Medicaid State Plan - Attachment 3

Services: General Provisions

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

_X__ Provided: ____ No limitations __X__ With limitations*

2.a. Outpatient hospital services.

_X__ Provided: ____ No limitations __X__ With limitations*

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

_X__ Provided: __X_ No limitations ___ With limitations*

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

__X_ Provided: _X_ No limitations ___ With limitations*

3. Other laboratory and x-ray services.

_X__ Provided: ___ No limitations _X_ With limitations*

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

__X__ Provided: ____ No limitations __X__With limitations*

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

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

__X__ Provided: __X__ No limitations ____ With limitations*

d. Tobacco cessation counseling services for pregnant women

1) Face-to-face tobacco cessation counseling services

_X_ Provided ___ No limitations _X_ With limitations

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

_X_ Provided _X_ No limitations ___ With limitations

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*Limitations described on following pages.

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

__X__ Provided: ____ No limitations __X__With limitations*

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

__X__ Provided: ____No limitations __X__With limitations*

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

a. Podiatrists' services.

__X__ Provided: ____ No limitations __X__With limitations*

Not Provided: ____

b. Optometrists' services.

__X__ Provided: ____No limitations __X__With limitations*

Not Provided: ____

c. Chiropractor's services.

____ Provided: ____No limitations ____With limitations*

Not Provided: __X__

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

__X__ Provided: ____No limitations __X__With limitations*

Not Provided: ____

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7. Home health services.

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

__X__ Provided: ____No limitations __X__With limitations*

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

__X__ Provided: ____No limitations __X__With limitations*

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

__X__ Provided: ____ No limitations __X__ With limitations*

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

__X__ Provided: ____ No limitations __X__ With limitations*

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

__X__ Provided: ____ No Limitations __X__ With limitations*

8. Private duty nursing services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

9. Clinic services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

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10. Dental services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

11. Physical therapy and related services.

a. Physical therapy.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

b. Occupational therapy.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

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

__X__ Provided: ____ No Limitations __X__ With limitations*

Not Provided: ____

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

a. Prescribed drugs.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

b. Dentures.

__X__ Provided: ____ No limitations __X__ With limitations*

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

c. Prosthetic devices.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

d. Eyeglasses.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

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

a. Diagnostic services.

____ Provided: ____ No limitations ____ With limitations*

Not Provided: _X___

b. Screening services.

____ Provided: ____ No limitations ____ With limitations*

Not Provided: __X__

1. Preventive services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

2. Rehabilitative services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

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

a. Inpatient hospital services.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

b. Nursing facility services.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

c. Intermediate care facility services.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

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

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

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

____ Provided: ____ No limitations ____ With limitations*

Not Provided: __X__

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

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

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17. Nurse -midwife services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

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

__X__ Provided: ____ No limitations

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

__X__ With limitations* Not Provided: ____

19. Case management services and Tuberculosis related services.

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

__X__ Provided: ____ With limitations*

Not Provided: ____

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

____ Provided: ____ With limitations*

Not Provided: _X__

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

____ Provided: ____ With limitations*

Not Provided__X_

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20. Extended services for pregnant women.

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

__X__ Additional coverage ++

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

__X__ Additional coverage ++

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

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

____ Provided ____ No limitations ____ With limitations*

Not Provided: __X__

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

__X__ Provided: ____ No limitations __X__ With limitations

Not Provided: ____

23. Certified pediatric or family nurse practitioners' services.

__X__ Provided: __X__ No limitations ____ With limitations*

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

a. Transportation.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

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

____ Provided: ____ No limitations ____ With limitations*

Not Provided: __X__

c. Reserved.

____ Provided: ____ No limitations ____ With limitations*

Not Provided: __X__

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

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

e. Emergency hospital services.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

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

____ Provided: __X__ Not Provided

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

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

____ Not Provided

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

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

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

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

29. Licensed or Otherwise State-Approved Freestanding Birthing Center

_X_ Provided ___ No limitations _X_ With Limitations*

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* Limitations described on following pages

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TELEMEDICINE

Telemedicine is when a health care practitioner uses interactive real-time audio and video telecommunications to deliver covered services that are within his or her scope of practice to a client at a site other than the site where the provider is located.

PROVIDERS
The following providers are eligible to provide telemedicine services within their scope of practice:

- Physicians (must be licensed per chapter 18.71 RCW and chapter 246-919 WAC)
- Dentists (must be licensed per chapter 18.32 RCW and chapter 246-817 WAC)
- Advanced Registered Nurse Practitioners (must be licensed per chapter 18.79 RCW and chapter 246-840 WAC)
- Psychiatric Advanced Registered Nurse Practitioners (must be licensed per chapter 18.73 RCW and chapter 246-840 WAC)
- Physician Assistants (must be licensed per chapter 18.57A, 18.71.A and chapters 246-854 WAC and 246-918 WAC)
- Independent Clinical Social Workers (must be licensed per chapter 18.225 RCW and chapter 246-809 WAC)
- Advanced Clinical Social Workers (must be licensed per chapter 18.225 RCW and chapter 246-809 WAC)
- Mental Health Counselors (must be licensed per chapter 18.225 RCW and chapter 246-809 WAC)
- Marriage and Family Therapists (must be licensed per chapter 18.225 RCW and chapter 246-809 WAC)
- Psychologists (must be licensed per chapter 18.83 and chapter 246-924 WAC)
- Certified counselors acting as a lead behavior analyst therapist (must be licensed per chapters 185.19 RCW and 246-810 WAC)

SERVICES
Telemedicine is covered fee-for-service when it is used to substitute for a face-to-face, “hands on” encounter. Only the following services are covered using telemedicine:

- Consultations
- Office or other outpatient visits
- Psychiatric intake and assessment
- Individual psychotherapy
- Visit for drug monitoring

The following services are **not** covered as telemedicine:

- Email, telephone, and facsimile transmissions
- Installation or maintenance of any telecommunication devices or systems
- Home health monitoring
- “Store and forward” telecommunication-based services (store and forward is the asynchronous transmission of medical information to be reviewed at a later time by the physician or practitioner at the distant site)

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Telemedicine (cont)

SITES
An originating site is the physical location of the client at the time the service is provided through telemedicine. Approved originating sites are:

- The office of a physician or practitioner
- A hospital
- A critical access hospital
- A rural health clinic (RHC)
- A federally qualified health center (FQHC)
- A home
- A school

A distant site is the physical location of the physician or practitioner providing the service through telemedicine.

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Description of Service Limitations

I. Inpatient hospital services

a. Prior authorization is required for psychiatric inpatient care.

b. Chronic pain management is limited to inpatient services provided by a Department of Social and Health Services (department)-approved pain center in a hospital.

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

2. a. Outpatient hospital services

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

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

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

I. Rural Health Clinics (RHC)

A rural health clinic (RHC) is:

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

II. Covered services

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

III. Other ambulatory services

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

III. Core Service Providers

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

IV. Additional providers

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

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

Federally qualified health centers (FQHC)

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

II. Covered services

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

III. Other ambulatory services

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

IV. Core service providers

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

V. Additional providers

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

3. Other laboratory and x-ray services

a. Laboratory services

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

Drug screens only when medically necessary and when:

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

One each of the following, per client per day:

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

b. Radiology services

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

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

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

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

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4. a. Nursing facility services.

Prior approval of admission is required.

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

Specialized add-on services for certain NF residents

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

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

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

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4. a. Nursing facility services (cont)

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

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

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

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

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

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

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4. a. Nursing facility services (cont)

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

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

VI. Staff/family consultation and training
   A. Staff/family consultation and training is professional assistance to families, NF staff, or direct service providers to help them better meet the habilitative goals of the NF resident. Topics on which consultation and training are provided include:
      1. Health and medication monitoring
      2. Positioning and transfer
      3. Basic and advanced instructional techniques
      4. Positive behavior support
      5. Augmentative communication systems
      6. Diet and nutritional guidance
      7. Disability information and education
      8. Strategies for effectively and therapeutically interacting with the participant
      9. Environmental consultation
      10. Individual and family counseling

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

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

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

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4. a. Nursing facility services (cont)

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

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

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

VIII. Transportation Services

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

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

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4. a. Nursing facility services (cont)

IX. Other habilitative services and supplies

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

B. Limitations

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

X. Providers

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

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

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

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

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

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

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

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

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4. b. EPSDT (cont)

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

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

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

5. Home health services;

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

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

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

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4. b. EPSDT (cont)

6. Hospice care, including palliative care

7. School-based health care services

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

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

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

(i) *Physical Therapist* – A 'licensed physical therapist' is an individual who has met the requirements set forth in 42 CFR 440.110(a), passed the National Physical Therapy Examination (NPTE), and who is currently licensed according to the Washington State Board of Physical Therapy. Physical therapy services may be provided by a 'licensed physical therapy assistant' who has passed the National Physical Therapy Examination (NPTE), and meets the requirements of Chapter 18.74 RCW and Chapter 246-915 WAC. A 'licensed physical therapist assistant' must be under the direction and supervision of a licensed physical therapist.

(ii) *Occupational Therapist* – A 'licensed occupational therapist' is an individual who has met the requirements set forth in 42 CFR 440.110(b), has passed the National Board for Certification in Occupational Therapy's (NBCOT) examination, and who is currently licensed according to the Washington State Occupational Therapy Practice Board. Occupational therapy services may be provided by a 'licensed occupational therapy assistant' who has passed the National Board for Certification in Occupational Therapy's (NBCOT) examination, and meets the requirements of Chapter 18.59 RCW and Chapter 246-847 WAC. A 'licensed occupational therapist assistant' must be under the direction and supervision of a licensed occupational therapist.

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

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4. b. EPSDT (cont)

assistant' who has met the requirements of Chapter 18.35 RCW and Chapter 246-828 WAC . A 'certified speech-language pathology assistant' must be under the direction and supervision of a licensed speech-language pathologist.

(iv) *Audiologist* – A 'licensed audiologist' is an individual who has met the requirements set forth in 42 CFR 440.110(c)(2), is currently licensed, and has passed the examination or received official verification from the American Speech and Hearing Association (ASHA), clinical competency certifications from the American Board of Audiology (ABA) or the American Academy of Audiology (AAA). The licensed audiologist must be in compliance with the Washington State Board of Health and Speech, and conform to Chapter 18.250 RCW and Chapter 246-828 WAC.

(v) *Registered Nurse or Licensed Practical Nurse* – A 'registered nurse or licensed practical nurse' is an individual who is currently licensed according to the Washington State Health Nursing Commission, and is in compliance with 42 CFR 440.60. Registered nurses must conform to Chapter 18.79 RCW, 246-840 of the Washington Administrative Codes. A licensed practical nurse must meet the requirements of Chapter 18.79 RCW and Chapter 246-840 WAC.

(vi) *Psychologist* – A 'psychologist' is an individual who is currently licensed according to the Washington State Examining Board of Psychology, has passed the Examination for Professional Practice of Psychology (EPPP), and is in compliance with 42 CFR 440.130(d). A licensed psychologist must meet the requirements of Chapter 18.83 RCW and Chapter 246-924 WAC.

(vii) *Social Worker* – A 'social worker' is an individual who is currently licensed according to the Washington State Board of Health, has passed the American Association of Social Work Boards (ASWB), and is in compliance with 42 CFR 440.130(d). A licensed social worker must meet the requirements of Chapter 18.225 RCW and Chapter 246-809 WAC.

(viii) *Mental Health Counselor* – A 'licensed mental health counselor' is an individual who is currently licensed according to the Washington State Board of Health, has passed the National Board for Certified Counselors (NBCC), and is in compliance with 42 CFR 440.130(d). Mental health services may be provided by a 'licensed mental health counselor associate' who has not taken the National Board for Certified Counselors (NBCC) examination, but meets the requirements of Chapter 18.225 RCW and Chapter 246-809 WAC. A 'licensed mental health counselor associate' must be under the direction and supervision of a licensed mental health counselor.

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4. b. EPSDT (cont)

(ix) In those circumstances when a healthcare related service is provided under the direction and supervision of a licensed therapist *(e.g., Occupational, Physical, or Speech Language Pathologist)*, the following restrictions apply. Documentation must be kept to support the licensed therapist's supervision of services and ongoing treatment of services. The supervising therapist must:

See the child face-to-face at the beginning of service and periodically during treatment;

- Be familiar with the treatment plan as recommended by the prescribing physician under state law;
- Have a continued involvement in the child's care recommended by the prescribing physician; and
- Review the need for continued services through treatment.

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

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

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

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

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

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

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4. b. EPSDT (cont)

vi. *Psychological assessments and counseling services* – Psychological assessments include testing and psychotherapy to assist a child in adjusting to their disability.

vii. *Counseling assessments and therapy services* – Therapeutic intervention services to assist a child in adjusting to their disability.

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

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d. Tobacco cessation counseling services for pregnant women

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

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

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

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

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

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

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

Please describe any limitations:

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

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5. a. Physicians' services

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

(1) Critical care.

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

(2) Newborn care and neonatal intensive care unit (NICU) services.

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

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

(4) Physical exams:
Routine physical exams are covered in specific instances, including but not limited to:

- EPSDT screening
- Nursing facility placement exams
- Disability determinations for Title XVI-related individuals
- Yearly exams for developmental disability determination (DDD) clients

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

(6) Physician standby services.
Must be:

- Requested by another physician;
- Involve prolonged physician attendance without direct (face-to-face) patient contact; and
- Exceed 30 minutes.

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5. a. Physicians' services (continued)

(7) Physician visits.

Limited to:

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

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

(8) Psychiatric services.

Limited to:

Inpatient care

- One hospital call per day for direct psychiatric care

Outpatient care

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

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

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5. a. Physicians' services (continued)

(9) Clients participating in the department-approved smoking cessation program may receive presecription medication(s).

(10) Physiatry services

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

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

Services may be provided by a physician, doctor of dentistry, or doctor of dental surgery.

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

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6. Other Practititioners Services

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

a. Podiatrists' services

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

(2) Reimbursement is according to Attachment 4.19-B III. Physicians' Services.

b. Optometrists' services

(1) The Medicaid agency covers medically necessary eye examinations, refractions, and fitting fees every 24 months for asymptomatic adults 21 years or older.

(2) Exceptions will be considered for all individuals based on medical necessity.

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

d. Other practitioners' services

(1) All other practitioners covered by the Medicaid agency include, but are not limited to, the following licensed practitioners: naturopathic physicians (services are limited to physician-related primary care services), physician assistants, advanced registered nurse practitioners including certified registered nurse anesthetists, psychologists, dental hygienists, denturists, chiropractors (for EPSDT only), opticians, and licensed non-nurse midwives, These practitioners are limited to services within their scope of practice and specialty area.

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

(3) Mental health outpatient services may be provided by the following providers licensed by the state under 42 CFR 440.060(a): Licensed Psychologists; Licensed Psychiatric Advanced Nurse Practitioners; Licensed Independent Clinical Social Workers; Licensed Advance Social Workers; Licensed Marriage and Family Therapists; and Licensed Mental Health Counselors.

The practitioners listed above who want to diagnose and treat clients eighteen years of age and younger must have a minimum of two years' experience in the diagnosis and treatment of clients eighteen years of age and younger, including one year of supervision by a mental health professional trained in child and family mental health.

Back to TOC Mental health payment rates methodology is in accordance with Attachment 4.19-B.

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6. d. Other practitioners' services (cont.)

(4) The Medicaid agency does not cover services provided by:
- Acupuncturists
- Christian Science practitioners or theological healers
- Herbalists
- Homeopathists
- Masseuses
- Masseurs
- Sanipractors

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

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

(7) Intensive behavior services (EPSDT only) provided by:
A. A lead behavior analysis therapist (LBAT) who under Washington State law is licensed under one of the following provisions and either a board-certified applied behavior analyst (BCBA) or is deemed board-qualified by the Behavior Analyst Certification Board, **and** one of the following:
- A psychiatrist, psychiatric advanced nurse practitioner, psychologist, mental health counselor, marriage or family therapist, or clinical social worker licensed by the Department of Health (DOH) and practicing under the scope of state law as defined by DOH RCW and WAC;

- A licensed certified counselor or counselor advisor practicing under the scope of state law as defined by DOH RCW and WAC and supervised by a mental health professional licensed by the DOH and practicing under the scope of state law as defined by DOH RCW and WAC; or

- A licensed mental health professional as defined in Attachment 3.1-A 13 d.7 of the State Plan, who is employed or contracted with an agency licensed by DOH or by the Department of Social and Health Services (DSHS) as a Community Mental Health Agency and also holds a certificate to provide Applied Behavior Analysis (ABA) therapy services. This professional must also be licensed as a registered agency-affiliated counselor with DOH and practicing consistent with the provisions of DOH RCW, WAC and DSHS WAC.

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Note: These professionals may supervise other providers, including intensive behavior therapy assistants licensed and practicing under applicable DOH RCW, WAC and DSHS WAC.

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6. d. Other practitioners' services (cont)

B. A therapy assistant who is one of the following:

A licensed certified counselor or counselor advisor practicing under the scope of state law and supervised by an LBAT who is a mental health professional licensed by the DOH and practicing under the scope of state law as defined by DOH RCW and WAC;

or

A licensed registered agency-affiliated counselor, who is employed or contracted with an agency licensed by the DOH or by DSHS as a Community Mental Health Agency and also holds a certificate to provide ABA therapy services. These providers must practice under applicable DOH RCW, WAC and DSHS WAC, are supervised by an LBAT who is a licensed mental health professional as described above, employed or contracted by the licensed agency and practicing consistent with applicable DOH RCW, WAC and DSHS WAC. Their services are billed for by the agency.

C. The State provides assurance that these licensed providers are:

- Providing services consistent with §440.60.
- Supervising according to the State's Scope of Practice Act for licensed practitioners.
- Assuming professional responsibility for the services provided by the therapy assistants

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7. Home health care services

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

1) Applies to home health agency and to services provided by a registered nurse when no home health agency exists in the area.

2) Approval required when period of service exceeds limits established by the department.

3) Nursing care services are limited to:

(a) Services that are medically necessary;

(b) Services that can be safely provided in the home setting;

(c) Two visits per day (except for the services listed below);

(d) Three high risk obstetrical visits per pregnancy; and

(e) Infant home phototherapy that was not initiated in the hospital setting.

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

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

Home health aide services must be:

1) Intermittent or part time;

2) Ordered by a physician on a plan of care established by the nurse or therapist;

3) Provided by a Medicare-certified home health agency;

4) Limited to one medically necessary visit per day; and

5) Supervised by the nurse or therapist biweekly in the client's home.

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

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7. Home health care services (cont.)

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

Medical supplies, equipment and appliances must be:
- Medically necessary;
- In the client's plan of care; and
- Ordered by the treating physician and renewed annually.

All of the following apply to durable medical equipment (DME) and related supplies, prosthetics, orthotics, medical supplies and related services suitable for use in the home:
- Purchase of equipment and appliances and rental of durable medical equipment require prior approval.
- Specific reusable and disposable medical supplies, prosthetics, orthotics, and non-durable equipment that have set limitations, require prior approval (PA) to exceed those limitations.

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

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

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

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

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

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

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7. Home health care services (cont.)

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

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

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

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

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

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

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8. Private duty nursing services

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

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

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

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9. Clinic Services

a. Freestanding kidney centers

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

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

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

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

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

b. Freestanding ambulatory surgery centers

Allowed procedures are covered when they:

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

Some procedures are covered only when they:

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

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- Dental services and dentures

The Medicaid Agency covers the services listed below for eligible clients as indicated. Some of these services may require prior authorization. Limitations described do not apply for children age 20 and under for EPSDT purposes and may be exceeded based on documented medical necessity with prior authorization. See section III for additional covered services for clients of the Developmental Disabilities Administration.

1. For clients age 21 and over

A. Preventive care
   1. Behavior management (limited to clients with autism and clients of the Developmental Disabilities Administration regardless of age)
   2. Examinations
      a. Periodic oral evaluations once every 6 months
      b. Comprehensive evaluations once every 5 years
   3. Fluoride, once in a 12-month period, per client, per provider/clinic
   4. Prophylaxis
      a. Once every 12 months
      b. Not covered in conjunction with periodontal maintenance or root planing/scaling
      c. Must be at least 12 months after periodontal maintenance or root planing/scaling
   5. X-rays (radiographs)
      a. Intraoral complete series once every 3 years
      b. Maximum of 4-bitewing x-rays every 12 months
      c. Panoramic x-rays in conjunction with 4-bitewings once every 3 years, only if the agency has not paid for an intraoral complete series in the same 3-year period

B. Treatment
   1. Biopsy
      a. Soft oral tissue
      b. Brush
   2. Endodontic treatment for permanent anterior teeth
   3. Extractions
      a. Prior authorization required for extractions of 4 or more teeth in a 6 month period resulting in edentulism
      b. Prior authorization required for unusual and complicated surgical extractions
   4. Periodontic services
      a. Scaling and root planning performed at least 12 months after periodontal maintenance
      b. Maintenance performed at least 12 months after scaling and root planing
   5. Resin-based composite restorations 1 time in a 2-year period unless the restoration has an additional adjoining carious surface.

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10. Dental services and dentures (cont)

6. Non-emergency oral surgeries performed in an inpatient hospital setting are not covered. The exception is for clients of the Developmental Disabilities Administration whose surgery cannot be performed in an office setting.

Documentation must be maintained in the client's record.

C. Dentures
1. Complete and overdentures
a. 1 maxillary and 1 mandibular in a 5-year period
b. Prior authorization required
2. Complete or partial rebase or relines once every 3 years when performed at least 6 months after the seating date
3. Resin partial dentures
a. Once every 3 years
b. Prior authorization required

I. For clients age 20 and under

A. Preventive care
1. Examinations
a. Periodic oral evaluations once every 6 months
b. Comprehensive evaluations once every 5 years
2. Fluoride (per client, per provider/clinic)
a. For clients age 6 and younger, 3 times in a 12-month period
b. For clients age 7 through 18, 2 times in a 12-month period
c. For clients age 19 through 20, 1 time in a 12-month period
3. Oral hygiene instruction
a. For clients age 8 and younger only
b. Up to 2 times in a 12-month period in a setting other than a dental office
4. Prophylaxis
a. Not covered in conjunction with periodontal maintenance or root scaling/planing
b. For clients age 18 and younger
i. Once every 6 months
ii. Must be at least 6 months after periodontal maintenance or root scaling/planing
c. For clients age 19 through 20
i. Once every 12 months
ii. Must be at least 12 months after periodontal maintenance or root scaling/planing

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10. Dental services and dentures (cont)

5. Pulp vitality test, one per visit
6. Sealants
a. Once per tooth in a 3-year period
b. Only for permanent teeth 2, 3, 14, 15, 18, 19, 30, 31
c. Only for primary teeth A, B, I, J, K, L, S, T
d. Only when placed on a tooth with no preexisting occlusal restoration or any occlusal restoration placed on the same day
7. Space maintenance
a. Only one space maintainer per quadrant
b. Fixed unilateral or fixed bilateral space maintainers, including recementation for missing primary molars A, B, I, J, K, L, S, T
8. X-rays (radiographs)
a. Occlusal intraoral x-rays once in a 2-year period
b. Intraoral complete series for clients age 4 and older
c. Maximum of 4-bitewing x-rays every 4 months
d. Panoramic x-rays in conjunction with 4-bitewings once every 3 years, only if the agency has not paid for an intraoral complete series in the same 3-year period

B. Treatment
1. Apexification/apicoestomy
a. Apexification for apical closures for anterior permanent teeth
i. Limited to the initial visit and 3 interim treatment visits
ii. Prior authorization required
b. Apicoestomy for anterior teeth only
2. Biopsy
a. Soft oral tissue
b. Brush
3. Crowns
a. Prefabricated stainless steel crowns
i. For primary anterior and posterior teeth once every 3 years for clients age 20 and younger
ii. For permanent posterior teeth, excluding 1, 16, 17, 32
Prior authorization required for anterior teeth for clients age 13 through 20
b. Indirect crowns
i. Once every 5 years for permanent anterior teeth for clients age 15 through 20
ii. Prior authorization required
4. Endodontic treatment
a. For primary incisor teeth D, E, F, and G if entire root is present
b. For permanent anterior, bicuspid, and molar teeth, excluding 1, 16, 17, 32
5. Extractions
a. Prior authorization required for unusual and complicated surgical extractions
b. Prior authorization required for extractions of 4 or more teeth in a 6-month period resulting in edentulislm
6. Occlusal orthotic devices for clients age 12 through 20 with prior authorization

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10. Dental services and dentures (cont)

7. Office-based anesthesia – prior authorization required for clients age 9 through 20
8. Oral surgery
    a. In an ambulatory surgery center, outpatient, or inpatient hospital setting when the service cannot be performed in an office setting
    b. Prior authorization required for clients age 9 through 20
    c. Prior authorization not required for clients of the Disability Determination Administration
9. Periodontic services
    a. Prior authorization required for gingivectomy/gingivoplasty
    b. Periodontal scaling/root planing for clients age 13 through 20
        i. Once per quadrant, per client, in a 2-year period
        ii. Must be performed at least 12 months after periodontal maintenance
        iii. Prior authorization required for clients age 13 through 18
    c. Periodontal maintenance for clients age 13 through 20
        i. Once per client in a 12-month period
        ii. Must be performed at least 12 months after periodontal root scaling/planing
        iii. Prior authorization required for clients age 13 through 18
10. Pulpotomy
    a. Therapeutic pulpotomy on primary teeth
    b. Pulpal debridement on permanent teeth, excluding 1, 16, 17, 32
11. Surgical incisions
    a. For frenuloplasty/frenulectomy
    b. Prior authorization required for clients age 7 through 20

C. Orthodontic treatment
    1. Limited to medically necessary treatment

D Dentures
    1. Complete and overdentures
        a. 1 maxillary and 1 mandibular denture in a 5-year period
        b. Prior authorization required
    2. Partial dentures
        a. Cast metal, once every 5 years
        b. Resin, once every 3 years and requires prior authorization
    3. Complete or partial rebase or reline once every 3 years when performed at least 6 months after the seating date.

