(5) (A) of the Act	(r)	The State makes available to the public information respecting surveys and certification of nursing facilities including statements of deficiencies, plans of correction, copies of cost reports, statements of ownership and the information disclosed under section 1126 of the Act.
1919(g)(5) (B) of the Act	(s)	The State notifies the State long-term care ombudsman of of the State's finding of non-compliance with any of the requirements of subsection (b), (c), and (d) or of any adverse actions taken against a nursing facility.
1919(g)(5) (c) of the Act	(t)	If the State finds substandard quality of care in a facility, the State notifies the attending physician of each resident with respect to which such finding is made and the nursing facility administrator licensing board.
1919(g)(5) (D) of the Act	(u)	The State provides the State Medicaid fraud and abuse agency access to all information concerning survey and certification actions.

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Revision: HCFA-PM-92-2 (HSQB) OMB No.:
MARCH 1992

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Citation		
Sections 1919(b)(3) and 1919(e)(5) of the Act	4.41 (a)	The State specifies the instrument to be used by nursing facilities for conducting a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity as required in §1919(b)(3)(A) of the Act.
1919(e)(5) (A) of the Act	(b)	The State is using: / / the resident assessment instrument designated by the Health Care Financing Administration (see Transmittal #241 of the State Operations Manual) [§1919(e)(5)(A)]; or /X/ a resident assessment instrument that the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines as specified by the Secretary (see Section 4470 of the State Medicaid Manual for the Secretary's approval criteria) [[§1919(e)(5)(B)].

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation
1902 (a)(68) of the Act, P.L. 109-171

4.42 Employee Education About False Claims Recoveries

(a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(1) Definitions.

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under Title XIX or under any waiver of such plan, totaling at least $5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payments arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental

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health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

(B) An "employee" includes any officer or employee of the entity.

(C) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

(2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

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State/Territory: WASHINGTON

(3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

(4) The requirements of this law should be incorporated into each State's provider enrollment agreements.

(5) The State will implement this State Plan Amendment on Jan. 1, 2007.

(b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

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Citation 1902(a)(69) of The Act, P.L. 109-171 (section 6034)	4.43	Cooperation with Medicaid Integrity Program Efforts The Medicaid agency assures it complies with such requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936 of the Act.

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Citation		
Section 1902(a)(80) of the Act P.L. 111-148 (Section 6505)	4.44	Medicaid Prohibition on Payments to Institutions or Entities Located Outside of the United States _X_ The State shall not provide any payments for items or Services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.

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4.46 Provider Screening and Enrollment

Citation
1902(a)(77)
1902(a)(39)\
1902(kk)
P.L. 111-148 and
P.L. 111-152

The State Medicaid Agency gives the following assurances:

42 CFR 455
Subpart E

PROVIDER SCREENING

_X__ Assures that the State Medicaid Agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77), and 1902(kk) of the Act.

The State Medicaid Agency will be compliant no later than January 2013.

42 CFR 455.410

ENROLLMENT AND SCREENING OF PROVIDERS

_X__ Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq.

The State Medicaid Agency will be compliant no later than January 2013.

_X__ Assures that the State Medicaid Agency requires all ordering or referring physicians or other professionals to be enrolled under the State Plan or under a waiver of the Plan as a participating provider.

The State Medicaid Agency will be compliant no later than July 2012.

The State Medicaid Agency requires the NPI of ordering and referring physicians and other professionals to be specified on claims.

The State Medicaid Agency will require ordering and referring physicians and other professional to be enrolled under the State Plan no later than July 2012.

4.46 Provider Screening and Enrollment (cont)

42 CFR 455.412

VERIFICATION OF PROVIDER LICENSES

_X__ Assures that the State Medicaid Agency has a method for verifying providers licensed by a State and that such providers' licenses have not expired or have no current limitations.

42 CFR 455.414

REVALIDATION OF ENROLLMENT

_X__ Assures that providers will be revalidated regardless of provider type at least every 5 years.

The State Medicaid Agency will be compliant no later than January 2013 when the MMIS system changes for the Affordable Care Act upgrades are anticipated to be implemented.

