

Guidance for Pursuing Washington Apple Health (Medicaid) Funding

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Overview

The purpose of this document is to inform you about Apple Health (Medicaid) requirements and help you determine whether a specific program or service you provide may qualify for Medicaid funding. This document explores Medicaid funding options that may be available to you and the steps you will need to take before contacting someone at Medicaid.

The Health Care Authority (HCA) is Washington’s single state Medicaid agency, solely responsible for administering any Medicaid-funded program or service. This means all Medicaid funding must come through HCA and HCA must administer or oversee the administration of all Medicaid programs and services (see [42 CFR 431.10](#)). The federal Centers for Medicare and Medicaid Services (CMS) must approve any new Medicaid-funded program or service before it can be implemented and paid for with Medicaid funds. If the legislature allocates state funds for a new Medicaid program or service, HCA must seek CMS approval through a State Plan Amendment (SPA), waiver or waiver amendment, or a Cost Allocation Plan (CAP) for Medicaid Administrative Claiming (MAC) before administering or paying for the program or service. Approved Medicaid-funded programs may require Washington Administrative Code (WACs) to implement. Examples of each of the funding strategies are included within this document.

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General Information

1. **Types of funding.** To receive CMS approval to qualify for Medicaid funding, the service or program must be one of the following:
 - a. **Included in the [Medicaid State Plan](#).** The Medicaid State Plan is the officially recognized document describing the nature and scope of Washington State's Medicaid program. Any new program or service must be described in the State Plan through a State Plan Amendment (SPA).
 - b. **Approved in a [waiver](#).** Medicaid waivers are exceptions to State Plan requirements regarding the provision of Medicaid services. States may use various waivers to test new and innovative approaches to delivering and paying for health care services.
 - c. **Described in a Cost Allocation Plan for [Medicaid Administrative Claiming \(MAC\)](#).** MAC is a federal program that allows governmental agencies to receive partial reimbursement for performing certain Medicaid administrative activities when those activities support provision of services as outlined in the Washington Medicaid State Plan.
2. **Non-HCA program administrators.** Any state agency other than the Health Care Authority (HCA) that manages Medicaid-funded programs must have an interagency agreement with HCA. The agreement must describe the working relationship, outline the responsibilities of each agency, and specify that HCA has the ultimate responsibility to manage, monitor, and oversee those programs. The Medicaid State Plan must describe any such agreement; a SPA must be submitted to include this information in the State Plan or this relationship must be described in any proposed waiver.
3. **Provider requirements.** To be paid for furnishing Medicaid services to eligible clients, servicing providers that are billing through ProviderOne must enroll as a Medicaid provider by signing a Core Provider Agreement with HCA and complying with the requirements described on HCA's [New Providers](#) webpage.
 - a. Providers must agree to accept Medicaid payments as payment in full. Providers may not get other funding or bill the Medicaid client to make up any difference between the Medicaid payment and their usual and customary charge for the service rendered. See [42 CFR 447.15](#).
 - b. Providers must bill Medicaid according to the requirements in [Washington Administrative Code](#) (WAC) and applicable billing instructions found in [Medicaid Provider Guides](#).

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Getting Started

Review the funding options below to see which one may fit your proposal. Then contact us as described below to help you proceed.

Funding Option 1 – Medicaid State Plan

1. The program/service must meet the following federal requirements in order to be included in the [Medicaid State Plan](#).
 - a. Statewide coverage. Health care services available under the State Plan must be available throughout the state. See [42 USC 1396a\(a\)\(1\)](#)
 - b. Comparability of services. Health care services provided to any categorically needy (CN) client must be comparable to those provided to any medically needy (MN) client and services available to any individual in the CN or MN group must be equal for all clients within that group. See [42 USC 1396a\(a\)\(10\)\(B\)](#) and [42 CFR 440.240\(b\)](#).
 - c. Freedom of choice. Medicaid clients must be allowed to choose their own health care professionals from a range of participating providers (doctors, pharmacies, institutions, agencies, etc.). See [42 USC 1396a\(a\)\(23\)](#).
2. Covered State Plan services. Determine whether your proposed service is classified as a mandatory Medicaid service or an optional Medicaid service by CMS. See the list of these services at [Medicaid.gov](#). If your proposed service does not fall under one of these categories, it may qualify as a [waiver](#) service.
3. Payment or rate structure. Payment methodology for services available under the State Plan must be consistent with efficiency, economy, and quality of care, allow sufficient provision of services, and safeguard against unnecessary or overuse of services. See [42 USC 1396a\(a\)\(30\)\(A\)](#).
4. Determine if your program or service fits into an existing Medicaid State Plan benefit. If so, the benefit will be described in Attachment 3 of the [Medicaid State Plan](#).
 - a. Categorically Needy (CN) services are described in Attachment 3.1-A, pages 1 – 11, with detailed explanations of each service on the following pages.
 - b. Medically Needy (MN) services are described in Attachment 3.1-B, pages 1 -11, with detailed explanations of each service on the following pages.