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

    a. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders are provided in accordance with 42 CFR 440.110.
    b. Duplicate services for occupational, physical, and speech therapy are not allowed for the same client when providers are performing the same or similar procedure(s).
    c. Limitations do not apply for clients under the age of 21 under EPSDT.
    d. Prior authorization is required to exceed set limits for clients twenty-one (21) years of age and older as follows:

        (1) For physical therapy (PT) services beyond one PT evaluation and 24 units (approximately 6 hours) PT per calendar year, per client.
        (2) For occupational therapy (OT) services beyond one OT evaluation and 24 OT units (approximately 6 hours) per calendar year, per client.
        (3) For speech therapy (ST) services beyond one speech evaluation and 6 units/visits of speech therapy per calendar year, per client.

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

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

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

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12. a. Prescribed drugs

Drug Coverage

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

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

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

Prior Authorization

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

(5) HRSA determines which prescription drugs may require prior authorization by reviewing the drug(s) for the following:

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

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

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12. a. Prescribed drugs (continued)

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

Supplemental Rebate Agreement

(7) The state is in compliance with Section 1927 of the Act. The state will cover drugs of manufacturers participating in the Medicaid Drug Rebate Program. Based on the requirements for Section 1927 of the Act, the state has the following policies for drug rebate agreements:

- Manufacturers are allowed to audit utilization rates.
- The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification, in accordance with Section 1927 (b)(3)(D).
- A rebate agreement between the state and a drug manufacturer for drugs provided to the Washington Medicaid population, submitted to CMS on July 15, 2008, entitled “State of Washington Supplemental Rebate Contract,” has been authorized by CMS.
- The state reports rebates from separate agreements to the Secretary for Health and Human Services. The state will remit the federal portion of any cash state supplemental rebates collected on the same percentage basis applied under the national rebate agreement.
- All drugs covered by the program, irrespective of a prior authorization agreement, will comply with provisions of the national drug rebate agreement.

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12. a. Prescribed drugs (continued)

Preferred Drug List

a. Pursuant to 42 U.S.C. section 1396r-8, the State is establishing a preferred drug list with prior authorization for drugs not included on the preferred drug list. Prior authorization programs for covered outpatient drugs provide for a response within 24 hours of a request for prior authorization, and provides for the dispensing of at least a 72-hour supply of medications in emergency situations, in accordance with provisions of section 1927(d)(5) of the Social Security Act. The prior authorization process is described in chapter 388-530 WAC.
b. Prior authorization will be established for certain drug classes or particular drugs in accordance with Federal law. All drugs covered by the program, irrespective of a prior authorization requirement, will comply with the provisions of the national drug rebate agreement.
c. A preferred drug list does not prevent Medicaid beneficiaries from obtaining access to medically necessary drugs of manufacturers that participate in the national drug rebate program.
d. The State will utilize the Drug Utilization Review board to assure, that in addition to pricing consideration, preferred drugs are clinically appropriate.

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12. a. Prescribed Drugs (continued)

Citation	**Provision**
1935(d)(1)	In January 2006, the Medicaid agency ceased covering any Part D drug for full-benefit dual eligible e individuals who are entitled to receive Medicare benefits under Part A or Part B.
1927(d)(2) and 1935(d)(2)	(a) The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D.

_X_ **The following excluded drugs are covered:**

select (i) Agents when used for anexoria, weight loss, weight gain: progestin derivative appetite stimulant, androgenic agents

_no_ (ii) Agents when used to promote fertility

_no_ (iii) Agents when used for cosmetic purposes or hair growth

select (iv) Agents when used for the symptomatic relief cough and colds: antitussives, expectorants, decongestants, nasal spray, and only the following generic, single ingredient formulations:

Guiafenesin 100mg/5ml liquid or syrup;
Dextromethorphan 15mg/5ml liquid or syrup;
Pseudoephderine 30mg or 60mg tablets;
Saline nasal spray 0.65%; and
Generic combination product: detromethorphan-guaifenesin 10-100mg/5ml syrup, including sugar-free formulations.

_X_ (v) Prescription vitamins and mineral products, except prenatal vitamins and fluoride, for documented deficiency.

select (vi) Nonprescription (OTC) drugs when determined by the department to be the least costly therapeutic alternative for a medically accepted indication in the following therapeutic classes: allylamines, analgesics, antacids, anthelmintics, anti-inflammatories, antiallergics, antibacterials, antidiarrheals, antiemetics, antiflatulents, antifungals, antihistamines, antihypoglycemics, anti-infectives, antiparasitics, antipruritics, antipyretics, antitussives, antivertigo agents, cathartics, contraceptive foams, contraceptives, corticosteroids, decongestants, EENT preparations, emergency contraceptives, emetics,

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12. a. Prescribed Drugs (continued)

expectorants, gi antihistamines, histamine h2-antagonists, iron preparations, keratoplastic agents, laxatives, liniments, lotions, mucolytics, nicotine replacement therapies, nonsteroidal anti-inflammatory, pediculicides, progestins, proton-pump inhibitors, respiratory tract agents, salicylates, scabicides, steroidal anti-inflammatories, sympathomimetics, vasoconstrictors.

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

____ No excluded drugs are covered.

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12. b. Dentures

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

12. c. Prosthetic devices

- Prior approval required
- Hearing aids provided on the basis of minimal decibel loss

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

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13. c. Preventive services

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

The Medicaid agency covers alcohol and substance misuse counseling through screening, brief interventions, and referral to treatment (SBIRT) when provided by, or under the supervision of, a certified physician or other certified licensed healthcare provider within the scope of their practice.

PROVIDERS

1. The following health care professionals are eligible to become qualified SBIRT providers to deliver SBIRT services or supervise qualified staff to deliver SBIRT services:
   - Advanced registered nurse practitioner (ARNP) (must be licensed per chapters 18.79 RCW and 246-840 WAC)
   - Chemical dependency professional (must be licensed per chapters 18.205 RCW and 246-811 WAC)
   - Licensed practical nurse (must be licensed per chapters 18.79 RCW and 246-840 WAC)
   - Mental health counselor (must be licensed per chapters 18.225 RCW and 246-809 WAC)
   - Marriage and family therapist (must be licensed per chapters 18.225 RCW and 246-809 WAC)
   - Independent and advanced social worker (must be licensed per chapters 18.225 RCW and 246-809 WAC)
   - Physician (must be licensed per chapters 18.71 RCW and 246-919 WAC)
   - Physician assistant (must be licensed per chapters 18.71A RCW and 246-918 WAC)
   - Psychologist (must be licensed per chapters 18.83 RCW and 246-840 WAC)
   - Registered nurse (must be licensed per chapters 18.79 RCW and 246-840 WAC)
   - Dentist (must be licensed per chapters 18.260 and 246-817 WAC)
   - Dental hygienist (must be licensed per chapters 18.29 RCW and 246-818 WAC)

2. To qualify as a qualified SBIRT provider, eligible licensed health care professionals must complete a minimum of 4 hours of SBIRT training and mail or fax proof of SBIRT training completion to the Medicaid agency.

3. The following qualified SBIRT health care professionals may bill for SBIRT services:
   - Advanced registered nurse practitioner (ARNP) (must be licensed per chapters 18.79 RCW and 246-840 WAC)
   - Marriage and family therapist (must be licensed per chapters 18.225 RCW and 246-809 WAC)
   - Independent and advanced social worker (must be licensed per chapters 18.225 RCW and 246-809 WAC)
   - Physician (must be licensed per chapters 18.71 RCW and 246-919 WAC)
   - Psychologist (must be licensed per chapters 18.83 RCW and 246-840 WAC)

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13. c. Preventive services

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

- Dentist (must be licensed per chapters 18.260 and 246-817 WAC)
- Dental hygienist (must be licensed per chapters 18.29 RCW and 246-818 WAC)

SERVICES

1. SBIRT services must be provided in a primary care setting (includes dentist offices).
2. SBIRT services are covered for determining risk factors that are related to alcohol and other drug use disorders. SBIRT services are:
   - Screening and assessment (occurs during an E/M exam)
   - Brief intervention in the form of counseling (limited to 4 sessions per client per provider per calendar year)
   - Referral for treatment, if indicated
3. Washington covers and reimburses all United States Preventive Services Task Force (USPSTF) grade A and B preventive services and approved vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), and their administration, without cost-sharing, when provided in a practitioners' office setting.

   Preventive services specified in section 4106 of the Affordable Care Act are all available under the State Plan and are covered under the following service benefits and are reimbursed according to the methodologies provided in Attachment 4.19-B for such services:
   - Clinics
   - Physicians
   - Dentists
   - Other licensed practitioners

   In addition to the services specified under section 4106 of the Affordable Care Act, Washington covers, without cost-sharing, services specified under PHS 2713 which is in alignment with the Alternative Benefit Plans.

   The State will maintain documentation supporting expenditures claimed for these preventive services and ensure that coverage and billing codes comply with any changes made to the USPSTF or ACIP recommendations.

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13. d. Rehabilitative services

(1) Physical medicine and rehabilitation as requested and approved.

(2) Alcohol and drug treatment services

(a) Alcohol/drug screening and brief intervention

(i) Description of services
A combination of services designed to screen for risk factors that appear to be related to alcohol and other drug use disorders, provide interventions to enhance patient motivation to change, and make appropriate referral as needed.

(ii) Provider qualifications
Alcohol/drug screening and brief intervention services must be performed by the following practitioners who are licensed and/or certified by the Washington State Department of Health (DOH) according to DOH Revised Code of Washington (RCW) and Washington Administrative Code (WAC) in effect as of July 1, 2009, as follows:

(A) Advanced registered nurse practitioner (ARNP) - chapter 18.79 RCW and chapter 246-840 WAC. Must be licensed in Washington as a registered nurse and graduated from an advanced nursing education program within the last year.

(B) Chemical dependency professionals (CDP) - chapter 18.205 RCW and chapter 246-811 WAC. Must have an AA in human services or a related field from an approved school or completion of 90 quarter or 60 semester credits. At least 45 quarter or 30 semester credits must be in courses related to the CDP profession.

(C) Mental health counselor – chapter 18.225 RCW and chapter 246-809 WAC. Must have a Master's or Doctoral level degree in mental health counseling or a related field from an approved college or university.

(D) Marriage and family therapist – chapter 18.225 RCW and chapter 246-809 WAC. Must have a Master's or Doctoral degree in marriage and family therapy or in behavioral science, with equivalent course work from an approved school. American Association for Marriage and Family Therapy (AAMFT) clinical membership meets education requirements.

(E) Social worker – chapter 18.225 RCW and chapter 246-809 WAC. Must have a Master's or Doctoral degree from an educational program accredited by the Council on Social Work Education.

(F) Physician (MD) - chapter 18.71 RCW and chapter 246-919 WAC. Must be a graduate of a school of medicine approved by the Washington State Medical Quality Assurance Commission (WSMQA) and complete two years of postgraduate medical training in a program acceptable to WSMQA.

(G) Physician assistant (PA) - chapter 18.71A RCW and chapter 246-918 WAC. Must have a Physician Assistant degree from an accredited program and successfully complete the National Commission on Certification of Physician Assistants (NCCPA) examination.

(H) Psychologist - chapter 18.83 RCW and chapter 246-924 WAC. Must have a Doctoral degree from a regionally accredited institution.

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13. d. Rehabilitative Services (cont)

(iii) Settings
Services may be delivered in residential facilities that do not exceed 16 beds, outpatient facilities, and Indian Health Service facilities. All service delivery settings must meet the requirements of chapters 388-805 and 246-337 WAC in effect as of July 1, 2010, including but not limited to the following: have a Department of Health or business license, whichever is applicable; have sufficient qualified staff to deliver services; have a department-approved program/treatment plan; and develop and maintain administration, personnel, and clinical policies and procedures.

(b) Inpatient alcohol and drug detoxification

(i) Alcohol detoxification is limited to three days.
(ii) Drug detoxification is limited to five days.
(iii) Services required for the care and/or treatment of individuals intoxicated or incapacitated by alcohol or other drugs are provided during the initial period of care and treatment while the person recovers from the transitory effects of acute or chronic intoxication or withdrawal from alcohol or other drugs. Services are provided in certified facilities with 16 beds or less and exclude room and board. Services include:
(A) Screening and detoxification of intoxicated persons; and
(B) Counseling of persons admitted to a program within a certified facility, regarding their illness in order to stimulate motivation to obtain further treatment, and referral of detoxified chemically dependent (alcoholism or drug addiction) persons to other appropriate chemical dependency services providers (treatment programs).
(iv) Screening and detoxification of intoxicated persons
(A) All personnel providing patient care, except licensed medical and nursing staff, must complete a minimum of forty hours of documented training before assignment of patient care duties. Training includes:
(I) Chemical dependency;
(II) HIV/AIDS and hepatitis B education;
(III) TB prevention and control;
(IV) Detoxification screening, admission, and signs of trauma;
(V) Cardio-pulmonary resuscitation (CPR); and
(VI) First aid.
(B) If providing acute detoxification services, a licensed nurse must be on-site to monitor the screening and detoxification of the intoxicated person.
(C) If providing sub-acute detoxification services, the certified facility must establish agreements with authorized health care providers or hospitals that include:
(I) Criteria for determining the degree of medical stability of a resident;
(II) Monitoring the resident after being admitted;
(III) Reporting abnormal symptoms according to established criteria;
(IV) Criteria requiring immediate transfer to a hospital, when necessary; and
(V) Resident discharge or transfer criteria.
(v) Screening, detoxification, and referral services must be performed by the following practitioners, as indicated below, who are licensed and/or certified by DOH according to DOH RCW and WAC:.

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13. d. Rehabilitative Services (cont)

(A) Advanced registered nurse practitioner (ARNP): provides screening, detoxification, and referral. Meets requirements of chapter 18.79 RCW and chapter 246-840 WAC. See section (2)(a)(ii) *Provider Requirements* above.

B) Chemical dependency professionals (CDP): provides screening and referral. Meets requirements of chapter 18.205 RCW and chapter 246-924 WAC. See section (2)(a)(ii) *Provider Requirements* above.

(C) Licensed practical nurse (LPN): provides screening, detoxification, and referral. Meets requirements of chapter 18.79 RCW and chapter 246-840 WAC. Must be graduated from an approved practical nursing program.

(D) Mental health counselor: provides screening and referral. Meets requirements of chapter 18.225 RCW and chapter 246-809 WAC. See section (2)(a)(ii) *Provider Requirements a*bove.

(E) Marriage and family therapist: provides screening and referral. Meets requirements of chapter 18.225 RCW and chapter 246-809 WAC. See section (2)(a)(ii) *Provider Requirements* above.

(F) Social worker: provides screening and referral. Meets requirements of chapter 18.225 RCW and chapter 246-809 WAC. See section (2)(a)(ii) *Provider Requirements* above.

(G) Physician (MD): provides screening, detoxification, and referral. Meets requirements of chapter 18.71 RCW and chapter 246-919 WAC. See section (2)(a)(ii) *Provider Requirements* above.

(H) Physician assistant (PA): provides screening, detoxification, and referral. Meets requirements of chapter 18.71A RCW and chapter 246-918 WAC. See section (2)(a)(ii) *Provider Requirements* above.

(I) Psychologist: provides screening and referral. Meets requirements of chapter 18.83 RCW and chapter 246-924 WAC. See section (2)(a)(ii) *Provider Requirements* above.

(J) Registered nurse (RN): provides screening, detoxification, and referral. Meets requirements of chapter 18.79 RCW and chapter 246-840 WAC. Must successfully complete an approved nursing education program

(vi) Counseling services for persons admitted must be performed by a Chemical Dependency Professional (CDP) certified in chemical dependency counseling by DOH. To be certified, a CDP must meet the education, training, and experience required in chapter 246-811 WAC in effect as of July 1, 2010. See section (2)(a)(ii) *Provider Requirements* above.

(vii) Alcohol and drug detoxification is provided on an inpatient basis in certified facilities which are:

(A) Within the physical location and the administrative control of a general hospital; or

(B) Freestanding facilities established to provide these services.

(viii) Provider qualifications

(A) The freestanding facility in which the care is provided must be:

(I) Licensed by DOH, ensuring it meets all health and safety standards for licensure and operations for residential treatment facilities under DOH's WAC; and

(II) Certified by the Division of Behavioral Health and Recovery (DBHR), ensuring it meets all standards and processes necessary to be a certified chemical dependency service provider (treatment program) under DBHR's WAC.

(B) The program under which services are provided must be certified by DBHR, ensuring it meets all standards and processes necessary to be a certified chemical dependency service provider (treatment program) under DBHR's WAC.

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13. d. Rehabilitative Services (cont)

(c) Chemical dependency treatment

(i) Description of services
- (A) Rehabilitative services of diagnostic evaluation and face-to-face individual or group counseling using therapeutic techniques that are:
  - (I) Directed toward patients who are harmfully affected by the use of mood-altering chemicals or are chemically dependent; and
  - (II) Directed toward a goal of abstinence for chemically dependent persons.
- (B) Patient placement decisions are based on admission, continued service, and discharge criteria found in the *Patient Placement Criteria for the Treatment of Substance-Related Disorders* as published by the American Society of Addiction Medicine (ASAM).

(ii) Provided in certified programs that include:
- (A) Outpatient treatment in chemical dependency treatment centers; and
- (B) Treatment services, *excluding board and room*, provided in residential treatment facilities with 16 beds or less.

(iii) Goal-oriented rehabilitation (treatment) plans are identified under a written rehabilitation plan that meets DBHR WAC requirements that include, but are not limited to:
- (A) Patient involvement in treatment planning;
- (B) Treatment goals and documentation of progress toward patient attainment of the treatment goals; and
- (C) Completeness of patient records, which include:
  - (I) Demographic information;
  - (II) Assessment and history of involvement with alcohol and other drugs:
  - (III) Initial and updated individual treatment plans;
  - (IV) Date, duration, and content of counseling sessions; and
  - (V) Voluntary consent to treatment, signed and dated by the patient.

(iv) Provider Qualifications
- (A) The outpatient chemical dependency service treatment center and program must be certified by DBHR, ensuring it meets all standards and processes necessary to be a certified chemical dependency service provider (treatment program) according to DBHR WAC.
- (B) The residential treatment facility in which the care is provided and program must be certified by DBHR and licensed by DOH, ensuring it meets:
  - (I) All health and safety standards for licensure and operations for residential treatment facilities according to DOH WAC; and
  - (II) All standards and processes necessary to be a certified chemical dependency treatment program according to DBHR WAC.

(v) Counseling services for persons admitted must be performed by a Chemical Dependency Professional (CDP) certified in chemical dependency counseling by DOH. To be certified, a CDP must meet the education, training, and experience required in chapter 246-811 WAC.

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13. d. Rehabilitative services (cont.)

Mental Health Rehabilitation services are integrated treatment services recommended by a mental health professional furnished by state licensed Community Mental Health Agencies. Services are provided to seriously mentally ill adults and seriously emotionally disturbed children for whom the services are determined to be medically necessary. These services must be provided to reach the goals of an Individualized Service Plan. The payment rates are established per Attachment 4.19-B XVII.

The services to be provided are:

- Brief Intervention Treatment;
- Crisis services;
- Day Support;
- Family treatment;
- Freestanding Evaluation and Treatment;
- Group treatment services;
- High Intensity Treatment;
- Individual Treatment Services;
- Intake evaluation;
- Medication Management;
- Medication Monitoring;
- Mental Health Services provided in Residential settings;
- Peer Support;
- Psychological Assessment;
- Rehabilitation Case Management;
- Special population evaluation;
- Stabilization Services; and,
- Therapeutic psychoeducation.

Definition of medical necessity as it relates to mental health services

Medical necessity or *medically necessary* – "A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause of physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. For the purpose of this chapter "course of treatment" may include mere observation, or where appropriate, no treatment at all.

Additionally, the individual must be determined to 1) have a mental illness covered by Washington State for public mental health services; 2) the individual's impairment(s) and corresponding need(s) must be the result of a mental illness;

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

3) the intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness; 4) the individual is expected to benefit from the intervention; and 5) any other formal or informal system or support can not address the individual's unmet need.

Medical necessity is determined by a mental health professional. All state plan modality services are accessible based on clinical assessment, medical necessity and individual need. Individuals will develop with their mental health care provider an appropriate individual service plan. The services are provided by Community Mental Health Agencies licensed or certified by the Mental Health Division and provided by, or under the supervision of, a mental health professional. Services are assured in accordance with 1902(a)(23).

The following is a descriptive list of the employees or contracted staff of community mental health agencies providing care.

(1) *Mental health professional* means:

(A) A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapter 71.05 and 71.34 RCW;

(B) A person with a masters degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional;

(C) A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986.

(D) A person who had an approved waiver to perform the duties of a mental health profession that was requested by the regional support network and granted by the mental health division prior to July 1, 2001; or

(E) A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the mental health division consistent with WAC 388-865-265.

Within the definition above are the following:

"Psychiatrist" means a person having a license as a physician in this state who has completed residency training in psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and is board eligible or board certified in psychiatry.

"Psychologist" means a person who has been licensed as a psychologist pursuant to chapter 18.83 RCW;

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

"Social worker" means a person with a master's or further advanced degree from an accredited school of social work or a degree deemed equivalent under rules adopted by the secretary;

"Child psychiatrist" means a person having a license as a physician and surgeon in this state, who has had graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board eligible or board certified in child psychiatry.

"Psychiatric nurse" means a registered nurse who has a bachelor's degree from an accredited college or university, and who has had, in addition, at least two years experience in the direct treatment of mentally ill or emotionally disturbed persons, such experience gained under the supervision of a mental health professional. "Psychiatric nurse" shall also mean any other registered nurse who has three years of such experience.

"Counselor" means an individual, practitioner, therapist, or analyst who engages in the practice of counseling to the public for a fee. A "counselor", engaging in the practice of counseling, can include an agency affiliated counselor, certified counselor, or certified adviser. Specific qualifications and licensing/certification requirements are described in chapter 18.19 RCW and chapter 246-810 WAC.

(2) *"Mental Health Care Provider"* means the individual with primary responsibility for implementing an individualized plan for mental health rehabilitation services. Minimum qualifications are B.A. level in a related field, A.A. level with two years experience in the mental health or related fields.

(3) *"Peer Counselor"* means the individual who: has self-identified as a consumer or survivor of mental health services; has received specialized training provided/contracted by the Mental Health Division; has passed a written/oral test, which includes both written and oral components of the training; has passed a Washington State background check; has been certified by the Mental Health Division; and is registered as a counselor with the Department of Health.

Peer Counselors must self identify as a consumer or survivor of mental health services. Peer Counselors must demonstrate:

- That they are well grounded in their own recovery for at least one year;
- Willingness to a pretest for reading comprehension and language composition; and,
- Qualities of leadership, including governance, advocacy, creation, implementation or facilitation of peer-to-peer groups or activities.

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

Peer Counselors must be able to:

- Identify services and activities that promote recovery by instilling hope and experiences which lead to meaning and purpose, and which decrease stigma in the environments in which they serve;
- Articulate points in their own recovery stories that are relevant to the obstacles faced by consumers of mental health services;
- Promote personal responsibility for recovery as the individual consumer or mental health services defines recovery;
- Implement recovery practices in the broad arena of mental health services delivery system;
- Provide a wide range of tasks to assist consumers in regaining control over their own lives and recovery process (e.g., promoting socialization, self advocacy, developing natural supports stable living arrangements, education, supported employment);
- Serve as a consumer advocate;
- Provide consumer information and peer support in a range of settings; and,
- Model competency in recovery and ongoing coping skills.

The training provided/contracted by the mental health division shall be focused on the principles and concepts of recovery and how this differs from the medical model, the creation of self-help and coping skills and advocacy. Training will include:

- Understanding the public mental health system;
- What is peer support and how it promotes recovery;
- How to advocate for age appropriate peer support projects;
- How to facilitate groups and teams;
- Understanding self-directed recovery;
- How to create your own self-help coping skills plan;
- How to start and sustain self-help/mutual support groups;
- How to form and sustain a personal support team;
- How to promote recovery, self-determination and community reintegration;
- Assist consumers to do for themselves and each other;
- Assist in skill building, goal setting, problem solving;
- Assist consumers to build their own self-directed recovery tools; and,
- Assist consumers by supporting them in the development of an individual service plan that has recovery goals and specific steps to attain each goal.

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

Peer Counselors who were trained prior to the implementation of the Washington Administrative Code by National Consultants to be Certified facilitators who pass the test and the background check, and are registered counselors may be grandfathered as Peer counselors until January 2005. After January 2005, it will be necessary for them to take the training.

(4) *"Registered nurse"* means a person licensed to practice registered nursing under chapter 18.79 RCW.

(5) *"Nurse practitioner"* means a person licensed to practice advanced registered nursing under chapter 18.79 RCW.

(6) *"Licensed practical nurse"* means a person licensed to practice practical nursing under chapter 18.79 RCW.

(7). *"Mental health specialist"* means:

(1) A "*child mental health specialist*" is defined as a mental health professional with the following education and experience:
(a) A minimum of one hundred actual hours (not quarter or semester hours) of special training in child development and the treatment of children and youth with serious emotional disturbance and their families; and
(b) The equivalent of one year of full-time experience in the treatment of seriously emotionally disturbed children and youth and their families under the supervision of a child mental health specialist.

(2) A "*geriatric mental health specialist*" is defined as a mental health professional who has the following education and experience:
(a) A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to the mental health problems and treatment of persons sixty years of age or older; and
(b) The equivalent of one year of full-time experience in the treatment of persons sixty years of age or older, under the supervision of a geriatric mental health specialist.

(3) An "*ethnic minority mental health specialist*" is defined as a mental health professional who has demonstrated cultural competence attained through major commitment, ongoing training, experience and/or specialization in serving ethnic minorities, including evidence of one year of service specializing in serving the ethnic minority group under the supervision of an ethnic minority mental health specialist; and
(a) Evidence of support from the ethnic minority community attesting to the person's commitment to that community; or

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

(b) A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to ethnic minority issues and treatment of ethnic minority consumers.

(4) A "*disability mental health specialist*" is defined as a mental health professional with special expertise in working with an identified disability group. For purposes of this chapter only, "disabled" means an individual with a disability other than a mental illness, including a developmental disability, serious physical handicap, or sensory impairment.

(a) If the consumer is deaf, the specialist must be a mental health professional with:

(i) Knowledge about the deaf culture and psychosocial problems faced by people who are deaf; and

(ii) Ability to communicate fluently in the preferred language system of the consumer.