MMIS system changes are required for the collection of managing employees and controlling interests as required under 455.104(b) and page 2 of the Dec. 23, 2011, CMCS Informational Bulletin. The MMIS system changes will also allow for the Federal Database Checks of the additional disclosures as required under 455.436(a). The revalidation process will not be started until these MMIS system changes are in place.

42 CFR 455.416

TERMINATION OR DENIAL OF ENROLLMENT

_X__ Assures that the State Medicaid Agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.

The State Medicaid Agency will be compliant no later than January 2013 when enrollment data collection and screening system upgrades for the Affordable Care Act are anticipated to be implemented.

The State Medicaid Agency is in compliance with this provision for the enrollment of providers and their ownership.

MMIS system changes to the online enrollment application are required in order to collect managing employees and controlling interests disclosures and be in compliance with 455.416(d).

42 CFR 455.420

REACTIVATION OF PROVIDER ENROLLMENT

_X__ Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.

The State Medicaid Agency will be compliant no later than January 2013 when the MMIS system changes for the Affordable Care Act upgrades are anticipated to be implemented.

4.46 Provider Screening and Enrollment (cont)

42 CFR 455.422

APPEAL RIGHTS

_X__ Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation

42 CFR 455.432

SITE VISITS

_X__ Assures that pre-enrollment and post-enrollment site visits of providers who are in “moderate” or “high” risk categories will occur.

The State Medicaid Agency will be compliant no later than January 2013, when the MMIS system changes for the Affordable Care Act upgrades are anticipated to be implemented.

The State Medicaid Agency conducts site visits for enrolling providers in the moderate or high risk categories, and will be compliant with the pre-enrollment site visit requirement no later than January 2013.

The post-enrollment sit visit requirement is dependent on the implementation of the Revalidation provision. The State Medicaid Agency will be compliant with the Revalidation provision no later than January 2013.

42 CFR 455.434

CRIMINAL BACKGROUND CHECKS

____ Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk of fraud, waste, or abuse for that category of provider.

The State Medicaid Agency awaits additional sub-regulatory guidance from CMS. The Agency will target implementation within 60 days of receipt of this guidance, as given in the CMCS Informational Bulletin issued December 23, 2011.

42 CFR 455.436

FEDERAL DATABASE CHECKS

_X__ Assures that the State Medicaid Agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.

The State Medicaid Agency will be compliant no later than January 2013 when the MMIS system changes for the Affordable Care Act upgrades are anticipated to be implemented.

4.46 Provider Screening and Enrollment (cont)

The State Medicaid Agency conducts the Federal Database Checks required under 455.436 on enrolling providers and their ownership.

MMIS system changes to the online enrollment application are required in order to collect managing employees and controlling interests and allow for the pre-enrollment Federal Database Checks of these additional disclosures required under 455.436(a).

In addition, managing employees and controlling interests must be added to the MMIS system in order to be in compliance with 455.436(b)(2), the requirement to check the LEIE and EPLS for exclusions no less frequently than monthly.

42 CFR 455.440

NATIONAL PROVIDER IDENTIFIER

_X__ Assures that the State Medicaid Agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

The State Medicaid Agency will be compliant no later than July 2012.

The State Medicaid Agency requires the NPI of ordering and referring physicians and other professionals to be specified on claims.

The State Medicaid Agency will require ordering and referring physicians and other professionals to be enrolled under the State Plan no later than July 2012.

42 CFR 455.450

SCREENING LEVELS FOR MEDICAID PROVIDERS

_X__ Assures that the State Medicaid Agency complies with 1902(a)(77) and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.

The State Medicaid Agency will be compliant no later than January 2013 when the MMIS system changes for the Affordable Care Act upgrades are anticipated to be implemented.

Changes are required in order to identify providers with a categorical risk level in the MMIS system, as well as provide the ability for this risk level to be adjusted as required under 455-450(e).

4.46 Provider Screening and Enrollment (cont)

42 CFR 455.460

APPLICATION FEE

_X__ Assures that the State Medicaid Agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460.

The State Medicaid Agency will be compliant no later than January 2013 when the MMIS system changes for the Affordable Care Act upgrades are anticipated to be implemented.