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5. Determine if this is a new benefit. New Medicaid benefits must fall under the federal guidelines for [mandatory or optional Medicaid benefits](#). If the new benefit is neither mandatory nor optional, consider a [waiver](#).
6. State how services are delivered to clients.
7. Please describe in detail the credentials of the providers who will be providing services. CMS requires providers to be professionally licensed or credentialed. See [42 CFR 440.1 through 440.185](#)
 - a. If a new licensing category or credential is necessary to support this program or service, you must pursue this through the legislative process. Example: A group identified the need for a new provider type, Physician Assistant for dental care. The organizers approached the legislature for the authority to create the new professional provider type. The request was approved, after which, the Department of Health (DOH) and the stakeholders created the new licensing and/or credentialing requirements.
 - b. If the provider is credentialed or licensed and wants to provide a new service that is not in that provider's scope of practice, then the provider must pursue these changes through the appropriate licensing or credentialing authority.
 - c. Providers must have a National Provider Identifier (NPI). See the [NPI Registry](#) for a list of providers who have an NPI in addition to instructions on [how to apply for an NPI](#).
 - d. Providers must select a national [Healthcare Provider Taxonomy Code](#) that describes their type/classification/specialization.
8. Describe how the services will be billed.
 - a. Are there nationally recognized HIPAA-compliant billing codes (HCPCS or CPT) to reimburse for the services? See the American Medical Association [Coding and Reimbursement for guidance](#).
 - b. Will the provider bill other insurers in addition to Medicaid? HCA's [Coordination of Benefits \(COB\)](#) section handles third party billings, coordinating benefits, insurance questions, etc.
9. Determine if any other states include the service or program you would like to provide in their State Plan. See a list of other states' SPAs at [Medicaid State Plan Amendments](#).
10. Generally, a 50% state match is required. Do you have budgetary authority for a state match?
NOTE: Federal funds cannot be used for matching Medicaid funds.

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1. Types of [waivers](#)
 - a. [1115 Research and Demonstration Projects](#) give program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP services; it must include a research component and demonstrate budget neutrality. (An example is the [TAKE CHARGE Family Planning Program waiver](#)).
 - b. [1915\(b\) Managed Care Waivers](#) enable provision of services through managed care delivery systems or otherwise limit clients' choice of providers. (An example is the [Washington State Integrated Community Mental Health Program waiver](#)).
 - c. [1915 \(c\) Home and Community-Based Waivers](#) enable provision of long-term care services in home and community settings rather than institutional settings. (An example is Washington State's [COPES waiver](#)).
 - d. [Concurrent 1915\(b\) and 1915 \(c\) Waivers](#) enable simultaneous implementation of waivers to provide a continuum of services to the elderly and people with disabilities, as long as all federal requirements for both programs are met. Washington currently has no concurrent 1915(b)(c) waivers .
2. Each type of waiver has its own requirements and application form. See the federal web pages linked above for these specifics and additional information. In general, you will need the following information:
 - a. Purpose of the waiver
 - b. Which of the following Medicaid requirements will be waived:

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- i. Statewide coverage
 - ii. Comparability of services
 - iii. Freedom of choice
 - iv. Other subsections of section 1902 of the Social Security Act
- c. Effective dates (waivers are not open-ended)
 - d. How the waiver will be administered and operated
 - e. Participant access and eligibility
 - f. Services, including limitations, delivery method(s), and rates
 - g. Financial information, including cost neutrality
3. If the proposed program or service fits under an existing waiver, you may be able to amend the existing waiver to include the program or service. The waiver application form explains the process.
4. The proposed program or service cannot duplicate a service already covered by an approved waiver or SPA.
5. CMS waiver approval may take anywhere from several months to over a year.

NOTE: For additional information regarding waivers please refer to [“At-a-Glance” Guide to Federal Medicaid Authorities Useful in Restructuring Medicaid Health Care Delivery or Payment](#)”.

Funding Option 3 – [Medicaid Administrative Claiming \(MAC\)](#)

The Medicaid Administrative Claiming (MAC) program is an optional and voluntary federal reimbursement program that allows governmental entities such as school districts, state health department, local health jurisdictions, and federally-recognized Tribes to be reimbursed a portion of the administrative costs incurred for performing allowable administrative activities in support of services included under the Medicaid State Plan. These administrative activities may include, but are not limited to:

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- Outreach to inform people about the benefits of Medicaid
- Assisting people in enrolling in Medicaid
- Linking individuals to appropriate health care services

Participation in the MAC program requires a CMS-approved Cost Allocation Plan (CAP).

The CAP is an administrative claiming implementation plan that provides a comprehensive description of the mechanisms and processes for claiming Medicaid administrative costs. Staff must participate in a statistically valid time study to determine the portion of their time spent performing allowable activities. The CAP submission and approval process may take up to one year. All MAC CAPs are based on the May 2003 CMS [Medicaid School-Based Administrative Claiming Guide](#).

Contact Us

For assistance with exploring the funding options please contact us at MedicaidFunding@hca.wa.gov or visit the HCA website at <http://test.hca.wa.gov/Pages/about.aspx> for more information about Medicaid.