(b) The specialist for consumers with developmental disabilities must be a mental health professional who:

(i) Has at least one year's experience working with people with developmental disabilities; or

(ii) Is a developmental disabilities professional as defined in RCW 71.05.020.

Staff Supervision means monitoring the administrative, clinical or clerical work performance of staff, students, interns, volunteers or contracted employees by persons with the authority to direct employment activities and require change. When supervision is clinical in nature, it shall occur regularly and may be provided without the consumer present or may include direct observation of the delivery of clinical care. Supervisory activities include the review of all aspects of clinical care including but not limited to review of assessment, diagnostic formulation, treatment planning, progress toward completion of care, identification of barriers to care, continuation of service and authorization of care.

B. Definitions

(1) Brief Intervention Treatment: Solution focused and outcomes oriented cognitive and behavioral interventions intended to ameliorate symptoms, resolve situational disturbances which are not amenable to resolution in a crisis service model of care and which do not require long term-treatment, to return the individual to previous higher levels of general functioning. Individuals must be able to select and identify a focus for care that is consistent with time-limited, solution-focused or cognitive-behavioral model of treatment.

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

Functional problems and/or needs identified in the Medicaid enrollee's Individual Service Plan must include a specific time frame for completion of each identified goal. This service does not include ongoing care, maintenance/monitoring of the enrollee's current level of functioning and assistance with self/care or life skills training. Enrollees may move from Brief Intervention Treatment to longer term Individual Services at any time during the course of care. This service is provided by or under the supervision of a Mental Health Professional.

(2) *Crisis Services:* Evaluation and treatment of mental health crisis to all Medicaid enrolled individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis services shall be available on a 24-hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Services are provided by or under the supervision of a mental health professional.

(3) *Day Support:* An intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) for Medicaid enrollees to promote improved functioning or a restoration to a previous higher level of functioning. The program is designed to assist the individual in the acquisition of skills, retention of current functioning or improvement in the current level of functioning, appropriate socialization and adaptive coping skills. Eligible individuals must demonstrate restricted functioning as evidenced by an inability to provide for their instrumental activities of daily living. This modality may be provided as an adjunctive treatment or as a primary intervention. The staff to consumer ratio is no more than 1:20 and is provided by or under the supervision of a mental health professional in a location easily accessible to the client (e.g., community mental health agencies, clubhouses, community centers). This service is available 5 hours per day, 5 days per week.

(4) *Family Treatment:* Psychological counseling provided for the direct benefit of a Medicaid enrolled individual. Service is provided with family members and/or other relevant persons in attendance as active participants.

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

Treatment shall be appropriate to the culture of the client and their family and should reinforce the family structure, improve communication and awareness, enforce and reintegrate the family structure within the community, and reduce the family crisis/upheaval. The treatment will provide family-centered interventions to identify and address family dynamics and build competencies to strengthen family functioning in relationship to the consumer. Family treatment may take place without the consumer present in the room but service must be for the benefit of attaining the goals identified for the individual in their individual service plan. This service is provided by or under the supervision of a mental health professional.

(5) *"Freestanding Evaluation and Treatment"* Services provided in freestanding inpatient residential (non-hospital/non-IMD) facilities licensed by the Department of Health and certified by the Mental Health Division to provide medically necessary evaluation and treatment to the Medicaid enrolled individual who would otherwise meet hospital admission criteria. These are not-for-profit organizations. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other mental health professionals, and discharge planning involving the individual, family, significant others so as to ensure continuity of mental health care. Nursing care includes but is not limited to, performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.

This service is provided for individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self due to the onset or exacerbation of a psychiatric disorder.

The severity of symptoms, intensity of treatment needs or lack of necessary supports for the individual does not allow them to be managed at a lesser level of care. This service does not include cost for room and board.

The Mental Health Division must authorize exceptions for involuntary length of stay beyond a fourteen-day commitment.

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

(6) *Group Treatment Services:* Services provided to Medicaid enrolled individuals designed to assist in the attainment of goals described in the Individual Service Plan. Goals of Group Treatment may include developing self care and/or life skills, enhancing interpersonal skills, mitigating the symptoms of mental illness, and lessening the results of traumatic experiences, learning from the perspective and experiences of others and counseling/psychotherapy to establish and /or maintain stability in living, work or educational environment. Individuals eligible for Group Treatment must demonstrate an ability to benefit from experiences shared by others, demonstrate the ability to participate in a group dynamic process in a manner that is respectful of other's right to confidential treatment and must be able to integrate feedback from other group members. This service is provided by or under the supervision of a mental health professional to two or more Medicaid enrolled individuals at the same time. Staff to consumer ratio is no more than 1:12. Maximum group size is 24.

(7) *High Intensity Treatment:* Intensive levels of service otherwise furnished under this state plan amendment that is provided to Medicaid enrolled individuals who require a multi-disciplinary treatment team in the community that is available upon demand based on the individual's need. Twenty-four hours per day, seven days per week, access is required if necessary. Goals for High Intensity Treatment include the reinforcement of safety, the promotion of stability and independence of the individual in the community, and the restoration to a higher level of functioning. These services are designed to rehabilitate individuals who are experiencing severe symptoms in the community and thereby avoid more restrictive levels of care such as psychiatric inpatient hospitalization or residential placement.

The team consists of the individual, Mental Health Care Providers, under the supervision of a mental health professional, and other relevant persons as determined by the individual (e.g., family, guardian, friends, neighbor). Other community agency members may include probation/parole officers*, teacher, minister, physician, chemical dependency counselor*, etc. Team members work together to provide intensive coordinated and integrated treatment as described in the individual service plan. The team's intensity varies among individuals and for each individual across time. The assessment of symptoms and functioning will be continuously addressed by the team based on the needs of the individual allowing for the prompt assessment for needed modifications to the individual service plan or crisis plan. Team members provide immediate feedback to the individual and to other team members. The staff to consumer ratio for this service is no more than 1:15.

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

Billable components of this modality include time spent by the mental health professionals, mental health care providers and peer counselors.
*Although they participate, these team members are paid staff of other Departments and therefore not reimbursed under this modality.

(8) *Individual Treatment Services:* A set of treatment services designed to help a Medicaid enrolled individual attain goals as prescribed in their individual treatment plan. These services shall be congruent with the age, strengths, and cultural framework of the individual and shall be conducted with the individual, his or her family, or others at the individual's behest who play a direct role in assisting the individual to establish and/or maintain stability in his/her daily life. These services may include, developing the individual's self-care/life skills; monitoring the individual's functioning; counseling and psychotherapy. Services shall be offered at the location preferred by the Medicaid enrolled individual. This service is provided by or under the supervision of a mental health professional.

(9) *Intake Evaluation:* An evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except crisis services, services, stabilization services and free-standing evaluation and treatment. The intake evaluation must be initiated within ten (10) working days of the request for services, establish the medical necessity for treatment and be completed within thirty (30) working days. Routine services may begin before the completion of the intake once medical necessity is established. This service is provided by a mental health professional.

(10) *Medication Management:* The prescribing and/or administering and reviewing of medications and their side effects. This service shall be rendered face-to-face by a person licensed to perform such services. This service may be provided in consultation with collateral, primary therapists, and/or case managers, but includes only minimal psychotherapy.

(11) *Medication Monitoring*: Face-to-face one-on-one cueing, observing, and encouraging a Medicaid enrolled individual to take medications as prescribed. Also includes reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid enrolled individual. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes. Enrollees with low medication compliance history or persons newly on medication are most likely to receive this service. This service is provided by or under the supervision of a mental health professional. Time spent with the enrollee is the only direct service billable component of this modality.

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

(12) *Mental Health Services provided in Residential Settings*: A specialized form of rehabilitation service (non hospital/non IMD) that offers a sub-acute psychiatric management environment. Medicaid enrolled individuals receiving this service present with severe impairment in psychosocial functioning or has apparent mental illness symptoms with an unclear etiology due to their mental illness and treatment cannot be safely provided in a less Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster restrictive environment and do not meet hospital admission criteria. Individuals in this service require a different level of service than High housing, SRO apartments) for extended hours to provide direct mental health care to a Medicaid enrollee. Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment.

The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. This service is billable on a daily rate. In order to bill the daily rate for associated costs for these services, a minimum of 8 hours of service must be provided. This service does not include the costs for room and board, custodial care, and medical services, and differs for other services in the terms of location and duration.

(13) *Peer Support:* Services provided by peer counselors to Medicaid enrolled individuals under the consultation, facilitation or supervision of a mental health professional who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Consumers actively participate in decision-making and the operation of the programmatic supports.

Self-help support groups, telephone support lines, drop-in centers, and sharing the peer counselor's own life experiences related to mental illness will build alliances that enhance the consumers' ability to function in the community. These services may occur at locations where consumers are known to gather (e.g., churches, parks, community centers, etc). Drop-in centers are required to maintain a log documenting identification of the consumer including Medicaid eligibility.

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

Services provided by peer counselors to the consumer are noted in the consumer's Individualized Service Plan which delineates specific goals that are flexible tailored to the consumer and attempt to utilize community and natural supports. Monthly progress notes document consumer progress relative to goals identified in the Individualized Service Plan, and indicates where treatment goals have not yet been achieved.

Peer counselors are responsible for the implementation of peer support services. Peer counselors may serve on High Intensity Treatment Teams.

Peer support is available daily no more than four hours per day. The ratio for this service is no more than 1:20.

(14) *Psychological Assessment:* All psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist. Psychological assessments shall: be culturally relevant; provide information relevant to a consumer's continuation in appropriate treatment; and assist in treatment planning within a licensed mental health agency.

(15) *Rehabilitation Case Management:* A range of activities by the outpatient community mental health agency's liaison conducted in or with a facility for the direct benefit of a Medicaid-enrolled individual in the public mental health system. To be eligible, the individual must be in need of case management in order to ensure timely and appropriate treatment and care coordination. Activities include assessment for discharge or admission community to mental health care, integrated mental health treatment planning, resource identification and linkage, to mental health rehabilitative services, and collaborative development of individualized services that promote continuity of mental health care. These specialized mental health coordination activities are intended to promote discharge, to maximize the benefits of the placement, and to minimize the risk of unplanned read mission and to increase the community tenure for the individual. Services are provided by or under the supervision of a mental health professional.

(16) *Special Population Evaluation:* evaluation by a child, geriatric, disabled, or ethnic minority specialist that considers age and cultural variables specific to the individual being evaluated and other culturally and age competent evaluation methods. This evaluation shall provide information relevant to a consumer's continuation in appropriate treatment and assist in treatment planning. This evaluation occurs after intake. Consultation from a non-staff specialist (employed by another CMHA or contracted by the CMHA) may also be obtained, if needed, subsequent to this evaluation and shall be considered an integral, billable component of this service.

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

(17) *Stabilization Services:* Services provided to Medicaid enrolled individuals who are experiencing a mental health crisis. These services are to be provided in the person's own home, or another home-like setting, or a setting which provides safety for the individual and the mental health professional. Stabilization services shall include short-term (less than two weeks per episode) face-to-face assistance with life skills training, and understanding of medication effects. This service includes: a) follow up to crisis services; and b) other individuals determined by a mental health professional to need additional stabilization services. Stabilization services may be provided prior to an intake evaluation for mental health services.

(18) *Therapeutic Psychoeducation:* Informational and experiential services designed to aid Medicaid enrolled individuals, their family members (e.g., spouse, parents, siblings) and other individuals identified by the individual as a primary natural support, in the management of psychiatric conditions, increased knowledge of mental illnesses and understanding the importance of their individual plan of care. These services are exclusively for the benefit of the Medicaid enrolled individual and are included in the Individual Service Plan.

The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, the symptoms, precautions related to decompensation, understanding of the "triggers" of crisis, crisis planning, community resources, successful interrelations, medication action and interaction, etc. Training and shared information may include brain chemistry and functioning; latest research on mental illness causes and treatments; diagnostics; medication education and management; symptom management; behavior management; stress management; crisis management; improving daily living skills; independent living skills; problem-solving skills, etc.

Services are provided at locations convenient to the consumer, by or under the supervision of a mental health professional. Classroom style teaching, family treatment, and individual treatment are not billable components of this service.

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13. d. 8. Therapeutic child-care

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

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

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

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

13. d. 9. Behavior Rehabilitation Services.

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

Service Settings

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

Service Description

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

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

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

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

Service Description (cont)

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

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

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

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

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

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

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

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

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

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

Population to be Served

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

Provider Qualifications and Responsibilities

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

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

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

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

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

Provider Qualifications and Responsibilities (cont)

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

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

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

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

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

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

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

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

A. Services

1. All curative treatment, including all related services and related medications, require prior authorization.
2. The Medicaid agency reviews all requests for curative treatment, related services, and related medications for medical necessity.
3. Exception to rule requests for non-covered services are reviewed for medical necessity.
4. Hospice care is provided in accordance with the State Medicaid Manual at section 4305.
5. Covered services
   a. Covered services are intermittent except during brief periods of acute symptom control.
   b. Core services are provided directly by hospice agency staff or contracted through a hospice agency as necessary, and include:

- Physician services related to administration of the plan of care.
- Nursing care provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of an RN.
- Medical social services provided by a social worker under the direction of a physician.
- Counseling services provided to a client and the client's family members or caregivers.
  - Additional services, which must be related to the hospice diagnosis, written in the plan of care, identified by the hospice interdisciplinary team, safe and meet the client's needs within the limits of the hospice program, and made available by the hospice agency on a 24-hour basis:
- A brief period of inpatient care for general or respite care provided in a Medicare-certified hospice care center, hospital, or nursing facility.
- Drugs, biologicals, and over-the-counter medications used for the relief of pain and symptom control of a client's terminal illness and related conditions.
- Home health aide, homemaker, and/or personal care services ordered by the client's physician and documented in the plan of care. (Home health aide services must be provided by a qualified home health aide and are an extension of skilled nursing or therapy services).
- Interpreter services as necessary for the plan of care.
- Medical equipment and supplies that are medically necessary for the palliation and management of a client's terminal illness and related conditions.
- Medical transportation services as required by the plan of care related to the terminal illness.
- Physical therapy, occupational therapy, and speech-language pathology therapy to manage symptoms or enable the client to safely perform activities of daily living and basic functional skills.
- Skilled nursing care.
- Other services or supplies documented as necessary for the palliation and management of the client's terminal illness and related conditions.
- Bereavement counseling

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

D. Hospice Agency and Practitioner Qualifications

1. Hospice agency requirements:

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

2. Practitioner requirements:

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

E. Hospice Election Periods

Hospice coverage is available for two (2) 90-day election periods followed by an unlimited number of 60-day election periods. A client or a client's authorized representative must sign an election statement to initiate or reinstate an election period for hospice care. An election period to receive hospice care continues through the initial election period and subsequent election periods without a break in care as long as the client:

- Remains in the care of a hospice agency; and
- Does not revoke the election.

F. Face-to-face Encounters

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

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

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

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

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

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

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

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

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

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

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22. Respiratory care services

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

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

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24. a. Transportation

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

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

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24. a. Transportation

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

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

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

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

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

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

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

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

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

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

24. a. Transportation (cont)

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

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

(a) Non-governmental entities
(1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a):
/ / (1) state-wideness (indicate areas of State that are covered)
Broker regions covered by SPA 08-028 (approved 08/17/2010 effective 10/01/2008):
1A: Chelan, Douglas, and Okanogan counties
3B: Snohomish County
4: King County
5: Pierce County
6B: Grays Harbor, Lewis, Mason-south, Pacific, and Thurston counties
6C: Clark, Cowlitz, Klickitat, Skamania, and Wahkiakum counties

Broker regions covered by SPA 11-11, effective 01/01/2011:
1B: Ferry, Pend Oreille, and Stevens counties
1C: Adams, Grant, and Lincoln counties
1D: Spokane County
1E: Asotin, Garfield, and Whitman counties
2: Benton, Columbia, Franklin, Kittitas, Walla Walla, and Yakima counties

Broker region covered by SPA 11-11, effective 04/01/2011:
6A: Clallam, Jefferson, Kitsap, and Mason-north counties

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

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

(2) Transportation services provided will include:
/X/ Wheelchair van
/X/ Taxi
/X/ Stretcher car
/X/ Bus passes
/X/ Tickets
/X/ Secured transportation
/X/ Other transportation

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24. a. Transportation (cont)

Instructions:

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

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

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

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

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

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24. a. Transportation (cont)

- State staff review, on-site at broker location, a random selection of trips, to include trips where costs are shared with non-Medicaid trips; review broker staff use of the allocation methodology, and test results.
- State staff desk review of cost allocation of shared trips, using the NEMT trips database.

Costs assigned to Medicaid will not exceed the cost of the least expensive method of transportation appropriate to the Medicaid beneficiary.

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

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

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

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

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

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

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

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

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

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24. a. Transportation (cont)

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

(6) Payment Methodology

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

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

Instructions:
Describe who will pay the transportation provider.

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24. a. Transportation (cont)

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

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

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

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

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

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

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

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

24. a. Transportation (cont)

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

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

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

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

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

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

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

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

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24. a. Transportation (cont)

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

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

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

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

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

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

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

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

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

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

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

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24. a. Transportation (cont)

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

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

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

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

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

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

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

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

24. a. Transportation (cont)

Description:

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

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

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

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

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

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

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

24. a. Transportation (cont)

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

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

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

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

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

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

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24. a. Transportation (cont)

(b) Governmental entities

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

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

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

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

(2) Transportation services provided will include:

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

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

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

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

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24. a. Transportation (cont)

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

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

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24. a. Transportation (cont)

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

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

(6) Payment Methodology

(A) The State will pay the contracted broker by the following method:

/ / (i) Risk capitation
/ / (ii) Non-risk capitation
/X/ (iii) Other (e.g., brokerage fee and direct payment to providers)

(B) Who will pay the transportation provider?

/X/ (i) Broker
/ / (ii) State
/ / (iii) Other

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24. a. Transportation (cont)

Instructions:
Describe who will pay the transportation provider.

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

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

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

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

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

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

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

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

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

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

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

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

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24. a. Transportation (cont)

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

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

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

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

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

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

Governmental broker serving region 3A.

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

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

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

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24. a. Transportation (cont)

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

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

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

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

The admission requires prior approval.

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

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

Provided
__X__ Not provided

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

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26. Personal care services

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

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

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

d. Services are provided by these provider types:
- State-licensed agencies providing personal care services, consisting of licensed home-care agencies and licensed adult residential care providers who are contracted with the Medicaid Agency. Home health agencies providing personal care services do not require Medicare certification;
- State-licensed adult residential care providers; and
- Individual providers of personal care, who:
- Must be age 18 or older;
- Are authorized to work in the United States;
- Are contracted with the Medicaid Agency; and
- Have passed a Medicaid Agency background check.

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

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27. Emergency Medical Services for Aliens

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

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

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

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

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

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CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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29. Licensed or Otherwise State-Approved Freestanding Birthing Center

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

b. Covered practitioners providing services in the freestanding birthing center

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

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

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

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

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HIV/AIDS CASE MANAGEMENT SERVICES

A. Target Group:

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

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

/X/ Entire State.

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

C. Comparability of Services:

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

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

D. Definition of Services

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

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

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HIV/AIDS CASE MANAGEMENT SERVICES (cont.)

D. Definition of Services (continued)

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

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

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

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

Description of Services:

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

Core Functions:

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

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

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HIV/AIDS CASE MANAGEMENT SERVICES (cont.)

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

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

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

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

Support Functions:

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

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

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

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

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

E. Qualifications of Providers:

Provider Qualifications - Individual case managers

An HIV/AIDS case manager shall:

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

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HIV/AIDS CASE MANAGEMENT SERVICES (cont.)

E. Qualifications of Providers (continued)

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

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

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

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

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

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

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

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

Provider qualification - Case management agencies

An HIV/AIDS case management agency must:

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

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

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

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HIV/AIDS CASE MANAGEMENT SERVICES (cont.)

E. Qualifications of Providers (continued)

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

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

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

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

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

F. Choice of Providers

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

1. HIVIAIDS case management services; and

2. Other medical care under the plan.

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

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II. VULNERABLE ADULTS

1915(g)(1) TARGET POPULATION

Recipients age 18 and over who:

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

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

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

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

1915 (g) (1) STATEWIDENESS

This service will be offered on a statewide basis.

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

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

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

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

1915 (g) (2) DEFINITION OF SERVICE

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

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Case Management, Vulnerable Adults, cont.

DESCRIPTION OF SERVICE:

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

Core Functions:

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

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

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

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

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

Support Functions:

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

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

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Case Management, Vulnerable Adults, cont.

Description of Service (cont.)

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

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

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

PROVIDERS:

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

QUALIFICATIONS:

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

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

OR

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

OR

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

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

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

OR

2. Geographically isolated.

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(Case Management, Vulnerable Adults, cont)

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

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

RELATION TO STATE AGENCY:

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

ASSURANCES

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

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

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

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INFANT CASE MANAGEMENT SERVICES

Target Group

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

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

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

B. Comparability of services

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

C. Components of Infant Case Management Services

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

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

The core functions of the infant case manager are to:

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

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Infant Case Management Services (cont.)

C. Components of Infant Case Management Services (cont)

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

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

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

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

D. Qualifications of Providers

Infant case managers must:

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

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

3. Meet one of the following:

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

-OR-

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

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Infant Case Management Services (cont.)

D. Qualifications of Providers (cont)

-OR-

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

E. Case Management Agencies:

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

F. Access to Services

The state assures:

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

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

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

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

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Infant Case Management Services (cont.)

H. Payment

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

I. Case Records

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

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

J. Federal Financial Participation (FFP) Assurances

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

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

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TARGETED CASE MANAGEMENT SERVICES
[Target Group]

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

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

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

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

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

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

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

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

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

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

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

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

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

Monitoring and follow-up activities:

a. activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    - services are being furnished in accordance with the individual's care plan;
    - services in the care plan are adequate; and
    - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers. [Specify the type of monitoring and justify the frequency of monitoring.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[Specify any additional limitations.]

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CASE MANAGEMENT SERVICES

A. Targeted Population:

Title XIX eligible individuals who:

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

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

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

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

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

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

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

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

_X_ Entire State

This service will be offered on a statewide basis.

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

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(Case Management, LES, cont)

C. Comparability of Services:

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

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

D. Definition of Service:

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

Core Functions:

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

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

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(Case Management, LES, cont)

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

Support Function:

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

E. Qualification of Providers:

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

1. Case Management Agencies:

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

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

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

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

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

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(Case Management, LES, cont)

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

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

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

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

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

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

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CASE MANAGEMENT SERVICES

A. Target Group:

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

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

/X/ Entire State

C. Comparability of Services:

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

D. Definition of Services:

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

Description of Services:

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

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

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

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(Case Management, Alcohol/Drug Dependent, cont)

D. Description of services (con't)

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

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

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

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

E. Qualifications of Providers:

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

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

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(Case Management, Alcohol/Drug Dependent, cont)

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

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

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

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

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

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

2. Home and community care services are available Statewide.

   _____ Yes _____ No

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

   _____

   _____

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

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

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

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

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

4. Additional targeting restrictions (specify):

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

   _____

   _____

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

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

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

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

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

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

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

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

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

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

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

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

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

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AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
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b. based on such assessment or review, determine whether the individual is (or continues to be) functionally disabled.

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

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

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

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

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

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

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

e. may specify other services required by the individual.

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

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

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

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

a. _____ Homemaker services

b. _____ Home health aide services

c. _____ Chore services

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d. _____ Personal care services

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

f. _____ Respite care

g. _____ Training for family members in managing the individual

h. _____ Adult day care

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

1. _____ Day treatment/Partial hospitalization

2. _____ Psychosocial rehabilitation services

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

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

1. _____ Habilitation

A. _____ Residential Habilitation

B. _____ Day Habilitation

2. _____ Environmental modifications

3. _____ Transportation

4. _____ Specialized medical equipment and supplies

5. _____ Personal Emergency Response Systems

6. _____ Adult companion services

7. _____ Attendant Care Services

8. _____ Private Duty Nursing Services

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

A. _____ Physician Services

B. _____ Home health care services

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C. _____ Physical therapy services

D. _____ Occupational therapy services

E. _____ Speech, hearing and language services

F. _____ Prescribed drugs

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

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

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

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

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

22. The State provides the following assurances to HCFA:

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

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

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

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

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

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

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

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

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

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

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

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

c. the number of days in such quarter.

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

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

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

27. The State will comply with the requirements of section 1929(i) of the Act, regarding the compliance of providers of home and community care and reviews of this compliance, as set forth in Appendix C.

28. The State will provide for an enforcement process for providers of community care, as required by section 1929(j) of the Act. This process is described in Appendix C.

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29. The State assures that payment for home and community care services will be made through rates which are reasonable and adequate to meet the costs of providing care efficiently and economically, in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

30. Payment will not be made for home and community care to reimburse (or otherwise compensate) a provider of such care for payment of a civil money penalty imposed under title XIX or title XI of the Social Security Act or for legal expenses in defense of an exclusion or civil money penalty under title XIX or title XI of the Social Security Act if there is no reasonable legal ground for the provider's case.

31. The State will begin provision of services under section 1905(a)(23) of the Social Security Act effective (specify date):

_____

These services will be provided to eligible individuals for a minimum of four calendar quarters, beginning on this date.

32. Services will be provided to eligible recipients for the duration of the period specified in item 31, above, without regard to the amount of Federal *financial participation* available to the State.

33. The State assures that it will monitor the appropriateness and accuracy of the assessments and reviews. Through its monitoring, the State assures the appropriateness and accuracy of the assessments and periodic reviews. The State assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the nature and severity of any deficiencies noted.

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MEDICAID ELIGIBILITY GROUPS SERVED

a. Home and community care services will be made available to individuals age 65 or older, when the individuals have been determined to be functionally disabled as specified in Appendix B.

b. Individuals served under this provision must meet the following Medicaid eligibility criteria (check all that apply):

1. _____ Age 65 or older who have been determined to be functionally disabled (as determined under the SSI program) as specified in Appendix B.

A. _____ The agency uses the same methodologies for treatment of income and resources as used in the SSI program (or the optional State supplement program which meets the requirements of 42 CFR 435.230, as appropriate). Individuals must be receiving SSI/SSP benefits to be eligible under this provision.

B. _____ The agency uses methodologies for treatment of income and resources that differ from those of the SSI program. These differences result from restrictions applied under section 1902(f) of the Act. The methodologies are described in Supplement 5 to Attachment 2.6-A. Individuals must be eligible for Medicaid under the State's plan to be eligible under this provision.