42 CFR 455.470

TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS

_X__ Assures that the State Medicaid Agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries' access to medical assistance

REVISION: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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SECTION 5 PERSONNEL ADMINISTRATION

Citation
42 CFR 432.10 (a)
AT-78-90
AT-79-23
AT-80-34

5.1 Standards of Personnel Administration

(a) The Medicaid agency has established and will maintain methods of personnel administration in conformity with standards prescribed by the U.S. Civil Service Commission in accordance with Section 208 of the Intergovernmental Personnel Act of 1970 and the regulations on Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.

/ / The plan is locally administered and State-supervised. The requirements of 42 CFR 432.10 with respect to local agency administration are met.

(b) Affirmative Action Plan

The Medicaid agency has in effect an affirmative action plan for equal employment opportunity that includes specific action steps and timetables and meets all other requirements of 5 CFR Part 900, Subpart F.

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May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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5.2 Reserved

REVISION: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Citation		
42 CPR Part 432, Subpart B AT-78-90	5.3	Training Programs; Subprofessional and Volunteer Programs The Medicaid agency meets the requirements of 42 CFR Part 432, Subpart B, with respect to a training program for agency personnel and the training and use of subprofessional staff and volunteers.

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May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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SECTION 6 FINANCIAL ALMINISTRATICN

Citation		
42 CFR 433.32 AT-79-29	6.1	Fiscal Policies and Accountability The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements. The requirements of 42 CFR 433.32 are met.

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REVISION: HCFA-AT-81 (BPP)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Citation		
42 CFR 433.34	6.2	Cost Allocation There is an approved cost allocation plan on file with the HHS Division of Cost Allocation In accordance with the requirements contained in 45 CFR Part 95, Subpart E.

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REVISION: HCFA-AT-80-38 (BPP)
May 22, 1980

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Citation

42 CFR 433.33
AT-79-29
AT-80-34

6.3 State Financial Participation

(a) State funds are used in buoth assistance and administration.

/ / State funds are used to pay all of the non-Federal share of total expenditures under the plan.

/X/ There is local participation. State funds are used to pay not less than 40 percent of the non-Federal share of the total expenditures under the plan. There is a method of apportioning Federal and State funds among the political subdivisions of the State on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services of level of administration under the plan in any part of the State.

(b) State and Federal funds are apportioned among the political subdivisions of the State an a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.

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REVISION: HCFA-PM-91-4 (BPD)
August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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SECTION 7 - GENERAL PROVISIONS

Citation		
	7.1	Plan Amendments
42 CFR 430.12(c)		The plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material change in State law, organization, policy or State agency operation.

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Citation		
45 CFR Parts 80 and 84	7.2	Nondiscrimination In accordance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. sea.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), and the regulations at 45 CFR Parts 80 and 84, the Medicaid agency assures that no individual shall be subject to discrimination under this plan on the grounds of race, color, national origin, or handicap. The Medicaid agency has methods of administration to assure that each program or activity for which it receives Federal financial assistance will be operated in accordance with title VI regulations. These methods for title VI are described in ATTACHMENT 7.2-A.

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REVISION: HCFA-PM-91-4 (VPD) OMB No.: 0938-
August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Citation	7.3	Maintenance of AFDC Efforts
1902(c) of	/X/	The State agency has in effect under its approved AFDC plan payment levels that are equal to or more than the AFDC payment levels in effect on May 1, 1988.

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REVISION:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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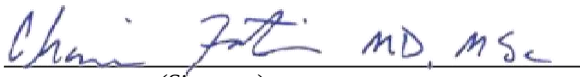
Citation	7.4	State Governor's Review
42 CFR 430.12(b)		The Medicaid agency will provide opportunity for the office of the Governor to review the State plan amendments, long range program planning projections, and other periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Centers for Medicare and Medicaid Services with such documents.
		/X/ Not applicable. The Governor –
		/X/ Does not wish to review any plan material
		/ / Wishes to review only the plan materials specified in the enclosed document:

I hereby certify that I am authorized to submit this plan on behalf of:

THE WASHINGTON STATE HEALTH CARE AUTHORITY
(Designated Single State Agency)

Date: June 26, 2023



(Signature)

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