2. _____ Medically needy, age 65 or older who have been determined to be functionally disabled as specified in Appendix B. In determining the individual's eligibility, the State may, at its option, provide for the determination of the individual's anticipated medical expenses (to be deducted from income). (Check one):

A. _____ The State does not consider anticipated medical expenses.

B. _____ The State considers anticipated medical expenses over a period of _____ months (not to exceed 6 months).

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INDIVIDUALS PREVIOUSLY COVERED UNDER A WAIVER

a. _____ The State used a health insuring organization before January 1, 1986, and had in effect a waiver under §1115 of the Act, which provides personal care services under the State plan for functionally disabled individuals, and which was in effect on December 31, 1990. In accordance with S1929(b)(2)(B) of the Act, the following individuals will be eligible to receive home and community care services. (Check all that apply):

1. _____ Age 65 or older.

2. _____ Disabled, receiving SSI.

These individuals meet the resource requirement and income standards that apply in the State to individuals described in 51902(a)(10)(A)(ii)(V) of the Act.

b. _____ In accordance with S1929(b)(2)(A) the Act, individuals age 65 or older who were served under a waiver granted pursuant to section 1915(c) of the Act on the date on which that waiver was terminated. This waiver was terminated during the period in which the State furnished home and community care to functionally disabled elderly individuals under its state plan. Financial eligibility standards for these individuals (which are the same as those in effect on the date on which the waiver was terminated) are attached to this Appendix.

c. _____ In accordance with S1929(b)(2)(A) the Act, individuals age 65 or older, who were served under a waiver granted pursuant to section 1915(d)of the Act on the date on which that waiver was terminated. This waiver was terminated during the period in which the State furnished home and community care to functionally disabled elderly individuals under its State plan. Financial eligibility standards for these individuals (which are the same as those in effect on the date on which the waiver was terminated) are attached to this Appendix.

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FUNCTIONAL DISABILITY

Home and community care services, as defined in this Supplement, are provided to the following classifications of individuals who have been found on the basis of an assessment to be functionally disabled. Services will be limited to individuals who meet the following targeting criteria.

Check all that apply:

a. _____ Services are provided to individuals, who have been determined, on the basis of an assessment, to require substantial human assistance with at least two of the following activities of daily living: toileting, transferring, eating.

b. _____ Services are provided to individuals, who have been determined, on the basis of an assessment, to require substantial human assistance with each of the following activities of daily living: toileting, transferring, eating.

c. _____ Services are provided to individuals who have been determined, on the basis of an assessment, to have a primary or secondary diagnosis of Alzheimer's Disease, and are unable to perform without substantial human assistance (including verbal reminding or physical cueing) or supervision, at least 2 of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.

d. _____ Services are provided to individuals, who have been determined, on the basis of an assessment, to have a primary or secondary diagnosis of Alzheimer's Disease, and are unable to perform without substantial human assistance (including verbal reminding or physical cueing) or supervision, (check one):

1. _____ at least 3 of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.

2. _____ at least 4 of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.

3. _____ all of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.

e. _____ Services are provided to individuals who have been determined, on the basis of an assessment, to have a primary or secondary diagnosis of Alzheimer's Disease, and are sufficiently cognitively impaired so as to require substantial supervision from another individual because they engage in inappropriate behaviors that pose serious health or safety hazards to themselves or others.

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AGE

Check all that apply:

a. _____ Services are provided to individuals age 65 and older.

b. _____ Services are provided to individuals who have reached at least the following age, greater than 65 (specify): _____

c. _____ Services are provided to individuals who meet the criteria set forth in item 3.b. of Supplement 2, as set forth in Appendix B-3, who were 65 years of age or older on the date of the waiver's discontinuance.

d. _____ Services are provided to individuals who meet the criteria set forth in item 3.c. of Supplement 2, as set forth in Appendix B-3, who were served under the waiver on the date of its discontinuance.

e. _____ Services are provided to individuals who meet the criteria in item 3.d. of Supplement 2, who fall within the following age categories (check all that apply):

1. _____ Age 65 and older

2. _____ Age greater than 65. Services are limited to those who have attained at least the age of (specify): _____

3. _____ Age less than 65. Services will be provided to those in the following age category (specify): _____

4. _____ The State will impose no age limit.

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INDIVIDUALS PREVIOUSLY SERVED UNDER WAIVER AUTHORITY

a. _____ In accordance with 1929(b)(2)(A) of the Act, the State will discontinue the following home and community-based services waiver(s), approved under the authority of $1915(c) or §1915(d) of the Act. (Specify the waiver numbers):

Waiver Number	Last date of waiver operation
_____	_____
_____	_____
_____	_____
_____	_____

b. For each waiver specified in Appendix B-3-a, above, the State will furnish at least 30 days notice of service discontinuance to those individuals under 65 years of age, and to those individuals age 65 or older who do not meet the test of functional disability specified in Appendix B-1 (except those individuals who will continue to receive home and community-based services under a different waiver program).

c. Individuals age 65 years of age or older, who were eligible for benefits under a waiver specified in Appendix B-3-a on the last date of waiver operation, who would, but for income or resources, be eligible for home and community care under the State plan, shall be deemed functionally disabled elderly individuals for so long as they would have remained eligible for services under the waiver.

d. The financial eligibility standards which were in effect on the last date of waiver operation are attached to this Appendix.

e. The following are the schedules, in effect on the last date of waiver operation, under which individuals served under a waiver identified in Appendix B-3-a were reevaluated for financial eligibility (specify):

Waiver Number	Reevaluation schedule
_____	_____
_____	_____
_____	_____
_____	_____

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Appendix C1/C2 removed via SPA 08-009

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ASSESSMENT

a. The State will provide for a comprehensive functional assessment for a financially eligible individual who meet the targeting requirements set forth in items 3 and 4 of Supplement 2.

b. This assessment will be provided at the request of the individual, or another person acting on the individual's behalf.

c. The individual will not be charged a fee for this assessment.

d. Attached to this Appendix is an explanation of the procedures by which the state will ensure the performance of the assessment.

e. The assessment will be reviewed and revised not less often than (check one):

1. _____ Every 12 months

2. _____ Every 6 months

3. _____ Other period not to exceed 12 months (Specify): _____
_____

f. Check one:

1. _____ The State will use an assessment instrument specified by HCFA.

2. _____ The State will use an assessment instrument of its own specification. A copy of this instrument is attached to this Appendix. The State certifies that this instrument will measure functional disability as specified in section 1929(b) and (c) of the Act. The State requests that HCFA approve the use of this instrument, and certifies that at such time as HCFA may publish a minimum data set (consistent with section 1929(c)(2) of the Act), the assessment instrument will be revised, as determined necessary by HCFA, to conform to the core elements, common definitions, and uniform guidelines which are contained in the minimum data set.

g. In conducting the assessment (or the periodic review of the assessment), the interdisciplinary team must:

1. Identify in each such assessment or review each individual's functional disabilities; and

2. Identify in each such assessment or review each individual's need for home and community care. This identification shall include:

A. Information about the individual's health status;

B. Information about the individual's home and community environment; and

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C. Information about the individual's informal support system.

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ASSESSMENT (con't)

3. Determine whether the individual is, or continues to be, functionally disabled. This determination will be made on the basis of the assessment or review.

h. The interdisciplinary team conducting the assessment shall furnish the results to the Medicaid agency and to the qualified community care case manager designated by the Medicaid agency (as specified in Appendix F,) to establish, review and revise the individual's ICCP.

i. The Medicaid agency will monitor the appropriateness and accuracy of the assessments and periodic reviews on an ongoing basis, and whenever it is informed by a qualified community care case manager that inaccuracies appear to exist in the assessment of an individual. All problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the nature and severity of any deficiencies noted.

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INTERDISCIPLINARY TEAM

a. Initial assessments will be performed by interdisciplinary teams designated by the State. The agency will designate interdisciplinary teams that meet the following criteria (check all that apply):

1. _____ The interdisciplinary teams will be employed directly by the Medicaid agency.

2. _____ The interdisciplinary teams will be employed directly by other agencies of State government, under contract with the Medicaid agency.

3. _____ The interdisciplinary teams will be employed directly by agencies of local government under contract with the Medicaid agency.

4. _____ The interdisciplinary teams will be employed directly by nonpublic organizations which do not provide home and community care or nursing facility services and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation, or relationship with, an entity that provides community care or nursing facility services.

Interdisciplinary teams may utilize data gathered by other professionals, and may consult with service providers in conducting comprehensive functional assessments.

When assessments are provided under contract with an agency or organization which is not part of the Medicaid agency, the Medicaid agency will specify, as part of the contract, that the contracting agency or organization may not subcontract with another entity for the performance of the assessments without the prior written approval of the Medicaid agency.

b. Periodic reviews of assessments will be performed by interdisciplinary teams designated by the State. The agency will designate interdisciplinary teams that meet the following criteria (check all that apply):

1. _____ The interdisciplinary teams will be employed directly by the Medicaid agency.

2. _____ The interdisciplinary teams will be employed directly by other agencies of State government, under contract with the Medicaid agency.

3. _____ The interdisciplinary teams will be employed directly by agencies of local government under contract with the Medicaid agency.

4. _____ The interdisciplinary teams will be employed directly by nonpublic organizations which do not provide home and community care or nursing facility services and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation, or relationship with, an entity that provides community care or nursing facility services.

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INTERDISCIPLINARY TEAM (con't)

Interdisciplinary teams may utilize data gathered by other professionals, and may consult with service providers in conducting periodic reviews of the individuals' comprehensive functional assessments.

When periodic reviews of assessments are provided under contract with an agency or organization which is not part of the Medicaid agency, the Medicaid agency will specify, as part of the contract, that the contracting agency or organization may not subcontract with another entity for the performance of the periodic reviews without the prior written approval of the Medicaid agency.

c. The interdisciplinary teams conducting initial assessments shall consist, at a minimum, of (check all that apply, but at least 2):

1. _____ Registered nurse, licensed to practice in the State

2. _____ Licensed Practical or Vocational nurse, acting within the scope of practice under State law

3. _____ Physician (M.D. or D.O.), licensed to practice in the State

4. _____ Social Worker (qualifications attached to this Appendix)

5. _____ Case manager

6. _____ Other (specify): _____
_____

d. The interdisciplinary teams conducting periodic reviews of assessments shall consist, at a minimum, of (check all that apply, but at least 2):

1. _____ Registered nurse, licensed to practice in the State

2. _____ Licensed Practical or Vocational nurse, acting within the scope of practice under State law

3. _____ Physician (M.D. or D.O.), licensed to practice in the State

4. _____ Social Worker (qualifications attached to this Appendix)

5. _____ Case manager

6. _____ Other (specify): _____
_____

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

INDIVIDUAL COMMUNITY CARE PLAN (ICCP)

a. A written individual community care plan (ICCP) will be developed for each individual who has been determined, on the basis of a comprehensive functional assessment performed in accordance with Appendix D, to be a functionally disabled elderly individual, according to the criteria set forth in Appendices A and B.

b. The ICCP will be established, and periodically reviewed and revised, by a Qualified Community Care Case Manager after a face-to-face interview with the individual or primary caregiver.

c. The ICCP will be based on the most recent comprehensive functional assessment of the individual conduced according to Appendix D.

d. The ICCP will specify, within the amount, duration and scope of service limitations set forth in Appendix C, the home and community care to be provided to such individual under the plan.

e. The ICCP will indicate the individual's preferences for the types and providers of services.

f. The ICCP will specify home and community care and other services required by such individual. (Check one):

1. _____ Yes 2. _____ No

g. The ICCP will designate the specific providers (who meet the qualifications specified in Appendix C-2) which will provide the home and community care. (Check one):

1. _____ Yes 2. _____ No

h. Neither the ICCP, nor the State, shall restrict the specific persons or individuals (who meet the requirements of Appendix C-2) who will provide the home and community care specified in the ICCP.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

QUALIFIED COMMUNITY CARE CASE MANAGERS

a. "Qualified Community Care Case Manager" will meet each of the following qualifications for the provision of community care case management.

1. Be a nonprofit or public agency or organization;

2. Have experience or have been trained in:

A. Establishing and periodically reviewing and revising ICCPs; and

B. The provision of case management services to the elderly.

The minimum standards of experience and training which will be employed by the State are attached to this Appendix;

3. Have procedures for assuring the quality of case management services. These procedures will include a peer review process.

4. The State will assure that community care case managers are competent to perform case management functions, by requiring the following educational or professional qualifications be met. (Check all that apply):

A. _____ Registered nurse, licensed to practice in the State

B. _____ Physician (M.D. or D.O.), licensed to practice in the State

C. _____ Social Worker (qualifications attached to this Appendix)

D. _____ Other (specify): _____
_____
_____

b. When community care case management is provided by a nonprofit, nonpublic agency, the agency providing the community case management will not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides home and community care or nursing facility services and will not furnish home and community care or nursing facility services itself. (Check one):

1. _____ Yes

2. _____ Not applicable. The State will not use nonprofit, nonpublic agencies to provide community care case management.

c. The State will employ procedures to assure that individuals whose home ad community care is managed by qualified community care case managers are not at risk of financial exploitation due to such managers. An explanation of these procedures is attached to this Appendix

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

QUALIFIED COMMUNITY CARE CASE MANAGERS (cont)

d. The State requests that the requirements of item E-2-b be waived in the case of a nonprofit agency located in a rural area. The State's definition of "rural area" is attached to this Appendix. (Check one):

1. _____ Yes 2. _____ No

3. _____ Not applicable. The State will not use nonprofit nonpublic agencies to provide community care case management.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

COMMUNITY CARE CASE MANAGEMENT FUNCTIONS

a. A qualified community care case manager is responsible for:

1. Assuring that home and community care covered under the State plan and specified in the ICCP is being provided;

2. Visiting each individual's home or community care setting where care is being provided not less often than once every 90 days;

3. Informing the elderly individual or primary caregiver how to contact the case manager if service providers fail to properly provide services or other similar problems occur. This information will be provided verbally and in writing.

4. Completes the ICCP in a timely manner; and

5. Reviews and discusses new and revised ICCPs with elderly individuals or primary caregivers.

b. Whenever a qualified community care case manager has reason to believe that an individual's assessment or periodic review (conducted under Appendix D) appears to contain inaccuracies, the community care case manager will bring these apparent discrepancies to the attention of the agency which has performed the assessment or review. If the assessors and the community care case manager are unable to resolve the apparent conflict, the case manager shall report the situation to the component of the Medicaid agency which is responsible for monitoring the program.

1. _____ Yes 2. _____ No

c. Whenever a qualified community care case manager is informed by an elderly individual or primary caregiver that provider(s) have failed to provide services, or that other similar problems have occurred, the community care case manager shall take whatever steps are necessary to verify or disprove the complaint. If a problem is confirmed by this monitoring, the community care case manager shall address the problem in an appropriate and timely manner, consistent with the nature and severity of any deficiencies noted. This may include reporting the situation to the component of the Medicaid agency which is responsible for monitoring the program.

1. _____ Yes 2. _____ No

d. Whenever a qualified community care case manager is informed by a provider of service (whether paid or unpaid) that there has been a change in the individual's condition, or that a problem may have arisen which is not currently being addressed, the community care case manager shall take whatever steps are necessary to verify or disprove the information. If a problem is confirmed by this monitoring, the community care case manager shall address it in an appropriate and timely manner, consistent with the nature and severity of the situation.

1. _____ Yes 2. _____ No

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

COMMUNITY CARE CASE MANAGEMENT FUNCTIONS (con't)

e. Community care case managers shall verify the qualifications of each individual or agency providing home and community care services prior to the initiation of services, and at such intervals as are specified in Appendix C, thereafter. (Check one):

1. _____ Yes 2. _____ No

f. Where the provision of services in an individual's ICCP is not governed by State licensure or certification requirements, the community care case manager shall verify the qualifications of the individual or entity furnishing the services, and as necessary, provide or arrange for the training specified in Appendix C-2. (Check one):

1. _____ Yes 2. _____ No

3. _____ Not applicable. All services are governed by State licensure or certification requirements.

g. Community care case managers shall inform each elderly individual for whom an ICCP is established of the person's right to a fair hearing should the individual disagree with the contents of the ICCP.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

RIGHTS SPECIFIED IN THE STATUTE

The State assures that home and community care provided under the State plan will meet the following requirements:

a. Individuals providing care are competent to provide such care. The State will maintain documentation to show that each provider of care meets or exceeds the applicable minimum qualifications specified in Appendix C-2.

b. Individuals receiving home and community care shall be assured the following rights:

1. The right to be fully informed in advance, orally and in writing, of the following:

   a. the care to be provided,

   b. any changes in the care to be provided; and

   c. except with respect to an individual determined incompetent, the right to participate in planning care or changes in care.

2. The right to voice grievances with respect to services that are for fail to be) furnished without discrimination or reprisal for voicing grievances, and to be told how to complain to State and local authorities. A description of the procedures which the State will utilize to ensure this right is attached to this Appendix.

3. The right to confidentiality of personal and clinical records.

4. The right to privacy and to have one's property treated with respect.

5. The right to refuse all or part of any care and to be informed of the likely consequences of such refusal.

6. The right to education or training for oneself and for members of one’s family or household on the management of care.

7. The right to be free from physical or mental abuse, corporal punishment, and any physical or chemical restraints imposed for purposes of discipline or convenience and not included in the individual's ICCP.

8. The right to be fully informed orally and in writing of the individual's rights.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

ADDITIONAL RIGHTS

The State assures that home and community care provided under the State plan will meet the following additional requirements:

a. The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community care services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities. Copies of these standards are maintained at the Medicaid agency.

b. In the case of an individual who has been adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the individual are exercised by the person appointed under State law to act on the individual's behalf.

c. In the case of an individual who resides in his or her own home, or in the home of a relative, when the individual has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the individual's rights to the extent provided by State law. In addition, all rights to be informed of the care to be provided, and to have input into the development of the ICCP specified in Appendix F-1-b shall be extended to the principal caregiver.

d. In the case of an individual who resides in a community care setting, and who has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the individual's rights to the extent provided by State law.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

GUIDELINES FOR PROVIDER COMPENSATION

a. The following advisory guidelines are provided for such minimum compensation for individuals providing home and community care. These guidelines will be used to assure the availability and continuity of competent individuals to provide such care for functionally disabled individuals who have functional disabilities of varying levels of severity.

1. For services which are the same as, or similar (in content, complexity and provider qualifications) to those provided under the approved Medicaid State plan, the State will compensate the providers on the same basis as that which is approved as part of the plan.

A. _____ Yes B. _____ No

2. For services which are the same as, or similar (in content, complexity and provider qualifications) to those provided under another program funded and operated by the State, the State will compensate the providers on a basis which is equivalent to that used by the other publicly funded program.

A. _____ Yes B. _____ No

3. For services which are dissimilar to those provided under the plan or another program funded and operated by the State, the State will develop methods of compensation which are sufficient to enlist an adequate number of providers, taking into account the number of individuals receiving the service and their geographic location.

A. _____ Yes B. _____ No

b. The State assures that it will comply with these guidelines.

1. _____ Yes 2. _____ No

c. The methods by which the State will reimburse providers are described in attachment 4.19-B.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

COMMUNITY CARE SETTINGS-GENERAL

a. Definitions.

1. Small residential community care setting. A small residential community care setting is defined as a facility in which between 3 and 8 unrelated adults reside, and in which personal services (other than merely board) are provided in conjunction with residing in the setting. To qualify as a small residential community care setting, at least one resident must receive home and community care under this benefit.

2. Small nonresidential community care setting. A small nonresidential community care setting is defined as a facility in which an organized program is operated (by the facility or on the premises of the facility) which serves between 3 and 8 individuals, at least one of which receives home and community care under this benefit at the setting.

3. Large residential community care setting. A large residential community care setting is a facility in which more than 8 unrelated adults reside, and in which personal services are provided in conjunction with residing in the setting. To qualify as a large residential community care setting, at least one resident must receive home and community care under this benefit.

4. Large nonresidential community care setting. A large nonresidential community care setting is defined as a facility in which an organized program is operated (by the facility or on the premises of the facility) which serves more than 8 individuals, at least one of which receives home and community care under this benefit at the setting.

5. Unrelated adults. Unless defined differently under State law, for purposes of this benefit, unrelated adults are individuals who are 13 years of age or older, and who do not have any of the following relationships to other adults resident in the facility: spouses, parent (including stepparent) or child (including stepchild), or siblings.

6. Personal services. Personal services are those services provided to the individual by the setting, which are intended to compensate for the absence, loss, or diminution of a physical or cognitive function. Personal services, as defined here, are not equated with personal care services available under either 42 CFR 440.170, or personal care services provided under the home and community care benefit.

b. The State will provide home and community care to individuals in the following settings:

1. _____ Nonresidential settings that serve 3 to 8 people.

2. _____ Residential settings that serve 3 to 8 people, and in which personal services (other than merely board) are provided in conjunction with residing in the setting.

3. _____ Nonresidential settings that serve more than 8 people.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

COMMUNITY CARE SETTINGS-GENERAL (con't)

4. _____ Residential settings that serve more than 8 people, and in which personal services (other than merely board) are provided in conjunction with residing in the setting.

5. _____ Not applicable. The State will not provide services in these types of community care settings.

c. The State assures that the requirements of sections 1929(g) and (h) of the Act (as applicable to the specific setting) will be met for each setting in which home and community care is provided under this section.

d. FFP will not be claimed for home and community care which is provided in settings which have been found not to meet the requirements of sections 1929(g) and (h) of the Act.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

SMALL NONRESIDENTIAL COMMUNITY CARE SETTINGS

The requirements of this Appendix shall apply to small nonresidential community care settings.

The State will require that small nonresidential community care settings meet requirements specified in this Appendix.

a. The setting shall protect and promote the rights of each client, including each of the following rights:

1. The setting shall extend to each client the right to choose a personal attending physician.

2. Each client shall be fully informed in advance about care and treatment, and of any changes in care or treatment that may affect his or her well-being.

3. Each client shall have the right to participate in planning care and treatment or changes in care or treatment. For clients who have been adjudged incompetent, this right shall be extended to the individual who has been appointed to make decisions on behalf of the client.

4. The setting shall ensure that each client has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms.

5. Restraints may only be imposed –

A. to ensure the physical safety of the individual or other clients served in the setting, and

B. only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances when such restraints are determined to be necessary to prevent immediate and significant threat to the life or safety of the individual, staff members, or other clients until such an order can reasonably be obtained).

6. The setting shall ensure the right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of client groups.

7. The setting shall preserve the individual's right to confidentiality of personal and clinical records. The setting shall grant the individual (or legal representative) access to any current clinical records maintained by the setting upon request of the individual or legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

8. The setting shall extend to the individual the right to receive services consistent with the individual's needs and preferences and the types of services provided by the setting, except where the health or safety of the individual or other clients would be endangered.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

SMALL NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

9. The individual shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the setting to resolve those grievances the client may have, including those with respect to the behavior of other clients.

10. The setting shall extend to the client the right to organize and participate in client groups in the setting and the right of the client's family to meet in the setting with the families of other clients in the setting.

11. The setting shall not restrict the right of the client to participate in social, religious and community activities that do not interfere with the rights of other clients in the setting.

12. The setting shall extend the right to examine, upon reasonable request, the results of the most recent survey of the setting conducted by HCFA or the State with respect to the setting and any plan of remedial action in effect with respect to the setting.

b. In the case of an individual adjudged incompetent under the laws of the State, the rights of the client shall devolve upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the individual's behalf.

c. Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the individual's ICCP) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each client receiving such drugs.

d. A small nonresidential community care setting must extend to each individual served the following access and visitation rights.

1. Permit immediate access to any client by any representative of HCFA, by any representative of the State, by an ombudsman or agency described in section 1919(c)(2)(B)(iii)(II), (III), or (IV) of the Social Security Act, or by the clients individual physician or case manager.

2. Permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by the immediate family or other relatives of the client.

3. Permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client.

4. Permit reasonable access to a client by any entity or individual that provides health, social, Legal, or other services to the client, subject to the client's right to deny or to withdraw consent at any time.

5. Permit representatives of the State ombudsman (described in section 1919(c)(2)(B)(iii)(II) of the Social Security Act), with the permission of the client (or the client's legal representative) and consistent with State law, to examine a client's clinical records.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

SMALL NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

e. If the setting receives or holds funds from its clients, or exercises control over client funds, on a permanent or temporary basis, the setting must meet the following requirements.

1. The setting may not require clients to deposit their personal funds with the setting, and

2. Upon the written authorization of the client, the setting must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this Appendix.

3. The setting must purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of clients deposited with the setting.

4. The setting may not impose a charge against the personal funds of a client for any item or service for which payment is made under the plan or under Medicare.

Nothing in this Appendix shall be construed as requiring a setting to receive or hold funds from a client.

f. If the setting receives or holds funds from a client, the setting must manage and account for the personal funds of the client deposited with the facility as follows:

1. The setting must deposit any amount of personal funds in excess of $50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the setting's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the setting must maintain such funds in a non-interest bearing account or petty cash fund.

2. The setting must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a client deposited with the setting, and afford the client or legal representative, reasonable access to such record.

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) of the Social Security Act and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

4. Upon the death of a client with such an account, the community care setting must convey promptly the client's personal finds (and a final accounting of such funds) to the individual administering the client's estate.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

SMALL NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

g. Each small nonresidential community care setting shall be required to inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.

h. Each small nonresidential community care setting must meet any applicable State and local certification or license, zoning, building and housing codes, and State and local fire and safety regulations.

i. Each small nonresidential community care setting shall be designed, constructed, equipped and maintained in a manner to protect the health and safety of clients.

j. Nothing in this section shall be construed to require a small nonresidential community care setting to provide or arrange for medical care or treatment to clients served under this benefit if the setting does not provide this care to other clients who receive similar services in the facility.

k. Except to the extent dictated otherwise by State law, a small nonresidential community care setting shall not be held responsible for actions or inactions of persons not employed by the setting, who furnish medical care or treatment on its premises, when the setting has not arranged for the provision of care by these persons.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

SMALL RESIDENTIAL COMMUNITY CARE SETTINGS

The requirements of this Appendix shall apply to small nonresidential community care settings.

The State will require that small nonresidential community care settings meet requirements specified in this Appendix.

a. The setting shall protect and promote the rights of each client, including each of the following rights:

1. The setting shall extend to each client the right to choose a personal attending physician.

2. Each client shall be fully informed in advance about care and treatment, and of any changes in care or treatment that may affect his or her well-being.

3. Each client shall have the right to participate in planning care and treatment or changes in care or treatment. For clients who have been adjudged incompetent, this right shall be extended to the individual who has been appointed to make decisions on behalf of the client.

4. The setting shall ensure that each client has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms.

5. Restraints may only be imposed –

A. to ensure the physical safety of the individual or other clients served in the setting, and

B. only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances when such restraints are determined to be necessary to prevent immediate and significant threat to the life or safety of the individual, staff members, other clients until such an order can reasonably be obtained).

6. The setting shall ensure the right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of client groups. This shall not be construed to require the setting to furnish a private bedroom for the individual.

7. The setting shall preserve the individual's right to confidentiality of personal and clinical records. The setting shall grant the individual (or legal representative) access to any current clinical records maintained by the setting upon request of the individual or legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

8. The setting shall extend to the individual the right to receive services consistent with the individual's needs and preferences and the types of services provided by the setting, except where the health or safety of the individual or other clients would be endangered.

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State WASHINGTON

SMALL RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

9. The individual shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the setting to resolve those grievances the client may have, including those with respect to the behavior of other clients.

10. The setting shall extend to the client the right to receive notice before the room or the roommate of the resident in the setting is changed.

11. The setting shall extend to the client the right to organize and participate in client groups in the setting and the right of the client's family to meet in the setting with the families of other clients in the setting.

12. The setting shall not restrict the right of the client to participate in social, religious and community activities that do not interfere with the rights of other clients in the setting.

13. The setting shall extend the right to examine, upon reasonable request, the results of the most recent survey of the setting conducted by HCFA or the State with respect to the setting and any plan of remedial action in effect with respect to the setting.

b. In the case of an individual adjudged incompetent under the laws of the State, the rights of the client shall devolve upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the individual's behalf.

c. Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the individual's ICCP) designed to eliminate or 'modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each client receiving such drugs.

d. A small residential community care setting must extend to each individual served the following access and visitation rights.

1. Permit immediate access to any client by any representative of HCFA, by any representative of the State, by an ombudsman or agency described in section 1919(c)(2)(B)(iii)(II), (III), or (IV) of the Social Security Act, or by the clients individual physician or case manager.

2. Permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by the immediate family or other relatives of the client.

3. Permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client.

4. Permit reasonable access to a client by any entity or individual that provides health, social, legal, or other services to the client, subject to the client's right to deny or to withdraw consent at any time.

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SMALL RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

5. Permit representatives of the State ombudsman (described in section 1919(c)(2)(B)(iii)(II) of the Social Security Act), with the permission of the client (or the client's legal representative) and consistent with State law, to examine a client's clinical records.

e. If the setting receives or holds funds from its clients, or exercises control over client funds, on a permanent or temporary basis, the setting must meet the following requirements.

1. The setting may not require clients to deposit their personal funds with the setting, and

2. Upon the written authorization of the client, the setting must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this Appendix.

3. The setting must purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of clients deposited with the setting.

4. The setting may not impose a charge against the personal funds of a client for any item or service for which payment is made under the plan or under Medicare.

Nothing in this Appendix shall be construed as requiring a setting to receive or hold funds from a client.

f. If the setting receives or holds funds from a client, the setting must manage and account for the personal funds of the client deposited with the facility as follows:

1. The setting must deposit any amount of personal funds in excess of $50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the setting's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the setting must maintain such funds in a non-interest bearing account or petty cash fund.

2. The setting must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of a1: financial transactions involving the personal funds of a client deposited with the setting, and afford the client or legal representative, reasonable access to such record.

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) of the Social Security Act and the fact that if the amount in the account (in addition to the value of the clients other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

4. Upon the death of a client with such an account, the community care setting must convey promptly the client's personal finds (and a final accounting of such funds) to the individual administering the client's estate.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

SMALL RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

g. Each small residential community care setting shall be required to inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.

h. Each small residential community care setting must meet any applicable state and local, certification, licensure, zoning, building and housing codes, and State and local fire and safety regulations.

i. Each small residential community care setting shall be designed, constructed, equipped and maintained in a manner to protect the health and safety of residents.

j. Nothing in this section shall be construed to require a small residential community care setting to provide or arrange for medical care or treatment to clients served under this benefit if the setting does not provide this care to other clients who receive similar services in the setting.

k. Except to the extent dictated otherwise by State law, a small residential community care setting shall not be held responsible for the actions or inactions of persons not employed by the setting, who furnish medical care or treatment on its premises, when the setting has not arranged for the provision of care by these persons.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS

The requirements of this Appendix shall apply to large nonresidential community care settings.

The State will require that large nonresidential community care settings meet requirements specified in this Appendix.

a. The setting shall protect and promote the rights of each client, including each of the following rights:

1. The setting shall extend to each client the right to choose a personal attending physician.

2. Each client shall be fully informed in advance about care and treatment, and of any changes in care or treatment that may affect his or her well-being.

3. Each client shall have the right to participate in planning care and treatment or changes in care or treatment. For clients who have teen adjudged incompetent, this right shall be extended to the individual who has been appointed to make decisions on behalf of the client.

4. The setting shall ensure that each client has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms.

5. Restraints may only be imposed –

A. to ensure the physical safety of the individual or other clients served in the setting, and

B. only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances when such restraints are determined to be necessary to prevent immediate and significant threat to the life or safety of the individual, staff members, or other clients until such an order can reasonably be obtained).

6. The setting shall ensure the right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of client groups.

7. The setting shall preserve the individual's right to confidentiality of personal and clinical records. The setting shall grant the individual (or legal representative) access to any current clinical records maintained by the setting upon request of the individual or legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

8. The setting shall extend to the individual the right to receive services consistent with the individual's needs and preferences and the types of services provided by the setting, except where the health or safety of the individual or other clients would be endangered.

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LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

9. The individual shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the setting to resolve those grievances the client may have, including those with respect to the behavior of other clients.

10. The setting shall extend to the client the right to organize and participate in client groups in the setting and the right of the client's family to meet in the setting with the families of other clients in the setting.

11. The setting shall not restrict the right of the client to participate in social, religious and community activities that do not interfere with the rights of other clients in the setting.

12. The setting shall extend the right to examine, upon reasonable request, the results of the most recent survey of the setting conducted by HCFA or the State with respect to the setting and any plans of remedial action in effect with respect to the facility.

b. In the case of an individual adjudged incompetent under the laws of the state, the rights of the client shall devolve upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the individual's behalf.

c. Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the individual's ICCP) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each client receiving such drugs.

d. A large nonresidential community care setting must extend to each individual served the following access and visitation rights.

1. Permit immediate access to any client by any representative of HCFA, by any representative of the State, by an ombudsman or agency described in section 1919(c)(2)(B)(iii)(II), (III), or (IV) of the Social Security Act, or by the clients individual physician or case manager.

2. Permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by the immediate family or other relatives of the client.

3. Permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client.

4. Permit reasonable access to a client by any entity or individual that provides health, social, legal, or other services to the client, subject to the client's right to deny or to withdraw consent at any time.

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LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

5. Permit representatives of the State ombudsman (described in section 1919(c)(2)(B)(iii)(II) of the Social Security Act), with the permission of the client (or the client's legal representative) and consistent with State law, to examine a client's clinical records.

c. If the setting receives or holds funds from its clients, or exercises control over client funds, on a permanent or temporary basis, the setting must meet the following requirements.

1. The setting may not require clients to deposit their personal funds with the setting, and

2. Upon the written authorization of the client, the setting must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this Appendix.

3. The setting must purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of clients deposited with the setting.

4. The setting may not impose a charge against the personal funds of a client for any item or service for which payment is made under the plan or under Medicare.

Nothing in this Appendix shall be construed as requiring a setting to receive or hold funds from a client.

d. If the setting receives or holds funds from a client, the setting must manage and account for the personal funds of the client deposited with the facility as follows:

1. The setting must deposit any amount of personal funds in excess of $50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the setting's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the setting must maintain such funds in a non-interest bearing account or petty cash fund.

2. The setting must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a client deposited with the setting, and afford the client or legal representative, reasonable access to such record.

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1511(a)(3)(B) of the Social Security Act and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

4. Upon the death of a client with such an account, the community care setting must convey promptly the client's personal finds (and a final accounting of such funds) to the individual administering the client's estate.

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LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

e. Each large nonresidential community care setting shall be required to inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.

f. Each large nonresidential community care setting must be designed, constructed, equipped and maintained in a manner to protect the health and safety of clients, personnel and the general public.

g. Nothing in this section shall be construed to require a large nonresidential community care setting to provide or arrange for medical care or treatment to clients served under this benefit if the setting does not provide this care to other clients who receive similar services in the facility.

h. Except to the extent dictated otherwise by State law, a large nonresidential community care setting shall not be held responsible for the actions or inactions of persons not employed by the setting, who furnish medical care or treatment on its premises, when the setting has not arranged for the provision of care by these persons.

i. A large nonresidential community care setting must be licensed or certified under applicable State and local law.

j. A large nonresidential community care setting must meet such provisions of the most recent edition of the Life Safety Code of the National Fire Protection Association as are applicable to the type of setting.

1. The State requests that HCFA waive certain provisions of this Code, which if rigidly applied would result in unreasonable hardship upon a setting. The State certifies that such a waiver would not adversely affect the health and safety of clients or personnel. The specific request for waiver and supporting documentation are attached.

_____ Yes _____ No

2. The State certifies to HCFA that there is in effect a fire and safety code, imposed by State law, which adequately protects clients and personnel in certain types of nonresidential community care settings. The specific types of settings are identified in attached documentation. The State requests that the provisions of the State code be substituted for those of the Life Safety Code of the National fire Protection Association for those particular settings.

_____ Yes _____ No

k. Each large nonresidential community care setting must disclose persons with an ownership or control interest (including such persons as defined 'n section 1124(a)(3) of the Social Security Act) in the setting.

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LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

1. A large nonresidential community care setting may not have, as a person with an ownership or control interest in the setting, any individual or person who has been excluded from participation in the program under Medicaid or who has had such an ownership or control interest in one or more community care settings which have been found repeatedly to be substandard, or to have failed to meet the requirements of this Appendix.

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State WASHINGTON

LARGE RESIDENTIAL COMMUNITY CARE SETTINGS

The requirements of this Appendix shall apply to large residential community care settings.

The State will require that large residential community care settings meet requirements specified in this Appendix.

a. The setting shall protect and promote the rights of each client, including each of the following rights:

1. The setting shall extend to each client the right to choose a personal attending physician.

2. Each client shall be fully informed in advance about care and treatment, and of any changes in care or treatment that may affect his or her well-being.

3. Each client shall have the right to participate in planning care and treatment or changes in care or treatment. For clients who have been adjudged incompetent, this right shall be extended to the individual who has been appointed to make decisions on behalf of the client.

4. The setting shall ensure that each client has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms.

5. Restraints may only be imposed –

A. to ensure the physical safety of the individual or other clients served in the setting, and

B. only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances when such restraints are determined to be necessary to prevent immediate and significant threat to the life or safety of the individual, staff members, other clients until such an order can reasonably be obtained).

6. The setting shall ensure the right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of client groups. This shall not be construed to require the setting to furnish a private bedroom for the individual.

7. The setting shall preserve the individual's right to confidentiality of personal and clinical records. The setting shall grant the individual (or legal representative) access to any current clinical records maintained by the setting upon request of the individual or legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

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LARGE RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

8. The setting shall extend to the individual the right to receive services consistent with the individual's needs and preferences and the types of services provided by the setting, except where the health or safety of the individual or other clients would be endangered.

9. The individual shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the setting to resolve those grievances the client may have, including those with respect to the behavior of other clients.

10. The setting shall extend to the client the right to receive notice before the room or the roommate of the resident in the setting is changed.

11. The setting shall extend to the client the right to organize and participate in client groups in the setting and the right of the client's family to meet in the setting with the families of other clients in the setting.

12. The setting shall not restrict the right of the client to participate in social, religious and community activities that do not interfere with the rights of other clients in the setting.

13. The setting shall extend the right to examine, upon reasonable request, the results of the most recent survey of the setting conducted by HCFA or the State with respect to the setting and any plan of remedial action in effect with respect to the setting.

b. In the case of an individual adjudged incompetent under the laws of the State, the rights of the client shall devolve upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the individual's behalf.

c. Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the individual's ICCP) designed to eliminate or 'modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each client receiving such drugs.

d. A large residential community care setting must extend to each individual served the following access and visitation rights.

1. Permit immediate access to any client by any representative of HCFA, by any representative of the State, by an ombudsman or agency described in section 1919(c)(2)(B)(iii)(II), (III), or (IV) of the Social Security Act, or by the clients individual physician or case manager.

2. Permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by the immediate family or other relatives of the client.

3. Permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client.

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LARGE RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

4. Permit reasonable access to a client by any entity or individual that provides health, social, Legal, or other services to the client, subject to the client's right to deny or to withdraw consent at any time.

5. Permit representatives of the State ombudsman (described in section 1919(c)(2)(B)(iii)(II) of the Social Security Act), with the permission of the client (or the client's legal representative) and consistent with State law, to examine a client's clinical records.

e. If the setting receives or holds funds from its clients, or exercises control over client funds, on a permanent or temporary basis, the setting must meet the following requirements.

1. The setting may not require clients to deposit their personal funds with the setting, and

2. Upon the written authorization of the client, the setting must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this Appendix.

3. The setting must purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of clients deposited with the setting.

4. The setting may not impose a charge against the personal funds of a client for any item or service for which payment is made under the plan or under Medicare.

Nothing in this Appendix shall be construed as requiring a setting to receive or hold funds from a client.

f. If the setting receives or holds funds from a client, the setting must manage and account for the personal funds of the client deposited with the facility as follows:

1. The setting must deposit any amount of personal funds in excess of $50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the setting's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the setting must maintain such funds in a non-interest bearing account or petty cash fund.

2. The setting must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a client deposited with the setting, and afford the client or legal representative, reasonable access to such record.

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

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LARGE RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

4. Upon the death of a client with such an account, the community care setting must convey promptly the client's personal finds (and a final accounting of such funds) to the individual administering the client's estate.

g. Each large residential community care setting shall be required to inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.

h. Each large residential community care setting shall be designed, constructed, equipped and maintained in a manner to protect the health and safety of clients, personnel and the general public.

i. Nothing in this section shall be construed to require a large residential community care setting to provide or arrange for medical care or treatment to clients served under this benefit if the setting does not provide this care to other clients who receive similar services in the setting.

j. Except to the extent dictated otherwise by State law, a large residential community care setting shall not be held responsible for actions or inactions of persons not employed by the setting, who furnish medical care or treatment on its premises, when the setting has not arranged for the provision of care by these persons.

k. A large residential community care setting must be licensed or certified under applicable State and local law.

l. A large residential community care setting must meet such provisions of the most recent edition of the Life Safety Code of the National Fire Protection Association as are applicable to the type of setting.

1. The State requests that HCFA waive certain provisions of this Code, which if rigidly applied would result in unreasonable hardship upon a setting. The State certifies that such a waiver would not adversely affect the health and safety of clients or personnel. The specific request for waiver and supporting documentation are attached.
_____ Yes _____ No

2. The State certifies to HCFA that there is in effect a fire and safety code, imposed by State law, which adequately protects clients and personnel in certain types of residential community care settings. The specific types of settings are identified in attached documentation. The State requests that the provisions of the State code be substituted for those of the Life Safety Code of the National fire Protection Association.
_____ Yes _____ No

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LARGE RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

m. Each large residential community care setting must disclose persons with an ownership or control interest (including such persons as defined in section 1124(a)(3) of the Social Security Act) in the setting.

n. A large residential community care setting may not have, as a person with an ownership or control interest in the setting, any individual or person who has been excluded from participation in the program under Medicaid or who has had such an ownership or control interest in one or more community care settings which have been found repeatedly to be substandard, or to have failed to meet the requirements of this Appendix.

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Name and address of State Administering Agency, if different from the State Medicaid Agency:

The State Medicaid Agency will limit the number of PACE enrollees to 300.

I. Eligibility

_____ The State determines eligibility for PACE enrollees under rules applying to community groups.

A. __X__ The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

Individuals covered are those in the following sections of 42 CFR:
435.236

Note: Spousal impoverishment eligibility rules for individuals with a community spouse described in section 1924 of the Social Security Act apply.

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

B. _____ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II C - Compliance and State Monitoring of PACE.)

C. __X__ The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

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Regular Post Eligibility

1. __X__ SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

   (a) Sec. 435.726--States which do not use more restrictive eligibility requirements than SSI.

      1. Allowances for the needs of the:
         (A) Individual (check one)
            1. _____ The following standard included under the State plan (check one):
               (a) _____ SSI
               (b) _____ Medically Needy
               (c) _____ The special income level for the institutionalized
               (d) _____ Percent of the Federal Poverty Level: _____%
               (e) _____ Other (specify): _____

            2. _____ The following dollar amount: $_____
               Note: If this amount changes, this item will be revised.

            3. __X__ The following formula is used to determine the needs allowance.
               (a) 100% of Federal Poverty Level as a personal needs allowance
               (b) An allowance for the payment of guardianship fees of the individual under a Superior Court order of guardianship as allowed under the WAC
               (c) Earned income for the first $65 plus one-half of the remaining earned income
               (d) Total needs will not exceed the SIL for the maintenance needs of the waiver

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

         (B) Spouse only (check one):
            1. _____ SSI Standard
            2. _____ Optional State Supplement Standard

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3. _____ Medically Needy Income Standard
4. _____ The following dollar amount: $_____
5. _____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
6. _____ The amount is determined using the following formula:
_____
_____
7. _X_ Not applicable (N/A)

(C) Family (check one):
1. _____ AFDC Need Standard
2. _X_ Medically Needy Income Standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. _____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4. _____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
5. _____ The amount is determined using the following formula:
_____
_____
6. _____ Other
7. _X_ Not applicable (N/A)

(2) Medical and remedial care expenses in 42 CFR 435.726.

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Regular Post Eligibility

2. _____ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) **42 CFR 435.735**--States using more restrictive requirements than SSI.

1. Allowances for the needs of the:
   (A) Individual (check one)
      1. _____ The following standard included under the State plan (check one):
      (a) _____ SSI
      (b) _____ Medically Needy
      (c) _____ The special income level for the institutionalized
      (d) _____ Percent of the Federal Poverty Level: _____%
      (e) _____ Other (specify): _____

2. _____ The following dollar amount: $_____
   Note: If this amount changes, this item will be revised.

3. _____ The following formula is used to determine the needs allowance:
   _____
   _____

Note: If the amount protected for PACE enrollees in item 1 is **equal to, or greater than** the maximum amount of income a PACE enrollee may have and be eligible under PACE, **enter N/A in items 2 and 3**.

   (B) Spouse only (check one):
      1. _____ The following standard under 42 CFR 435.121:
      _____
      2. _____ The Medically Needy income standard
      _____

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3. _____ The following dollar amount: $_____
   Note: If this amount changes, this item will be revised.
4. _____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
5. _____ The amount is determined using the following formula:
   _____
   _____
6. _____ Not applicable (N/A)

(C) Family (check one):
1. _____ AFDC need standard
2. _____ Medically Needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. _____ The following dollar amount: $_____
   Note: If this amount changes, this item will be revised.
4. _____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
5. _____ The amount is determined using the following formula:
   _____
   _____
6. _____ Other
7. _____ Not applicable (N/A)

(b) Medical and remedial care expenses in 42 CFR 435.735.

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Spousal Post Eligibility

3. __X__ State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

   (a) Allowances for the needs of the:
      1. Individual (check one)
         (A) _____ The following standard included under the State plan (check one):
            1. _____ SSI
            2. _____ Medically Needy
            3. _____ The special income level for the institutionalized
            4. _____ Percent of the Federal Poverty Level: _____%
            5. _____ Other (specify):

         (B) _____ The following dollar amount:

         (C) __X__ The following formula is used to determine the needs allowance:
            (a) Personal Needs Allowance of 100% of the FPL for a participant who does not reside with a community spouse or the Medically Needy income standard for a participant who does reside with a community spouse
            (b) An allowance for the payment of guardianship fees of the individual under a Superior Court order of guardianship as allowed under the WAC
            (c) Earned income for the first $65 plus on-half of the remaining earned income
            (d) Total needs will not exceed the SIL for the maintenance needs of the waiver participant

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I f this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

_____
_____
_____

II. Compliance and State Monitoring of the PACE Program

For State Medicaid Agencies also serving as PACE State Administering Agencies, the State further assures all requirements of section 1934 of the Social Security Act will be met. All relevant provisions are included in the contract with the PACE entities, either as contractor or State responsibility. Both scheduled and unscheduled on-site reviews will be conducted by State staff.

A. Readiness Review: The State will perform a Readiness Review of the applicant entity that assures the entity has fully developed its policies and procedures, obtained commitments from key staff, developed its solvency plan and has a facility that meets State and Federal requirements at the time of the application, in accordance with Section 460.12(b)(1).

B. Monitoring During Trial Period: During the trial period, the State, in cooperation with CMS, will conduct comprehensive reviews of a PACE organization to ensure compliance with State and federal requirements.

At the conclusion of the trial period, the State, in cooperation with CMS, will continue to conduct reviews of a PACE organization, as appropriate, taking into account the quality of care furnished and the organization's compliance with State and federal requirements.

C. Annual Monitoring: The State assures that at least annually it will reevaluate whether a participant meets the level of care required under the State Medicaid plan for coverage of nursing facility services. The State understands that this determination may be waived if there is no reasonable expectation of improvement or significant change in the participant's conditions because of the severity of a chronic condition or the degree of impairment of functional capacity.

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D. Monitoring of Corrective Action Plans: The State assures it will monitor the effectiveness of corrective actions required to be taken by the PACE organization.

III. Rates and Payments

A. The State assures CMS that the capitated rates will be equal to or less than the cost to the agency of providing those with fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

Upper Payment Limit and Rate Methodology

The UPL is based on fee-for-service (FFS) costs derived from: a population of nursing home and HCBS eligibles located in comparable county(s) with comparable age (55 or older), gender, clinical complexity, and care settings. In order to develop the UPL, the data from sub-populations of nursing home and HCBS clients was blended into the final UPL table. In lieu of FFS costs, the capitated managed care mental health rates of the Statewide model for a population comparative to PACE were used, unchanged, as the mental health component of the PACE UPL. Incurred claims were the source data for the UPL calculation. Detailed claims data was obtained from the State's payment system. The State assures CMS that the capitated rates are less than comparable FFS costs as defined by the PACE UPL.

The following four groups, as approved by CMS, will be used to determine payment for PACE:

Medicaid Eligible Only, age 64 and under;
Medicaid Eligible Only, age 65 and above;
Medicaid & Medicare Eligible, age 64 and under;
Medicaid & Medicare Eligible, age 65 and above.

1. X Rates are set at a percent of fee-for-service costs.
A percentage of the UPL was used to establish the rate.
2. ____ Experience-based (contractors/State's cost experience or encounter date) (please describe) – See rate methodology above
3. _____ Adjusted Community Rate (please describe)
4. _____ Other (please describe)

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B. X The rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.
Actuary Tim Barclay, from Milliman USA, Incorporated, 1301 Fifth Avenue, Suite #3600, Seattle, WA 98101-2605 is responsible for determining the rates to be reasonable and predictable.

C. X The State will submit all capitated rates to the CMS Regional Office for prior approval.

A. IV. Enrollment and Disenrollment: For both State Medicaid Agencies and State Administering Agencies, the State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month. In cases where the State Medicaid Agency is separate from the State Administering Agency, the State Medicaid Agency assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the two agencies.

Enrollment Process (please describe):

The State Administering Agency assesses any potential participant including those who are not eligible for Medicaid to ensure that the individual meets the nursing facility level of care. Eligible individuals may enroll the first of the month following the date the PACE organization received the signed enrollment agreement. The agency will conduct a face-to-face reassessment of PACE clients every twelve (12) months and/or whenever the client's circumstances or physical condition substantially changes.

Medicaid Eligible Only, age 64 and under;
Medicaid Eligible Only, age 65 and above;
Medicaid & Medicare Eligible, age 64 and under;
Medicaid & Medicare Eligible, age 65 and above.

1. X Rates are set at a percent of fee-for-service costs
2. _____ Experience-based (contractors/State's cost experience or encounter date) (please describe) – See rate methodology above
3. _____ Adjusted Community Rate (please describe)
4. _____ Other (please describe)

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B. Enrollee Information (Please describe the information to be provided to enrollees): Enrollees shall receive a copy of their CARE: Service Summary, financial award notices, and notice of fair hearing rights for any adverse actions. Enrollees are entitled to a fair hearing after it has gone through the PACE organization's internal appeal process. Medicaid fair hearing rights shall be translated for individuals with limited English proficiency.

The State assures that the following information is provided to all enrollees prior to and at the time of enrollment and annually thereafter, by the PACE organization in accordance with its approved policies and procedures.

Detailed information about 460.112, Participant Rights, 460.120, 460.122, Grievance and Appeals processes; 460.154, Enrollment Agreement; and 460.156, Other enrollment procedures are contained in the Participant Handbook of which the Enrollment Agreement is a part.

The process for explaining the information contained in the Participant Handbook, in a manner understandable to the enrollee, is conducted in the following manner:

In accordance with Policy Number 301.03, issued 7/13/01, the process begins with a contact by telephone or in-person between the potential participant and the PACE Intake Coordinator. The Intake Coordinator, after making an initial determination of eligibility, arranges a home visit. During the home visit, the Intake Coordinator explains the PACE organization using the Participant Handbook and answers any questions from the individual and/or caregiver. If the individual is interested in joining, a site visit is arranged at which time the individual meets with members of the multidisciplinary team and again is provided with opportunities to ask questions.

At this time, the Intake Coordinator contacts the Aging and Disability Services Administration (ADSA) Home and Community Services (HCS) office to start the process of determining functional and financial eligibility for individuals requesting Medicaid coverage, or to determine functional eligibility only for individuals who pay privately.

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If the individual is determined to be eligible and if the individual agrees to accept the program conditions, he/she signs an enrollment agreement in accordance with Policy 301.04, issued 7/13/01 which requires that all individuals who enroll in PACE must sign an enrollment agreement. Prior to signing, the Intake Coordinator again reviews the Participant Handbook with the individual and he/she receives a copy of the Handbook for reference.

All enrollees also receive a PACE enrollment card in accordance with the requirements in 460.156.

The State undertakes the following steps:

At the time of enrollment, the HCS case manager sends the PACE organization proof of nursing home certification contained in the CARE Assessment document. HCS will send proof of recertification on an annual basis. In addition, the HCS case manager provides the authorization for enrollment for Medicaid recipients and calculates the monthly participant fee for the enrollee, if any.

C. Disenrollment Process (Please describe - voluntary and involuntary): The PACE organization will notify the state of involuntary disenrollments after the organization has followed its approved internal process. The state will respond within five business days of receiving the request for a review. The state will notify the enrollee of the adverse action and, the right to a fair hearing. Enrollees may choose to voluntarily disenroll from PACE at any time of the month. The state will assist with returning any disenrolled participant (voluntary or involuntary) to the previous Medicaid coverage program, effective the beginning of the next month possible.

The PACE organization follows Policy Number 302.1 for Voluntary Disenrollments:

All participants have the right to voluntarily disenroll from the PACE organization without cause at any time. Once the participant has notified the PACE organization staff that he/she wishes to disenroll, either in person or in writing, members of the multidisciplinary team work with the participants to see if the reasons(s) for disenrolling can be resolved. If there is no resolution, the PACE

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Social Worker has the individual or his/her caregiver sign the disenrollment form. The disenrollment form advises participants of the following:

- They may be contacted by HCS or CMS to verify their desire to disenroll
- Attests to the fact that they understand that they are disenrolling and
- That they have been informed that they will return to the traditional Medicare and Medicaid systems as of the disenrollment date and no longer are required to receive services through the PACE organization.

The social worker notifies the multidisciplinary team and the HCS case manager and financial worker regarding the anticipated date for disenrollment. The effective date of disenrollment will be the last day of the month administratively possible using the most expedient process available. The multidisciplinary team ensures that the participant is reinstated in other Medicare and Medicaid programs after disenrollment by making appropriate referrals, transferring medical records and coordinating with CMS and HCS to ensure participant's reinstatement. All services to the participant are continued during the disenrollment process.

The social worker sends the official disenrollment letter to the participant and his/her representative and the nursing home, if the participant is currently residing there. The social worker also notifies the PACE organization business office. The Accounting Assistant in the business office will remove the participant's name from the billing cycle and will report the disenrollment to CMS.

HCS undertakes the following steps:

An HCS representative may contact the former enrollee to verify his/her desire to disenroll.

D. The State assures that before an involuntary disenrollment is effective, it will review and determine in a timely manner that the PACE organization has adequately documented grounds for disenrollment.

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E. In the event a PACE participant disenrolls or is disenrolled from a PACE program, the State will work with the PACE organization to assure the participant has access to care during the transitional period.

F. The State assures it will facilitate reinstatement in other Medicaid/Medicare programs after a participant disenrolls.

G. The State assures that the State PACE requirements and State procedures will specify the process for how the PACE organization must submit participant information to the State.

VI. Marketing: For State Medicaid Agencies also acting as PACE State Administering Agencies, the State assures that a process is in place to review PACE marketing materials in compliance with Section 460.82(b)(ii).

VII. Services: The following items are the medical and remedial services provided to the categorically needy and medically needy. (Please specify): All services as allowed under the Washington State Medicaid State Plan, in Section 3.1A.

The State assures that the State agency that administers the PACE program will regularly consult with the State Agency on Aging in overseeing the operation of the PACE program in order to avoid service duplication in the PACE service area and to assure the delivery and quality of services to PACE participants.

VIII. Decisions that require joint CMS/State Authority

A. For State Medicaid Agencies also acting as PACE State Administering Agencies, waivers will not be granted without joint CMS/State agreement:

1. The State will consult with CMS to determine the feasibility of granting any waivers related to conflicts of interest of PACE organization governing board members.

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2. The State will consult with CMS to determine the feasibility of granting any waivers related to the requirements that: members of the multidisciplinary team are employees of the PACE organization; and that members of the multi- disciplinary team must serve primarily PACE participants.

B. Service Area Designations: The State will consult with CMS on changes proposed by the PACE organization related to service area designation.

C. Organizational Structure: The State will consult with CMS on changes proposed by the PACE organization related to organizational structure.

D. Sanctions and Terminations: The State will consult with CMS on termination and sanctions of the PACE organization.

IX. State Licensure Requirements

For State Medicaid Agencies also acting as PACE State Administering Agencies, the State assures that Life Safety Code requirements are met for facilities in which the PACE organization furnishes services to PACE participants in accordance with Section 460.72(b), unless CMS determines that a fire and safety code imposed by State law adequately protects participants and staff.

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The following ambulatory services are provided. *

Outpatient hospital services

Clinic services

Other laboratory services

Home health services

Physicians' services

Prescribed drugs, dentures, prosthetic devices and eyeglasses

Family planning services

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*Description provided on attachment.

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State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

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

__X__ Provided: ____ No limitations __X__ With limitations*

2.a. Outpatient hospital services.

__X__ Provided: ____ No limitations __X__ With limitations*

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

_X_Provided: __X_No limitations ___ With limitations*

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

__X_ Provided: _X_ No limitations ___ With limitations*

3. Other laboratory and x-ray services.

__X_ Provided: ___ No limitations _X_With limitations*

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

__X__ Provided: ____ No limitations __X__With limitations*

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

__X__ Provided

c. Family planning services and supplies for individuals of childbearing age.

__X__ Provided: __X__ No limitations ____ With limitations*

d. Tobacco cessation counseling services for pregnant women

1) Face-to-face tobacco cessation counseling services

_X_ Provided ___ No limitations _X_ With limitations

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

_X_ Provided _X_ No limitations ___ With limitations

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

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

__X__ Provided: ____ No limitations __X__With limitations*

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

__X__ Provided: ____No limitations __X__With limitations*

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

a. Podiatrists' services.

__X__ Provided: ____ No limitations __X__With limitations*

Not Provided: ____

b. Optometrists' services.

__X__ Provided: ____No limitations __X__With limitations*

Not Provided: ____

c. Chiropractor's services.

____ Provided: ____No limitations ____With limitations*

Not Provided: __X__

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

__X__ Provided: ____No limitations __X__With limitations*

Not Provided: ____

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State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

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7. Home health services.

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

__X__ Provided: ____No limitations __X__With limitations*

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

__X__ Provided: ____No limitations __X__With limitations*

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

__X__ Provided: ____ No limitations __X__ With limitations*

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

__X__ Provided: ____ No limitations __X__ With limitations*

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

__X__ Provided: ____ No Limitations __X__ With limitations*

8. Private duty nursing services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

9. Clinic services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

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10. Dental services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

11. Physical therapy and related services.

a. Physical therapy.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

b. Occupational therapy.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

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

__X__ Provided: ____ No Limitations __X__ With limitations*

Not Provided: ____

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

a. Prescribed drugs.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

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

b. Dentures.

__X__ Provided: ____ No limitations __X__ With limitations*

c. Prosthetic devices.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

d. Eyeglasses.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

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

a. Diagnostic services.

____ Provided: ____ No limitations ____ With limitations*

Not Provided: _X___

b. Screening services.

____ Provided: ____ No limitations ____ With limitations*

Not Provided: __X__

c. Preventive services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

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

d. Rehabilitative services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

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

a. Inpatient hospital services.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

b. Nursing facility services.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

c. Intermediate care facility services.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

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

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

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

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

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

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

17. Nurse -midwife services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

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

__X__ Provided: ____ No limitations

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

__X__ With limitations* Not Provided: ____

19 Case management services and Tuberculosis related services.

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

__X__ Provided: ____ With limitations*

Not Provided: ____

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19. Case management services and Tuberculosis related services. (continued)

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

____ Provided: ____ With limitations*

Not Provided: _X__

20. Extended services for pregnant women.

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

__X__ Provided: _____ Additional coverage ++

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

__X__ Provided __X__ Additional coverage ++

21. Certified pediatric or family nurse practitioners' services.

__X__ Provided __X__ No limitations ____ With limitations*

Not Provided: ____

* Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

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

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

____ Provided: ____ With limitations*

Not Provided_X__

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

__X__ Provided: ____ No limitations __X__ With limitations

Not Provided: ____

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

a. Transportation.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

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

____ Provided: ____ No limitations ____ With limitations*

Not Provided: __X__

c. Reserved.

____ Provided: ____ No limitations ____ With limitations*

Not Provided: __X__

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

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

e. Emergency hospital services.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

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

____ Provided: __X__ Not Provided

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

____ Provided: ____ State Approved (Not Physician) Service Plan Allowed

____ Services Outside the Home Also Allowed

____ Limitations Described on Attachment

_X_ Not Provided.

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

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

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

27. Licensed or Otherwise State-Approved Freestanding Birthing Center

_X_ Provided ___ No limitations _X_ With Limitations*

* Limitations described on following pages

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

TELEMEDICINE

Telemedicine is when a health care practitioner uses interactive real-time audio and video telecommunications to deliver covered services that are within his or her scope of practice to a client at a site other than the site where the provider is located.

PROVIDERS
The following providers are eligible to provide telemedicine services within their scope of practice:

- Physicians (must be licensed per chapter 18.71 RCW and chapter 246-919 WAC)
- Dentists (must be licensed per chapter 18.32 RCW and chapter 246-817 WAC)
- Advanced Registered Nurse Practitioners (must be licensed per chapter 18.79 RCW and chapter 246-840 WAC)
- Psychiatric Advanced Registered Nurse Practitioners (must be licensed per chapter 18.73 RCW and chapter 246-840 WAC)
- Physician Assistants (must be licensed per chapter 18.57A, 18.71.A and chapters 246-854 WAC and 246-918 WAC)
- Independent Clinical Social Workers (must be licensed per chapter 18.225 RCW and chapter 246-809 WAC)
- Advanced Clinical Social Workers (must be licensed per chapter 18.225 RCW and chapter 246-809 WAC)
- Mental Health Counselors (must be licensed per chapter 18.225 RCW and chapter 246-809 WAC)
- Marriage and Family Therapists (must be licensed per chapter 18.225 RCW and chapter 246-809 WAC)
- Psychologists (must be licensed per chapter 18.83 and chapter 246-924 WAC)
- Certified counselors acting as a lead behavior analyst therapist (must be licensed per chapters 185.19 RCW and 246-810 WAC)

SERVICES
Telemedicine is covered fee-for-service when it is used to substitute for a face-to-face, “hands on” encounter. Only the following services are covered using telemedicine:

- Consultations
- Office or other outpatient visits
- Psychiatric intake and assessment
- Individual psychotherapy
- Visit for drug monitoring

The following services are **not** covered as telemedicine:

- Email, telephone, and facsimile transmissions
- Installation or maintenance of any telecommunication devices or systems
- Home health monitoring
- “Store and forward” telecommunication-based services (store and forward is the asynchronous transmission of medical information to be reviewed at a later time by the physician or practitioner at the distant site)

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

Telemedicine (cont)

SITES
An originating site is the physical location of the client at the time the service is provided through telemedicine. Approved originating sites are:

- The office of a physician or practitioner
- A hospital
- A critical access hospital
- A rural health clinic (RHC)
- A federally qualified health center (FQHC)
- A home

A distant site is the physical location of the physician or practitioner providing the service through telemedicine.

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DESCRIPTION OF LIMITATION OF SERVICES

1. Inpatient hospital services

   a. Prior authorization is required for psychiatric inpatient care.

   b. Chronic pain management is limited to inpatient services provided by Department of Social and Health Services (department) approved pain centers in a hospital.

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

2. a. Outpatient hospital services

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

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

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

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

I. Rural Health Clinic (RHC)

A rural health clinic (RHC) is:

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

II. Covered services

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

III. Other ambulatory services

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

III. Core service providers

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

IV. Additional providers

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

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

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

I. Federally qualified health centers (FQHC)

An FQHC is a facility that is any of the following:

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

II. Covered services

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

III. Other ambulatory services

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

IV. Core service providers

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

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

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

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3. Other laboratory and x-ray services

a. Laboratory services

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

Drug screens only when medically necessary and when:

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

One each of the following, per client per day:

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

b. Radiology services

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

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

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

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

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4. a. Nursing facility services

Prior approval of admission

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

Specialized add-on services for certain NF residents.

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

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

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

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4. a. Nursing facility services (cont)

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

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

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

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

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

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

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4. a. Nursing facility services (cont)

V. Habilitative therapy services

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

B. Limitations

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

VI. Staff/family consultation and training

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

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

B. Limitations

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

VII. Supported employment services

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

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

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4. a. Nursing facility services (cont)

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

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

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

VIII. Transportation Services

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

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

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4. a. Nursing facility services (cont)

IX. Other habilitative services and supplies

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

B. Limitations

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

X. Providers

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

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

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

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

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

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

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

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4. b. EPSDT (cont)

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

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

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

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

5. Home health services;

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

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

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

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

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4. b. EPSDT (cont)

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

6. Hospice care, including palliative care

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

- Addresses the physical and/or mental disabilities of the child;
- Be prescribed by a currently licensed physician or another currently licensed healthcare practitioner within his or her scope of practice under state law; and
- Be in accordance with the Indiviudals with Disabilities Education Act (IDEA) by being included in the child's current Individual Education Plan (IEP) for Part B services, or Individualized Family Service Plan (IFSP) for Part C services.

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

(i) *Physical Therapist* – A 'licensed physical therapist' is an individual who has met the requirements set forth in 42 CFR 440.110(a), passed the National Physical Therapy Examination (NPTE), and who is currently licensed according to the Washington State Board of Physical Therapy. Physical therapy services may be provided by a 'licensed physical therapy assistant' who has passed the National Physical Therapy Examination (NPTE), and meets the requirements of Chapter 18.74 RCW and Chapter 246-915 WAC. A 'licensed physical therapist assistant' must be under the direction and supervision of a licensed physical therapist.

(ii) *Occupational Therapist* – A 'licensed occupational therapist' is an individual who has met the requirements set forth in 42 CFR 440.110(b), has passed the National Board for Certification in Occupational Therapy's (NBCOT) examination, and who is currently licensed according to the Washington State Occupational Therapy Practice Board. Occupational therapy services may be provided by a 'licensed occupational therapy assistant' who has passed the National Board for Certification in Occupational Therapy's (NBCOT) examination, and meets the requirements of Chapter 18.59 RCW and Chapter 246-847 WAC. A 'licensed occupational therapist assistant' must be under the direction and supervision of a licensed qualified occupational therapist.

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4. b. EPSDT (cont)

(iv) *Speech-Language Pathologist* – A 'licensed speech-language pathologist' is an individual who has met the requirements set forth in 42 CFR 440.110(c)(2), has passed the Speech and Hearing Association examination, and who is currently licensed according to the Washington State Board of Hearing and Speech. Speech-language pathology services may be provided by a 'certified speech-language pathology assistant' who has met the requirements of Chapter 18.35 RCW and Chapter 246-828 WAC . A 'certified speech-language pathology assistant' must be under the direction and supervision of a licensed speech-language pathologist.

(iv) *Audiologist* – A 'licensed audiologist' is an individual who has met the requirements set forth in 42 CFR 440.110(c)(2), is currently licensed, and has passed the examination or received official verification from the American Speech and Hearing Association (ASHA), clinical competency certifications from the American Board of Audiology (ABA) or the American Academy of Audiology (AAA). The licensed audiologist must be in compliance with the Washington State Board of Health and Speech, and conform to Chapter 18.250 RCW and Chapter 246-828 WAC.

(v) *Registered Nurse or Licensed Practical Nurse* – A 'registered nurse or licensed practical nurse' is an individual who is currently licensed according to the Washington State Health Nursing Commission, and is in compliance with 42 CFR 440.60. Registered nurses must conform to Chapter 18.79 RCW, 246-840 of the Washington Administrative Codes. A licensed practical nurse must meet the requirements of Chapter 18.79 RCW and Chapter 246-840 WAC.

(vi) *Psychologist* – A 'psychologist' is an individual who is currently licensed according to the Washington State Examining Board of Psychology, has passed the Examination for Professional Practice of Psychology (EPPP), and is in compliance with 42 CFR 440.130(d). A licensed psychologist must meet the requirements of Chapter 18.83 RCW and Chapter 246-924 WAC.

(vii) *Social Worker* – A 'social worker' is an individual who is currently licensed according to the Washington State Board of Health, has passed the American Association of Social Work Boards (ASWB), and is in compliance with 42 CFR 440.130(d). A licensed social worker must meet the requirements of Chapter 18.225 RCW and Chapter 246-809 WAC.

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(viii) *Mental Health Counselor* – A 'licensed mental health counselor' is an individual who is currently licensed according to the Washington State Board of Health, has passed the National Board for Certified Counselors (NBCC), and is in compliance with 42 CFR 440.130(d). Mental health services may be provided by a 'licensed mental health counselor associate' who has not taken the National Board for Certified Counselors (NBCC) examination, but meets the requirements of Chapter 18.225 RCW and Chapter 246-809 WAC. A 'licensed mental health counselor associate' must be under the direction and supervision of a licensed mental health counselor.

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4. b. EPSDT (cont)

(ix) In those circumstances when a healthcare related service is provided under the direction and supervision of a licensed therapist *(e.g., Occupational, Physical, or Speech Language Pathologist)*, the following restrictions apply. Documentation must be kept to support the licensed therapist's supervision of services and ongoing treatment of services. The supervising therapist must:

(B) See the child face-to-face at the beginning of service and periodically during treatment;

(B) Be familiar with the treatment plan as recommended by the prescribing physician under state law;

(C) Have a continued involvement in the child's care recommended by the prescribing physician; and

(D) Review the need for continued services through treatment.

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

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

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

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

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

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

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4. b. EPSDT (cont)

Psychological assessments and counseling services – Psychological assessments include testing and psychotherapy to assist a child in adjusting to their disability.

Counseling assessments and therapy services – Therapeutic intervention services to assist a child in adjusting to their disability.

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

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4. d. Tobacco cessation counseling services for pregnant women

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

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

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

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

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

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

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

Please describe any limitations:

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

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5. a. Physicians' Services

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

(1) Critical care.

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

(2) Hospital visits. No payment for visits on those days that exceed the allowed length of stay unless an extension was requested and has been approved.

(3) Newborn care and neonatal intensive care unit (NICU) services.

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

(4) Osteopathic manipulative therapy.

Up to ten osteopathic manipulations per client, per calendar year.

(5) Physical exams:

Routine physical exams are covered in specific instances, including but not limited to:

- EPSDT screening
- Nursing facility placement exams
- Disability determinations for Title XVI-related individuals
- Yearly exams for developmental disability determination (DDD) clients

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5. a. Physicians' services (cont.)

(6) Physician care plan oversight.

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

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

(8) Physician visits.
Limited to:

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

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

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

(9) Psychiatric services:
Limited to:
Inpatient care
- One hospital call per day for direct psychiatric care

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

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

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5. a. Physicians' services (cont.)

(10) Physiatry services

- The Department does not cover duplicate services for occupational and physical therapy for the same client when both providers are performing the same or similar procedure(s).
- The Department does not pay separately for physical therapy services that are included as part of the payment for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.
- The Department does not limit covered physical therapy services for clients 20 years of age and younger.
- For adults:

- 1 physical therapy evaluation (in addition to the 48 program unit limitation below) per calendar year
- 48 physical therapy program units per calendar year
- 2 DME needs assessments (in addition to the 48 program unit limitation) per calendar year
- 1 wheelchair needs assessment (in addition to the DMS needs assessments) per calendar year
- Prior authorization is required for additional program units that are medically necessary

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

Services may be provided by a physician, doctor of dentistry, or doctor of dental surgery.

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

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

a. Podiatrists' services

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

(2) Foot conditions for which treatment is not medically necessary (e.g. the treatment of flat feet, treatment of superficial fungal infection of the skin or nail, bunions, or hammertoes) are not covered.

(3) Reimbursement is according to Attachment 4.19-B III. Physicians' Services.

b. Optometrists' services

(1) The Medicaid agency covers medically necessary eye examinations, refractions, and fitting fees every 24 months for asymptomatic adults 21 years of age and older.

(2) Exceptions will be considered for all individuals based on medical necessity.

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

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6. d. Other practitioners' services

(1) All other practitioners covered by the department include, but are not limited to, the following licensed practitioners: naturopathic physicians (services are limited to physician-related primary care services), physician assistants, advanced registered nurse practitioners including certified registered nurse anesthetists, psychologists, dental hygienists, denturists, chiropractors (for EPSDT only), opticians, and licensed non-nurse midwives, These practitioners are limited to services within their scope of practice and specialty area.

(2) Counselors, social workers, and other practitioners are covered as specified in other sections of the State Plan and as approved by the department.

(3) Mental health outpatient services may be provided by the following providers licensed by the state under 42 CFR 440.060(a): Licensed Psychologists; Licensed Psychiatric Advanced Nurse Practitioners; Licensed Independent Clinical Social Workers; Licensed Advanced Social Workers; Licensed Marriage and Family Therapists; and Licensed Mental Health Counselors.

The practitioners listed above who want to diagnose and treat clients eighteen years of age and younger must have a minimum of two years' experience in the diagnosis and treatment of clients eighteen years of age and younger, including one year of supervision by a mental health professional trained in child and family mental health.

Mental health payment rate methodology is in accordance with Attachment 4.19-B.

(4) The Medicaid agency does not cover services provided by:
- Acupuncturists
- Christian Science practitioners or theological healers
- Herbalists
- Homeopathists
- Masseuses
- Masseurs
- Sanipractors

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

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

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6. d. Other practitioners' services (cont)

(7) Intensive behavior services (EPSDT only) provided by:

A. A lead behavior analysis therapist (LBAT) who under Washington State law is licensed under one of the following provisions and either a board-certified applied behavior analyst (BCBA) or is deemed board-qualified by the Behavior Analyst Certification Board, **and** one of the following:

- A psychiatrist, psychiatric advanced nurse practitioner, psychologist, mental health counselor, marriage or family therapist, or clinical social worker licensed by the Department of Health (DOH) and practicing under the scope of state law as defined by DOH RCW and WAC;
- A licensed certified counselor or counselor advisor practicing under the scope of state law as defined by DOH RCW and WAC and supervised by a mental health professional licensed by the DOH and practicing under the scope of state law as defined by DOH RCW and WAC; or
- A licensed mental health professional as defined in Attachment 3.1-B 13 d.7 of the State Plan, who is employed or contracted with an agency licensed by DOH or by the Department of Social and Health Services (DSHS) as a Community Mental Health Agency and also holds a certificate to provide Applied Behavior Analysis (ABA) therapy services. This professional must also be licensed as a registered agency-affiliated counselor with DOH and practicing consistent with the provisions of DOH RCW, WAC and DSHS WAC.

Note: These professionals may supervise other providers, including intensive behavior therapy assistants licensed and practicing under applicable DOH RCW, WAC and DSHS WAC.

B. A therapy assistant who is one of the following:

- A licensed certified counselor or counselor advisor practicing under the scope of state law and supervised by an LBAT who is a mental health professional licensed by the DOH and practicing under the scope of state law as defined by DOH RCW and WAC; or
- A licensed registered agency-affiliated counselor, who is employed or contracted with an agency licensed by the DOH or by DSHS as a Community Mental Health Agency and also holds a certificate to provide ABA therapy services. These providers must practice under applicable DOH RCW, WAC and DSHS WAC, are supervised by an LBAT who is a licensed mental health professional as described above, employed or contracted by the licensed agency and practicing consistent with applicable DOH RCW, WAC and DSHS WAC. Their services are billed for by the agency.

C. The State provides assurance that these licensed providers are:

- Providing services consistent with §440.60.
- Supervising according to the State's Scope of Practice Act for licensed practitioners.
- Assuming professional responsibility for the services provided by the therapy assistants.

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7. Home health services

a. Intermittent or part-time nursing services

(1) Applies to home health agency and to services provided by a registered nurse when no home health agency exists in the area.

(2) Approval required when period of service exceeds limits established by the single state agency.

(3) Nursing care services are limited to:

(a) Services that are medically necessary;

(b) Services that can be safely provided in the home setting;

(c) Two visits per day (except for the services listed below);

(d) Three obstetrical visits per pregnancy for high risk pregnancy clients; and

(e) Infant home phototherapy that was not initiated in the hospital setting.

(4) Exceptions are made on a case-by-case basis.

Approval required when period or services or total monthly reimbursement exceeds limits established by the single state agency. Applies to home health agency and to services provided by a registered nurse when no home health agency exists in area.

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

Home health aide services must be:

(1) Intermittent or part time;

(2) Ordered by a physician on a plan of care established by the nurse or therapist;

(3) Provided by a Medicare-certified home health agency;

(4) Limited to one medically necessary visit per day; and

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7. Home health services (cont.)

(5) Supervised by the nurse or therapist biweekly in the client's home.

(6) Exceptions are made on a case-by-case basis.

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

Medical supplies, equipment and appliances must be:

- Medically necessary;
- In the client's plan of care; and
- Ordered by the treating physician and renewed annually.

All of the following apply to durable medical equipment (DME) and related supplies, prosthetics, orthotics, medical supplies and related services suitable for use in the home:

- Purchase of equipment and appliances and rental of durable medical equipment require prior approval.
- Specific reusable and disposable medical supplies, prosthetics, orthotics, and non-durable equipment which have set limitations, require prior approval (PA) to exceed those limitations.

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

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

Limitations described below do not apply to the Medical Nutrition Program for clients under age 21 under EPSDT. All other exceptions to these limitations require prior authorization on a case-by-case basis and are based on medical necessity.

- Initial assessments limited to 2 hours (or 8 units) per year
- Reassessments limited to no more than 1 hour (or 4 units) per day
- Training and education provided to groups limited to 1 hour (or 4 units) per day

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

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

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

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7. d. Home health services (cont.)

Limitations for physical, occupational, and speech therapy

The following therapy units are limited as follows, per client per year:

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

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

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

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

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

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8. Private duty nursing services

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

The department contracts with State licensed home health agencies to provide PDN services. Within the home health agency, private duty nursing services must be performed by a licensed and appropriately trained registered nurse and/or a licensed practical nurse. For persons 18 years and older with an approved exception to policy, a private (non-home health agency) RN or LPN under the direction of a physician can provide PDN services only when the geographic location precludes a contracted home health agency from providing services, or when no contracted home health agency is willing to provide PDN services.

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

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9. Clinic services

a. Freestanding kidney centers

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

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

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

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

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

b. Freestanding ambulatory surgery centers

Allowed procedures are covered when they:

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

Some procedures are covered only when they:

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

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10. Dental services and dentures

The Medicaid Agency covers the services listed below for eligible clients as indicated. Some of these services may require prior authorization. Limitations described do not apply for children age 20 and under for EPSDT purposes and may be exceeded based on documented medical necessity with prior authorization. Beneficiaries who have a developmental disability, are clients of the Developmental Disabilities Administration (DDA), or qualify for services in the DDA may exceed the service limitations listed in sections I and II.

I.For clients age 21 and over

A. Preventive care
   1. Behavior management
   2. Examinations
      a. Periodic oral evaluations once every 6 months
      b. Comprehensive evaluations once every 5 years
   3. Fluoride, once in a 12-month period, per client, per provider/clinic
   4. Prophylaxis
      a. Once every 12 months
      b. Not covered in conjunction with periodontal maintenance or root planing/scaling
      c. Must be at least 12 months after periodontal maintenance or root planing/scaling
   5. X-rays (radiographs)
      a. Intraoral complete series once every 3 years
      b. Maximum of 4-bitewing x-rays every 12 months
      c. Panoramic x-rays in conjunction with 4-bitewings once every 3 years, only if the agency has not paid for an intraoral complete series in the same 3-year period

B. Treatment
   1. Biopsy
      a. Soft oral tissue
      b. Brush
      c. 2. Endodontic treatment for permanent anterior teeth
   3. Extractions
      a. Prior authorization required for extractions of 4 or more teeth in a 6 month period resulting in edentulism
      b. Prior authorization required for unusual and complicated surgical extractions
   4. Periodontic services
      a. Scaling and root planning performed at least 12 months after periodontal maintenance
      b. Maintenance performed at least 12 months after scaling and root planing
   5. Resin-based composite restorations 1 time in a 2-year period unless the restoration has an additional adjoining carious surface

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10. Dental services and dentures (cont)

6. Nonemergency oral surgeries performed in an inpatient hospital setting are not covered. The exception is for clients of the Developmental Disabilities Administration whose surgery cannot be performed in an office setting. Documentation must be maintained in the client's record.

C. Dentures

1. Complete and overdentures
   a. 1 maxillary and 1 mandibular in a 5-year period
   b. Prior authorization required
2. Complete or partial rebase or relines once every 3 years when performed at least 6 months after the seating date
3. Resin partial dentures
   a. Once every 3 years
   b. Prior authorization required

II. For clients age 20 and under

A. Preventive care

1. Examinations
   a. Periodic oral evaluations once every 6 months
   b. Comprehensive evaluations once every 5 years
2. Fluoride (per client, per provider/clinic)
   a. For clients age 6 and younger, 3 times in a 12-month period
   b. For clients age 7 through 18, 2 times in a 12-month period
   c. For clients age 19 through 20, 1 time in a 12-month period
3. Oral hygiene instruction
   a. For clients age 8 and younger only
   b. Up to 2 times in a 12-month period in a setting other than a dental office
4. Prophylaxis
   a. Not covered in conjunction with periodontal maintenance or root scaling/planing
   b. For clients age 18 and younger
      i. Once every 6 months
      ii. Must be at least 6 months after periodontal maintenance or root scaling/planing
   c. For clients age 19 through 20
      i. Once every 12 months
      ii. Must be at least 12 months after periodontal maintenance or root scaling/planing

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10. Dental services and dentures (cont)

5. Pulp vitality test, one per visit
6. Sealants
   a. Once per tooth in a 3-year period
   b. Only for permanent teeth 2, 3, 14, 15, 18, 19, 30, 31
   c. Only for primary teeth A, B, I, J, K, L, S, T
   d. Only when placed on a tooth with no preexisting occlusal restoration or any occlusal restoration placed on the same day
7. Space maintenance
   a. Only one space maintainer per quadrant
   b. Fixed unilateral or fixed bilateral space maintainers, including recementation for missing primary molars A, B, I, J, K, L, S, T
8. X-rays (radiographs)
   a. Occlusal intraoral x-rays once in a 2-year period
   b. Intraoral complete series for clients age 4 and older
   c. Maximum of 4-bitewing x-rays every 4 months
   d. Panoramic x-rays in conjunction with 4-bitewings once every 3 years, only if the agency has not paid for an intraoral complete series in the same 3-year period

B. Treatment
1. Apexification/apicoestomy
   a. Apexification for apical closures for anterior permanent teeth
      i. Limited to the initial visit and 3 interim treatment visits
      ii. Prior authorization required
   b. Apicoestomy for anterior teeth only
2. Biopsy
   a. Soft oral tissue
   b. Brush
3. Crowns
   a. Prefabricated stainless steel crowns
      i. For primary anterior and posterior teeth once every 3 years for clients age 20 and younger
      ii. For permanent posterior teeth, excluding 1, 16, 17, 32
      iii. Prior authorization required for anterior teeth for clients age 13 through 20
   b. Indirect crowns
      i. Once every 5 years for permanent anterior teeth for clients age 15 through 20
      ii. Prior authorization required
4. Endodontic treatment
   a. For primary incisor teeth D, E, F, and G if entire root is present
   b. For permanent anterior, bicuspid, and molar teeth, excluding 1, 16, 17, 32
5. Extractions
   a. Prior authorization required for unusual and complicated surgical extractions
   b. Prior authorization required for extractions of 4 or more teeth in a 6-month period resulting in edentulislm
6. Occlusal orthotic devices for clients age 12 through 20 with prior authorization

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10. Dental services and dentures (cont)

7. Office-based anesthesia – prior authorization required for clients age 9 through 20
8. Oral surgery
   a. In an ambulatory surgery center, outpatient, or inpatient hospital setting when the service cannot be performed in an office setting
   b. Prior authorization required for clients age 9 through 20
   c. Prior authorization not required for clients of the Disability Determination Administration
9. Periodontic services
   a. Prior authorization required for gingivectomy/gingivoplasty
   b. Periodontal scaling/root planing for clients age 13 through 20
      i. Once per quadrant, per client, in a 2-year period
      ii. Must be performed at least 12 months after periodontal maintenance
      iii. Prior authorization required for clients age 13 through 18
   c. Periodontal maintenance for clients age 13 through 20
      i. Once per client in a 12-month period
      ii. Must be performed at least 12 months after periodontal root scaling/planing
      iii. Prior authorization required for clients age 13 through 18
10. Pulpotomy
   a. Therapeutic pulpotomy on primary teeth
   b. Pulpal debridement on permanent teeth, excluding 1, 16, 17, 32
11. Surgical incisions
   a. For frenuloplasty/frenulectomy
   b. Prior authorization required for clients age 7 through 20

C. Orthodontic treatment
1. Limited to medically necessary treatment

D Dentures
1. Complete and overdentures
   a. 1 maxillary and 1 mandibular denture in a 5-year period
   b. Prior authorization required
2. Partial dentures
   a. Cast metal, once every 5 years
   b. Resin, once every 3 years and requires prior authorization
3. Complete or partial rebase or reline once every 3 years when performed at least 6 months after the seating date

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

    a. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders are provided in accordance with 42 CFR 440.110.
    b. Duplicate services for occupational, physical, and speech therapy are not allowed for the same client when providers are performing the same or similar procedure(s).
    c. Limitations do not apply for clients under the age of 21 under EPSDT.
    d. Prior authorization is required to exceed set limits for clients twenty-one (21) years of age and older as follows:

        (1) For physical therapy (PT) services beyond one PT evaluation and 24 units (approximately 6 hours) PT per calendar year, per client.
        (2) For occupational therapy (OT) services beyond one OT evaluation and 24 OT units (approximately 6 hours) per calendar year, per client.
        (3) For speech therapy (ST) services beyond one speech evaluation and 6 units/visits of speech therapy per calendar year, per client.

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

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

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

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12. a. Prescribed drugs

Drug Coverage

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

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

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

Prior Authorization

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

(5) HRSA determines which prescription drugs may require prior authorization by reviewing the drug(s) for the following:

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

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

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12. a. Prescribed drugs (cont.)

Supplemental Rebate Agreement

(7) The state is in compliance with Section 1927 of the Act. The state will cover drugs of manufacturers participating in the Medicaid Drug Rebate Program. Based on the requirements for Section 1927 of the Act, the state has the following policies for drug rebate agreements:

- Manufacturers are allowed to audit utilization rates;
- The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification, in accordance with Section 1927 (b)(3)(D);
- A rebate agreement between the state and a drug manufacturer for drugs provided to the Washington Medicaid population, submitted to CMS on July 15, 2008, entitled “State of Washington Supplemental Rebate Contract” has been authorized by CMS.
- The state reports rebates from separate agreements to the Secretary for Health and Human Services (HHS). The state will remit the federal portion of any cash state supplemental rebates collected on the same percentage basis applied under the national rebate agreement.
- All drugs covered by the program, irrespective of a prior authorization agreement, will comply with provisions of the national drug rebate agreement.

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12. a. Prescribed drugs (cont.)

Preferred Drug List

- Pursuant to 42 U.S.C. section 1396r-8, the State is establishing a preferred drug list with prior authorization for drugs not included on the preferred drug list. Prior authorization programs for covered outpatient drugs provide for a response within 24 hours of a request for prior authorization, and provides for the dispensing of at least a 72-hour supply of medications in emergency situations, in accordance with provisions of section 1927(d)(5) of the Social Security Act. The prior authorization process is described in chapter 388-530 WAC.
- Prior authorization will be established for certain drug classes or particular drugs in accordance with Federal law. All drugs covered by the program, irrespective of a prior authorization requirement, will comply with the provisions of the national drug rebate agreement.
- A preferred drug list does not prevent Medicaid beneficiaries from obtaining access to medically necessary drugs of manufacturers that participate in the national drug rebate program.
- The State will utilize the Drug Utilization Review Board to assure, that in addition to pricing consideration, preferred drugs are clinically appropriate.

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12. a. Prescribed Drugs (continued)

Citation	Provision
1935(d)(1)	Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full- benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.
1927(d)(2) and 1935(d)(2)	(a) The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D.

_X_ **The following excluded drugs are covered:**

select (i) Agents when used for anexoria, weight loss, weight gain: Progestin derivative appetite stimulant, androgenic agents

_No_ (ii) Agents when used to promote fertility

_No_ (iii) Agents when used for cosmetic purposes or hair growth

select (iv) Agents when used for the symptomatic relief cough and colds: antitussives, expectorants, decongestants, nasal spray, and only the following generic, single ingredient formulations:

_X_ (v) Prescription vitamins and mineral products, except prenatal vitamins and fluoride for documented deficiency

Guiafenesin 100mg/5ml liquid or syrup;
Dextromethorphan 15mg/5ml liquid or syrup;
Pseudoephedrine 30mg or 60 mg tablets;
Saline nasal spray 0.65%; and
Generic combination product:dextromethorphan-guaifenesin 10-100mg/5ml syrup, including sugar-free formulations.

_select (vi) Nonprescription (OTC) drugs when determined by the department to be the least costly therapeutic alternative for a medically accepted indication in the following therapeutic classes: allylamines, analgesics, antacids, anthelmintics, anti-inflammatories, antiallergics, antibacterials, antidiarrheals, antiemetics, antiflatulents, antifungals, antihistamines, antihypoglycemics, anti-infectives, antiparasitics, antipruritics, antipyretics, antitussives, antivertigo agents, cathartics, contraceptive foams, contraceptives,

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12. a. Prescribed Drugs (continued)

corticosteroids, decongestants, EENT preparations, emergency contraceptives, emetics, expectorants, gi antihistamines, histamine h2-antagonists, iron preparations, keratoplastic agents, laxatives, liniments, lotions, mucolytics, nicotine replacement therapies, nonsteroidal anti-inflammatory, pediculicides, progestins, proton-pump inhibitors, respiratory tract agents, salicylates, scabicides, steroidal anti-inflammatories, sympathomimetics, vasoconstrictors.

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

___ No excluded drugs are covered.

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12. b. Dentures

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

12. c. Prosthetic devices

(1) Prior approval required

(2) Hearing aids provided on the basis of minimal decibel loss

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

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13. c. Preventive services

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

The Medicaid agency covers alcohol and substance misuse counseling through screening, brief interventions, and referral to treatment (SBIRT) when provided by, or under the supervision of, a certified physician or other certified licensed healthcare provider within the scope of their practice.

PROVIDERS

1. The following health care professionals are eligible to become qualified SBIRT providers to deliver SBIRT services or supervise qualified staff to deliver SBIRT services:
   - Advanced registered nurse practitioner (ARNP) (must be licensed per chapters 18.79 RCW and 246-840 WAC)
   - Chemical dependency professional (must be licensed per chapters 18.205 RCW and 246-811 WAC)
   - Licensed practical nurse (must be licensed per chapters 18.79 RCW and 246-840 WAC)
   - Mental health counselor (must be licensed per chapters 18.225 RCW and 246-809 WAC)
   - Marriage and family therapist (must be licensed per chapters 18.225 RCW and 246-809 WAC)
   - Independent and advanced social worker (must be licensed per chapters 18.225 RCW and 246-809 WAC)
   - Physician (must be licensed per chapters 18.71 RCW and 246-919 WAC)
   - Physician assistant (must be licensed per chapters 18.71A RCW and 246-918 WAC)
   - Psychologist (must be licensed per chapters 18.83 RCW and 246-840 WAC)
   - Registered nurse (must be licensed per chapters 18.79 RCW and 246-840 WAC)
   - Dentist (must be licensed per chapters 18.260 and 246-817 WAC)
   - Dental hygienist (must be licensed per chapters 18.29 RCW and 246-818 WAC)

2. To qualify as a qualified SBIRT provider, eligible licensed health care professionals must complete a minimum of 4 hours of SBIRT training and mail or fax proof of SBIRT training completion to the Medicaid agency.

3. The following qualified SBIRT health care professionals may bill for SBIRT services:
   - Advanced registered nurse practitioner (ARNP) (must be licensed per chapters 18.79 RCW and 246-840 WAC)
   - Marriage and family therapist (must be licensed per chapters 18.225 RCW and 246-809 WAC)
   - Independent and advanced social worker (must be licensed per chapters 18.225 RCW and 246-809 WAC)
   - Physician (must be licensed per chapters 18.71 RCW and 246-919 WAC)
   - Psychologist (must be licensed per chapters 18.83 RCW and 246-840 WAC)

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13. c. Preventive services

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

- Dentist (must be licensed per chapters 18.260 and 246-817 WAC)
- Dental hygienist (must be licensed per chapters 18.29 RCW and 246-818 WAC)

SERVICES

1. SBIRT services must be provided in a primary care setting, including a dentist office.
2. SBIRT services are covered for determining risk factors that are related to alcohol and other drug use disorders. SBIRT services are:
    - Screening and assessment (occurs during an E/M exam)
    - Brief intervention in the form of counseling (limited to 4 sessions per client per provider per calendar year)
    - Referral for treatment, if indicated
3. Washington covers and reimburses all United States Preventive Services Task Force (USPSTF) grade A and B preventive services and approved vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), and their administration, without cost-sharing, when provided in a practitioners' office setting.

    Preventive services specified in section 4106 of the Affordable Care Act are all available under the State Plan and are covered under the following service benefits and are reimbursed according to the methodologies provided in Attachment 4.19-B for such services:
    - Clinics
    - Physicians
    - Dentists
    - Other licensed practitioners

    In addition to the services specified under section 4106 of the Affordable Care Act, Washington covers, without cost-sharing, services specified under PHS 2713 which is in alignment with the Alternative Benefit Plans.

    The State will maintain documentation supporting expenditures claimed for these preventive services and ensure that coverage and billing codes comply with any changes made to the USPSTF or ACIP recommendations.

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13. d. Rehabilitative services

(1) Physical medicine and rehabilitation as requested and approved.

(2) Alcohol and drug treatment services

(a) Alcohol/drug screening and brief intervention

(i) Description of services
A combination of services designed to screen for risk factors that appear to be related to alcohol and other drug use disorders, provide interventions to enhance patient motivation to change, and make appropriate referral as needed.

(ii) Provider qualifications
Alcohol/drug screening and brief intervention services must be performed by the following practitioners who are licensed and/or certified by the Washington State Department of Health (DOH) according to DOH Revised Code of Washington (RCW) and Washington Administrative Code (WAC) in effect as of July 1, 2009, as follows:

(A) Advanced registered nurse practitioner (ARNP) - chapter 18.79 RCW and chapter 246-840 WAC. Must be licensed in Washington as a registered nurse and graduated from an advanced nursing education program within the last year.

(B) Chemical dependency professionals (CDP) - chapter 18.205 RCW and chapter 246-811 WAC. Must have an AA in human services or a related field from an approved school or completion of 90 quarter or 60 semester credits. At least 45 quarter or 30 semester credits must be in courses related to the CDP profession.

(C) Mental health counselor – chapter 18.225 RCW and chapter 246-809 WAC. Must have a Master's or Doctoral level degree in mental health counseling or a related field from an approved college or university.

(D) Marriage and family therapist – chapter 18.225 RCW and chapter 246-809 WAC. Must have a Master's or Doctoral degree in marriage and family therapy or in behavioral science, with equivalent course work from an approved school. American Association for Marriage and Family Therapy (AAMFT) clinical membership meets education requirements.

(E) Social worker – chapter 18.225 RCW and chapter 246-809 WAC. Must have a Master's or Doctoral degree from an educational program accredited by the Council on Social Work Education.

(F) Physician (MD) - chapter 18.71 RCW and chapter 246-919 WAC. Must be a graduate of a school of medicine approved by the Washington State Medical Quality Assurance Commission (WSMQA) and complete two years of postgraduate medical training in a program acceptable to WSMQA.

(G) Physician assistant (PA) - chapter 18.71A RCW and chapter 246-918 WAC. Must have a Physician Assistant degree from an accredited program and successfully complete the National Commission on Certification of Physician Assistants (NCCPA) examination.

(H) Psychologist - chapter 18.83 RCW and chapter 246-924 WAC. Must have a Doctoral degree from a regionally accredited institution.

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13. d. Rehabilitative Services (cont)

(iii) Settings
Services may be delivered in residential facilities that do not exceed 16 beds, outpatient facilities, and Indian Health Service facilities. All service delivery settings must meet the requirements of chapters 388-805 and 246-337 WAC in effect as of July 1, 2010, including but not limited to, the following: have a Department of Health or business license, whichever is applicable; have sufficient qualified staff to deliver services; have a department-approved program/treatment plan; and develop and maintain administration, personnel, and clinical policies and procedures.

(b) Inpatient alcohol and drug detoxification

(i) Alcohol detoxification is limited to three days.

(ii) Drug detoxification is limited to five days.

(iii) Services required for the care and/or treatment of individuals intoxicated or incapacitated by alcohol or other drugs are provided during the initial period of care and treatment while the person recovers from the transitory effects of acute or chronic intoxication or withdrawal from alcohol or other drugs. Services are provided in certified facilities with 16 beds or less and exclude room and board. Services include:
(A) Screening and detoxification of intoxicated persons; and
(B) Counseling of persons admitted to a program within a certified facility, regarding their illness in order to stimulate motivation to obtain further treatment, and referral of detoxified chemically dependent (alcoholism or drug addiction) persons to other appropriate chemical dependency services providers (treatment programs).

(iv) Screening and detoxification of intoxicated persons
(A) All personnel providing patient care, except licensed medical and nursing staff, must complete a minimum of forty hours of documented training before assignment of patient care duties. Training includes:
(I) Chemical dependency;
(II) HIV/AIDS and hepatitis B education;
(III) TB prevention and control;
(IV) Detoxification screening, admission, and signs of trauma;
(V) Cardio-pulmonary resuscitation (CPR); and
(VI) First aid.
(B) If providing acute detoxification services, a licensed nurse must be on-site to monitor the screening and detoxification of the intoxicated person.
(C) If providing sub-acute detoxification services, the certified facility must establish agreements with authorized health care providers or hospitals that include:
(I) Criteria for determining the degree of medical stability of a resident;
(II) Monitoring the resident after being admitted;
(III) Reporting abnormal symptoms according to established criteria;
(IV) Criteria requiring immediate transfer to a hospital, when necessary; and
(V) Resident discharge or transfer criteria.

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13. d. Rehabilitative Services (cont)

(v) Screening, detoxification, and referral services must be performed by the following practitioners, as indicated below, who are licensed and/or certified by DOH according to DOH RCW and WAC in effect as of July 1, 2009, as follows:

(A) Advanced registered nurse practitioner (ARNP): provides screening, detoxification, and referral. Meets requirements of chapter 18.79 RCW and chapter 246-840 WAC. See section (2)(a)(ii) *Provider Requirements* above.

(B) Chemical dependency professionals (CDP): provides screening and referral. Meets requirements of chapter 18.205 RCW and chapter 246-924 WAC. See section (2)(a)(ii) *Provider Requirements* above.

(C) Licensed practical nurse (LPN): provides screening, detoxification, and referral. Meets requirements of chapter 18.79 RCW and chapter 246-840 WAC. Must be graduated from an approved practical nursing program.

(D) Mental health counselor: provides screening and referral. Meets requirements of chapter 18.225 RCW and chapter 246-809 WAC. See section (2)(a)(ii) *Provider Requirements* above.

(E) Marriage and family therapist: provides screening and referral. Meets requirements of chapter 18.225 RCW and chapter 246-809 WAC. See section (2)(a)(ii) *Provider Requirements* above.

(F) Social worker: provides screening and referral. Meets requirements of chapter 18.225 RCW and chapter 246-809 WAC. See section (2)(a)(ii) *Provider Requirements* above.

(G) Physician (MD): provides screening, detoxification, and referral. Meets requirements of chapter 18.71 RCW and chapter 246-919 WAC. See section (2)(a)(ii) *Provider Requirements* above.

(H) Physician assistant (PA): provides screening, detoxification, and referral. Meets requirements of chapter 18.71A RCW and chapter 246-918 WAC. See section (2)(a)(ii) *Provider Requirements* above.

(I) Psychologist: provides screening and referral. Meets requirements of chapter 18.83 RCW and chapter 246-924 WAC. See section (2)(a)(ii) *Provider Requirements* above.

(J) Registered nurse (RN): provides screening, detoxification, and referral. Meets requirements of chapter 18.79 RCW and chapter 246-840 WAC. Must successfully complete an approved nursing education program

(vi) Counseling services for persons admitted must be performed by a Chemical Dependency Professional (CDP) certified in chemical dependency counseling by DOH. To be certified, a CDP must meet the education, training, and experience required in chapter 246-811 WAC in effect as of July 1, 2010. See section (2)(a)(ii) *Provider Requirements* above.

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13. d. Rehabilitative Services (cont)

(vii) Alcohol and drug detoxification is provided on an inpatient basis in certified facilities which are:
- (A) Within the physical location and the administrative control of a general hospital; or
- (B) Freestanding facilities established to provide these services.

(viii) Provider qualifications
- (A) The freestanding facility in which the care is provided must be:
  - (I) Licensed by DOH, ensuring it meets all health and safety standards for licensure and operations for residential treatment facilities under DOH's WAC; and
  - (II) Certified by the Division of Behavioral Health and Recovery (DBHR), ensuring it meets all standards and processes necessary to be a certified chemical dependency service provider (treatment program) under DBHR's WAC.
- (B) The program under which services are provided must be certified by DBHR, ensuring it meets all standards and processes necessary to be a certified chemical dependency service provider (treatment program) under DBHR's WAC.

(c) Chemical dependency treatment

(i) Description of services
- (A) Rehabilitative services of diagnostic evaluation and face-to-face individual or group counseling using therapeutic techniques that are:
  - (I) Directed toward patients who are harmfully affected by the use of mood-altering chemicals or are chemically dependent; and
  - (II) Directed toward a goal of abstinence for chemically dependent persons.
- (B) Patient placement decisions are based on admission, continued service, and discharge criteria found in the *Patient Placement Criteria for the Treatment of Substance-Related Disorders* as published by the American Society of Addiction Medicine (ASAM).

(ii) Provided in certified programs that include:
- (A) Outpatient treatment in chemical dependency treatment centers; and
- (B) Treatment services, *excluding board and room*, provided in residential treatment facilities with 16 beds or less.

(iii) Goal-oriented rehabilitation (treatment) plans are identified under a written rehabilitation plan that meets DBHR WAC requirements that include, but are not limited to:
- (A) Patient involvement in treatment planning;
- (B) Treatment goals and documentation of progress toward patient attainment of the treatment goals; and
- (C) Completeness of patient records, which include:
  - (I) Demographic information;
  - (II) Assessment and history of involvement with alcohol and other drugs:
  - (III) Initial and updated individual treatment plans;
  - (IV) Date, duration, and content of counseling sessions; and
  - (V) Voluntary consent to treatment, signed and dated by the patient.

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13. d. Rehabilitative services (cont)

(iv) Provider Qualifications

(A) The outpatient chemical dependency service treatment center and program must be certified by DBHR, ensuring it meets all standards and processes necessary to be a certified chemical dependency service provider (treatment program) according to DBHR WAC.

(B) The residential treatment facility in which the care is provided and program must be certified by DBHR and licensed by DOH, ensuring it meets:

(I) All health and safety standards for licensure and operations for residential treatment facilities according to DOH WAC; and

(II) All standards and processes necessary to be a certified chemical dependency treatment program according to DBHR WAC.

(v) Counseling services for persons admitted must be performed by a Chemical Dependency Professional (CDP) certified in chemical dependency counseling by DOH. To be certified, a CDP must meet the education, training, and experience required in chapter 246-811 WAC. See section (2)(a)(ii) *Provider Requirements* above.

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13. d. Rehabilitative services (cont.)

7. Mental Health Rehabilitation services are integrated treatment services recommended by a mental health professional furnished by state licensed Community Mental Health Agencies. Services are provided to seriously mentally ill adults and seriously emotionally disturbed children for whom the services are determined to be medically necessary. These services must be provided to reach the goals of an Individualized Service Plan. Payment rates are established per Attachment 4.19-B XVIII.

The services to be provided are:

- Brief Intervention Treatment;
- Crisis services;
- Day Support;
- Family treatment;
- Freestanding Evaluation and Treatment;
- Group treatment services;
- High Intensity Treatment;
- Individual Treatment Services;
- Intake evaluation;
- Medication Management;
- Medication Monitoring;
- Mental Health Services provided in Residential settings;
- Peer Support;
- Psychological Assessment;
- Rehabilitation Case Management;
- Special population evaluation;
- Stabilization Services; and,
- Therapeutic psychoeducation.

A. Definition of medical necessity as it relates to mental health services

Medical necessity or *medically necessary* – “A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause of physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. For the purpose of this chapter "course of treatment" may include mere observation, or where appropriate, no treatment at all.

Additionally, the individual must be determined to 1) have a mental illness covered by Washington State for public mental health services; 2) the individual’s impairment(s) and corresponding need(s) must be the result of a mental illness; 3);

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the intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness

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

4) the individual is expected to benefit from the intervention; and 5) any other formal or informal system or support can not address the individual's unmet need.

Medical necessity is determined by a mental health professional. All state plan modality services are accessible based on clinical assessment, medical necessity and individual need. Individuals will develop with their mental health care provider an appropriate individual service plan. The services are provided by Community Mental Health Agencies licensed or certified by the Mental Health Division and provided by, or under the supervision of, a mental health professional. Services are assured in accordance with 1902(a)(23).

The following is a descriptive list of the employees or contracted staff of community mental health agencies providing care.

(1) *Mental health professional* means:
- (A) A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapter 71.05 and 71.34 RCW;
- (B) A person with a masters degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional;
- (C) A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986.
- (D) A person who had an approved waiver to perform the duties of a mental health profession that was requested by the regional support network and granted by the mental health division prior to July 1, 2001; or
- (E) A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the mental health division consistent with WAC 388-865-265.

Within the definition above are the following:

"Psychiatrist" means a person having a license as a physician in this state who has completed residency training in psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and is board eligible or board certified in psychiatry.

"Psychologist" means a person who has been licensed as a psychologist pursuant to chapter 18.83 RCW;

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

"Social worker" means a person with a master's or further advanced degree from an accredited school of social work or a degree deemed equivalent under rules adopted by the secretary;

"Child psychiatrist" means a person having a license as a physician and surgeon in this state, who has had graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board eligible or board certified in child psychiatry.

"Psychiatric nurse" means a registered nurse who has a bachelor's degree from an accredited college or university, and who has had, in addition, at least two years experience in the direct treatment of mentally ill or emotionally disturbed persons, such experience gained under the supervision of a mental health professional. "Psychiatric nurse" shall also mean any other registered nurse who has three years of such experience.

"Counselor" means an individual, practitioner, therapist, or analyst who engages in the practice of counseling to the public for a fee. A "counselor", engaging in the practice of counseling, can include an agency affiliated counselor, certified counselor, or certified adviser. Specific qualifications and licensing/certification requirements are described in chapter18.19 RCW and chapter 246-810 WAC.

(2) *"Mental Health Care Provider"* means the individual with primary responsibility for implementing an individualized plan for mental health rehabilitation services. Minimum qualifications are B.A. level in a related field, A.A. level with two years experience in the mental health or related fields.

(3) *"Peer Counselor"* means the individual who: has self-identified as a consumer or survivor of mental health services; has received specialized training provided/contracted by the Mental Health Division; has passed a written/oral test, which includes both written and oral components of the training; has passed a Washington State background check; has been certified by the Mental Health Division; and is registered as a counselor with the Department of Health.

Peer Counselors must self identify as a consumer or survivor of mental health services. Peer Counselors must demonstrate:

1. That they are well grounded in their own recovery for at least one year;
2. Willingness to a pretest for reading comprehension and language composition; and,
3. Qualities of leadership, including governance, advocacy, creation, implementation or facilitation of peer-to-peer groups or activities.

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

Peer Counselors must be able to:
Identify services and activities that promote recovery by instilling hope and experiences which lead to meaning and purpose, and which decrease stigma in the environments in which they serve;

- Articulate points in their own recovery stories that are relevant to the obstacles faced by consumers of mental health services;
- Promote personal responsibility for recovery as the individual consumer or mental health services defines recovery;
- Implement recovery practices in the broad arena of mental health services delivery system;
- Provide a wide range of tasks to assist consumers in regaining control over their own lives and recovery process (e.g., promoting socialization, self advocacy, developing natural supports stable living arrangements, education, supported employment);
- Serve as a consumer advocate;
- Provide consumer information and peer support in a range of settings; and,
- Model competency in recovery and ongoing coping skills.

The training provided/contracted by the mental health division shall be focused on the principles and concepts of recovery and how this differs from the medical model, the creation of self-help and coping skills and advocacy. Training will include:

- Understanding the public mental health system;
- What is peer support and how it promotes recovery;
- How to advocate for age appropriate peer support projects;
- How to facilitate groups and teams;
- Understanding self-directed recovery;
- How to create your own self-help coping skills plan;
- How to start and sustain self-help/mutual support groups;
- How to form and sustain a personal support team;
- How to promote recovery, self-determination and community reintegration;
- Assist consumers to do for themselves and each other;
- Assist in skill building, goal setting, problem solving;
- Assist consumers to build their own self-directed recovery tools; and,
- Assist consumers by supporting them in the development of an individual service plan that has recovery goals and specific steps to attain each goal.

Peer Counselors who were trained prior to the implementation of the Washington Administrative Code by National Consultants to be Certified facilitators who pass the test and the background check, and are registered counselors may be grandfathered as Peer counselors until January 2005. After January 2005, it will be necessary for them to take the training.

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

(4) “Registered nurse” means a person licensed to practice registered nursing under chapter 18.79 RCW.

(5) “Nurse practitioner” means a person licensed to practice advanced registered nursing under chapter 18.79 RCW.

(6) “Licensed practical nurse” means a person licensed to practice practical nursing under chapter 18.79 RCW.

(7). "Mental health specialist" means:

(1) A "*child mental health specialist*" is defined as a mental health professional with the following education and experience:
(a) A minimum of one hundred actual hours (not quarter or semester hours) of special training in child development and the treatment of children and youth with serious emotional disturbance and their families; and
(b) The equivalent of one year of full-time experience in the treatment of seriously emotionally disturbed children and youth and their families under the supervision of a child mental health specialist.

(2) A "*geriatric mental health specialist*" is defined as a mental health professional who has the following education and experience:
(a) A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to the mental health problems and treatment of persons sixty years of age or older; and
(b) The equivalent of one year of full-time experience in the treatment of persons sixty years of age or older, under the supervision of a geriatric mental health specialist.

(3) An "*ethnic minority mental health specialist*" is defined as a mental health professional who has demonstrated cultural competence attained through major commitment, ongoing training, experience and/or specialization in serving ethnic minorities, including evidence of one year of service specializing in serving the ethnic minority group under the supervision of an ethnic minority mental health specialist; and
(a) Evidence of support from the ethnic minority community attesting to the person's commitment to that community; or
(b) A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to ethnic minority issues and treatment of ethnic minority consumers.

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

(4) A "*disability mental health specialist*" is defined as a mental health professional with special expertise in working with an identified disability group. For purposes of this chapter only, "disabled" means an individual with a disability other than a mental illness, including a developmental disability, serious physical handicap, or sensory impairment.

(a) If the consumer is deaf, the specialist must be a mental health professional with:
  (i) Knowledge about the deaf culture and psychosocial problems faced by people who are deaf; and
  (ii) Ability to communicate fluently in the preferred language system of the consumer.

(b) The specialist for consumers with developmental disabilities must be a mental health professional who:
  (i) Has at least one year's experience working with people with developmental disabilities; or
  (ii) Is a developmental disabilities professional as defined in RCW 71.05.020.

Staff Supervision means monitoring the administrative, clinical or clerical work performance of staff, students, interns, volunteers or contracted employees by persons with the authority to direct employment activities and require change. When supervision is clinical in nature, it shall occur regularly and may be provided without the consumer present or may include direct observation of the delivery of clinical care. Supervisory activities include the review of all aspects of clinical care including but not limited to review of assessment, diagnostic formulation, treatment planning, progress toward completion of care, identification of barriers to care, continuation of service and authorization of care.

B. Definitions

(1) Brief Intervention Treatment: Solution focused and outcomes oriented cognitive and behavioral interventions intended to ameliorate symptoms, resolve situational disturbances which are not amenable to resolution in a crisis service model of care and which do not require long term-treatment, to return the individual to previous higher levels of general functioning. Individuals must be able to select and identify a focus for care that is consistent with time-limited, solution-focused or cognitive-behavioral model of treatment. Functional problems and/or needs identified in the Medicaid enrollee's Individual Service Plan must include a specific time frame for completion of each identified goal. This service does not include ongoing care, maintenance/monitoring of the enrollee’s current level of functioning and assistance with self/care or life skills training. Enrollees may move from Brief Intervention Treatment to longer term Individual Services at any time during the course of care. This service is provided by or under the supervision of a Mental Health Professional.

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

(2) Crisis Services: Evaluation and treatment of mental health crisis to all Medicaid enrolled individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis services shall be available on a 24-hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available.

Crisis services may be provided prior to completion of an intake evaluation. Services are provided by or under the supervision of a mental health professional.

(3) Day Support: An intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) for Medicaid enrollees to promote improved functioning or a restoration to a previous higher level of functioning. The program is designed to assist the individual in the acquisition of skills, retention of current functioning or improvement in the current level of functioning, appropriate socialization and adaptive coping skills. Eligible individuals must demonstrate restricted functioning as evidenced by an inability to provide for their instrumental activities of daily living. This modality may be provided as an adjunctive treatment or as a primary intervention. The staff to consumer ratio is no more than 1:20 and is provided by or under the supervision of a mental health professional in a location easily accessible to the client (e.g., community mental health agencies, clubhouses, community centers). This service is available 5 hours per day, 5 days per week.

(4) Family Treatment: Psychological counseling provided for the direct benefit of a Medicaid enrolled individual. Service is provided with family members and/or other relevant persons in attendance as active participants. Treatment shall be appropriate to the culture of the client and their family and should reinforce the family structure, improve communication and awareness, enforce and reintegrate the family structure within the community, and reduce the family crisis/upheaval. The treatment will provide family-centered interventions to identify and address family dynamics and build competencies to strengthen family functioning in relationship to the consumer. Family treatment may take place without the consumer present in the room but service must be for the benefit of attaining the goals identified for the individual in their individual service plan. This service is provided by or under the supervision of a mental health professional.

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

(5) "Freestanding Evaluation and Treatment" Services provided in freestanding inpatient residential (non-hospital/non-IMD) facilities licensed by the Department of Health and certified by the Mental Health Division to provide medically necessary evaluation and treatment to the Medicaid enrolled individual who would otherwise meet hospital admission criteria. These are not-for-profit organizations. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other mental health professionals, and discharge planning involving the individual, family, significant others so as to ensure continuity of mental health care.

Nursing care includes but is not limited to, performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.

This service is provided for individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self due to the onset or exacerbation of a psychiatric disorder.

The severity of symptoms, intensity of treatment needs or lack of necessary supports for the individual does not allow them to be managed at a lesser level of care. This service does not include cost for room and board.

The Mental Health Division must authorize exceptions for involuntary length of stay beyond a fourteen-day commitment.

(6) Group Treatment Services: Services provided to Medicaid enrolled individuals designed to assist in the attainment of goals described in the Individual Service Plan. Goals of Group Treatment may include developing self care and/or life skills, enhancing interpersonal skills, mitigating the symptoms of mental illness, and lessening the results of traumatic experiences, learning from the perspective and experiences of others and counseling/psychotherapy to establish and /or maintain stability in living, work or educational environment. Individuals eligible for Group Treatment must demonstrate an ability to benefit from experiences shared by others, demonstrate the ability to participate in a group dynamic process in a manner that is respectful of other's right to confidential treatment and must be able to integrate feedback from other group members. This service is provided by or under the supervision of a mental health professional to two or more Medicaid enrolled individuals at the same time. Staff to consumer ratio is no more than 1:12. Maximum group size is 24.

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

(7) High Intensity Treatment: Intensive levels of service otherwise furnished under this state plan amendment that is provided to Medicaid enrolled individuals who require a multi-disciplinary treatment team in the community that is available upon demand based on the individual's needs. Twenty-four hours per day, seven days per week, access is required if necessary. Goals for High Intensity Treatment include the reinforcement of safety, the promotion of stability and independence of the individual in the community, and the restoration to a higher level of functioning. These services are designed to rehabilitate individuals who are experiencing server symptoms in the community and thereby avoid more restrictive levels of care such as psychiatric inpatient hospitalization or residential placement.

The team consists of the individual, Mental Health Care Providers, under the supervision of a mental health professional, and other relevant positions as determined by the individual (e.g., family, guardian, friends, neighbor). Other community agency members may include probation/parole officers*, teacher, minister, physician, chemical dependency counselor*, etc. Team members work together to provide intensive coordinated and integrated treatment as described in the individual service plan. The team's intensity varies among individuals and for each individual across time. The assessment of symptoms and functioning will be continuously addressed by the team based on the needs of the individual service plan or crisis plan. Team members provide immediate feedback to the individual and to other team members. The staff to consumer ratio for this service is no more than 1:15.

Billable components of this modality include time spent by the mental health professionals, mental health care providers, and peer counselors.
*Although they participate, these team members are paid staff of other Departments and therefore not reimbursed under this modality.

(8) Individual Treatment Services: A set of treatment services designed to help a Medicaid enrolled individual attain goals as prescribed in their individual treatment plan. These services shall be congruent with the age, strengths, and cultural framework of the individual and shall be conducted with the individual, his or her family, or others at the individual's behest who play a direct role in assisting the individual to establish and/or maintain stability in his/her daily life. These services may include, developing the individual's self-care/life skills; monitoring the individual's functioning; counseling and psychotherapy. Services shall be offered at the location preferred by the Medicaid enrolled individual. This service is provided by or under the supervision of a mental health professional.

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

(9) Intake Evaluation: An evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except crisis services, services, stabilization services and free-standing evaluation and treatment. The intake evaluation must be initiated within ten (10) working days of the request for services, establish the medical necessity for treatment and be completed within thirty (30) working days. Routine services may begin before the completion of the intake once medical necessity is established. This service is provided by a mental health professional.

(10) Medication Management: The prescribing and/or administering and reviewing of medications and their side effects. This service shall be rendered face-to-face by a person licensed to perform such services. This service may be provided in consultation with collateral, primary therapists, and/or case managers, but includes only minimal psychotherapy.

(11) Medication Monitoring: Face-to-face one-on-one cueing, observing, and encouraging a Medicaid enrolled individual to take medications as prescribed. Also includes reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid enrolled individual. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes. Enrollees with low medication compliance history or persons newly on medication are most likely to receive this service. This service is provided by or under the supervision of a mental health professional. Time spent with the enrollee is the only direct service billable component of this modality.

(12) Mental Health Services provided in Residential Settings*:* A specialized form of rehabilitation service (non hospital/non IMD) that offers a sub-acute psychiatric management environment. Medicaid enrolled individuals receiving this service present with severe impairment in psychosocial functioning or has apparent mental illness symptoms with an unclear etiology due to their mental illness and treatment cannot be safely provided in a less restrictive environment and do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster housing, SRO apartments) for extended hours to provide direct mental health care to a Medicaid enrollee. Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment.

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

The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. This service is billable on a daily rate. In order to bill the daily rate for associated costs for these services, a minimum of 8 hours of service must be provided. This service does not include the costs for room and board, custodial care, and medical services, and differs for other services in the terms of location and duration.

(13) Peer Support: Services provided by certified Peer counselors to Medicaid enrolled individuals under the consultation, facilitation or supervision of a mental health professional who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Consumers actively participate in decision-making and the operation of the programmatic supports.

Self-help support groups, telephone support lines, drop-in centers, and sharing the peer counselor's own life experiences related to mental illness will build alliances that enhance the consumer's ability to function in the community. These services may occur where consumers are known to gather (e.g., churches, parks, community centers, etc.) Drop-in centers are required to maintain a log documenting identification of the consumer including Medicaid eligibility.

Services provided by Peer counselors to the consumer are noted in the consumers' Individualized Service Plan delineates specific goals that are flexible, tailored to the consumer and attempt to utilize community and natural supports. Monthly progress notes document consumer progress relative to goals identified in the Individualized Service Plan, but treatment goals have not yet been achieved.

Peer counselors are responsible for the implementation of peer support services. Peer counselors may serve on High Intensity Treatment Teams.

Peer support is available daily no more than four hours per day. The ratio for this service is no more than 1:20.

(14) Psychological Assessment*:* All psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist. Psychological assessments shall: be culturally relevant; provide information relevant to a consumer's continuation in appropriate treatment; and assist in treatment planning within a licensed mental health agency.

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

(15) Rehabilitation Case Management*:* A range of activities by the outpatient community mental health agency's liaison conducted in or with a facility for the direct benefit of a Medicaid-enrolled individual in the public mental health system. To be eligible, the individual must be in need of case management in order to ensure timely and appropriate treatment and care coordination. Activities include assessment for discharge or admission community to mental health care, integrated mental health treatment planning, resource identification and linkage, to mental health rehabilitative services, and collaborative development of individualized services that promote continuity of mental health care. These specialized mental health coordination activities are intended to promote discharge, to maximize the benefits of the placement, and to minimize the risk of unplanned read mission and to increase the community tenure for the individual. Services are provided by or under the supervision of a mental health professional.

(16) Special Population Evaluation*:* evaluation by a child, geriatric, disabled, or ethnic minority specialist that considers age and cultural variables specific to the individual being evaluated and other culturally and age competent evaluation methods. This evaluation shall provide information relevant to a consumer's continuation in appropriate treatment and assist in treatment planning. This evaluation occurs after intake. Consultation from a non-staff specialist (employed by another CMHA or contracted by the CMHA) may also be obtained, if needed, subsequent to this evaluation and shall be considered an integral, billable component of this service.

(17) Stabilization Services*:* Services provided to Medicaid enrolled individuals who are experiencing a mental health crisis. These services are to be provided in the person's own home, or another home-like setting, or a setting which provides safety for the individual and the mental health professional. Stabilization services shall include short-term (less than two weeks per episode) face-to-face assistance with life skills training, and understanding of medication effects. This service includes: a) follow up to crisis services; and b) other individuals determined by a mental health professional to need additional stabilization services. Stabilization services may be provided prior to an intake evaluation for mental health services.

(18) Therapeutic Psychoeducation: : Informational and experiential services designed to aid Medicaid enrolled individuals, their family members (e.g., spouse, parents, siblings) and other individuals identified by the individual as a primary natural support, in the management of psychiatric conditions, increased knowledge of mental illnesses and understanding the importance of their individual plan of care.

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

These services are exclusively for the benefit of the Medicaid enrolled individual and are included in the Individual Service Plan.

The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, the symptoms, precautions related to decompensation, understanding of the "triggers" of crisis, crisis planning, community resources, successful interrelations, medication action and interaction, etc. Training and shared information may include brain chemistry and functioning; latest research on mental illness causes and treatments; diagnostics; medication education and management; symptom management; behavior management; stress management; crisis management; improving daily living skills; independent living skills; problem-solving skills, etc.

Services are provided at locations convenient to the consumer, by or under the supervision of a mental health professional. Classroom style teaching, family treatment, and individual treatment are not billable components of this service.

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13. d. Rehabilitative services (cont.)

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

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

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

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

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13. d. Rehabilitative services (cont.)

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

Service Settings

BRS may be delivered in a group living setting (in the community), in a treatment foster home, or in a small number of cases, in the child's own home. In all setting, BRS is always provided by the credentialed staff of the BRS provider. Natural parents or foster parents do not provide BRS, nor does the State claim for such.

Service Description

Upon assessment and development of an individual service and treatment plan, specific services include milieu therapy, crisis counseling, regularly scheduled counseling and therapy, and health services. Care management and planning are ongoing and may include coordination with other agencies. When the child returns home, after care may be provided for up to six (6) months.

Milieu therapy: Refers to those activities performed with children to normalize their psycho-social development and promote the safety of the child and stabilize his or her behavior in any given environment. The child is monitored in structured activities conducive to interpersonal interaction (e.g., group work assignments), with the aim of promoting living skills development. As the child is monitored, intervention is provided to remediate the dysfunctional behaviors and encourage appropriate responses which the child may then apply in a broad range of settings. Aggression replacement training is provided to teach children to understand and replace aggression and anti-social behavior with positive alternatives. Providers include Social Service and Care Management staff. Child care staff provide assistance to these staff in the form of day-to-day supervision and behavioral feedback to the youth. (*see Provider Qualifications).*

Crisis counseling: Available on a 24 hour basis, providing immediate short term intervention to assist the child in responding to the crisis and/or stabilize the child's behavior until problems can be addressed in regularly scheduled counseling and therapy sessions. Children in the population served by BRS are subject to sudden, escalating disturbed behavior patterns. Crisis counseling is intended to quickly intervene and address escalating behavior, while scheduled counseling and therapy are intended to address the child's problems in the longer term. Example: A short term intervention would include the child having a face-to-face encounter with a counselor to discuss the nature of the child's current emotional/behavioral disturbance and his/her feelings that caused the disturbance. The child has the opportunity to work out a plan to cope with the immediate situation until longer term solutions can be developed. Providers include Social Service staff and Care Management staff (*see Provider Qualifications)*

Regularly scheduled counseling and therapy: May include psychological testing. Each child has an individual services and treatment plan which identifies the child's specific behavioral dysfunctions. Services and treatment are tailored to the child in his/her individual plan.

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13. d. 9. Rehabilitative services/Behavior rehabilitation (cont.)

Service Description (cont)

Therapy may be in an individual or group setting, which may include members of the child's peer group or family members, but therapy is directed at the child's behavioral problems. Irrespective of the therapeutic setting, counseling and therapy are provided to, or directed exclusively toward, the treatment of the Medicaid-eligible individual.

Providers include Social Services and Care Management staff. Child care staff may provide assistance to these staff in the form of day-to-day supervision and behavioral feedback to the youth (*see Provider Qualifications).*

Health Counseling: This component includes any service recommended by a licensed practitioner of the healing arts within the scope of his/her practice, aimed at reducing physical or mental disability of the individual and restoring the individual to his/her best possible functional level. Emergency and routine medical services are not claimed as BRS.

An EPSDT examination for the child must be arranged within the first 30 days of entry into BRS, and any recommendations resulting from the examination must be acted upon.

Youth may receive health counseling regarding health maintenance, disease prevention, nutrition, hygiene, pregnancy prevention, and prevention of sexually transmitted infections in a group setting or on a one-on-one basis with BRS social service staff or care management staff.

The population of youth served by BRS are at a higher risk of unsafe behaviors than the general population of youth in the community. They are also less concerned with maintaining personal habits that promote and sustain health such as nutrition, personal hygiene, and the prevention of disease. The counseling they receive reduces their dysfunctional behaviors.

BRS providers are required to provide or arrange for drug and/or alcohol treatment for all youth who require such treatment irrespective of the setting in which the youth resides, i.e., all settings. Drug and/or alcohol treatment may be sought in the community network of providers and paid for with the youth's Medicaid benefit and is not billed for in the BRS provider's rate. A small number of BRS providers have staff members who possess the required credentials to provide substance abuse treatment. In such cases, treatment could be provided within the facility without an increase in the provider's rate. Whether provided by a subcontracting community resource or within the BRS facility, substance abuse treatment is integrated into the youth's treatment plan and supported by the social service staff, the care management staff, and the child care staff.

Milieu therapy, crisis counseling, scheduled counseling and therapy, and health counseling are provided by care management staff and social service staff. The role of the child care staff is a supporting role to the care management and social service staff (see *Provider Qualifications and Responsibilities)*.

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13. d. 9. Behavior Rehabilitative Services (cont)

Demonstrations by staff of recreational or work activities are not claimed as BRS.

Population to be Served

Children who receive these services suffer from conditions that prevent them from functioning normally in their homes, schools, and communities. Dysfunctional behaviors may include drug and alcohol abuse; anti-social behaviors that require an inordinate amount of intervention and structure; sexual behavior problems; behaviors symptomatic of victims of severe family conflict; and behavioral disturbances resulting from psychiatric disorders of the parents.

Provider Qualifications and Responsibilities

Each provider must be licensed by the state's Division of Licensed Resources. Specific qualifications for all BRS providers' staff are listed below. In all settings, it is the providers' credentialed staff who perform BRS services.

Social Services Staff: The minimum qualification is a Masters Degree in social work or a social science such as psychology, counseling, or sociology. Social workers must meet the requirements in 18.225 RCW and chapter 246-809 WAC and have a Master's or Doctoral level degree from an educational program accredited by the Council on Social Work Education. Licensed/certified staff must successfully complete the Department of Health's examination and supervised/supervisory experience requirements. Social service staff without a Master's Degree must have a Bachelor's Degree in social work or a social science such as psychology, counseling, or sociology, and must consult at least eight hours per month with a person who has a Master's Degree.

Responsibilities include development of service plans; individual, group, and family counseling; and assistance to child care staff in providing appropriate treatment for clients.

The social service staff provides the child care staff with oversight and direction, when necessary, in the provision of appropriate treatment for children, in accordance with each child's specific treatment plan. Because the Social Service staff possess a higher educational credential and greater experience than the child care staff, they provide leadership to the child care staff.

Care Management Staff: The minimum qualification is a Master's Degree with major study in social work or a social science such as psychology, counseling, or sociology, or a Bachelor's Degree with major study in social work or a social science such as psychology, counseling, or sociology, and two (2) years' experience working with children and families. Mental health counselors must meet the requirements in 18.225 RCW and chapter 246-809WAC and have a Master's or Doctoral level degree in mental health counseling or a related field from an approved college or university. Licensed/certified staff must successfully complete the Department of Health's examination and supervised/supervisory experience requirements.

Responsibilities include case planning, individual and group counseling, assistance to child care staff in providing appropriate treatment for clients, coordination with other agencies, and documentation of client progress.

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13. d. 9. Behavior Rehabilitative Services (cont)

Care managers are in a leadership role to the child care staff. The care manager is responsible for maintaining oversight and providing direction to child care staff on a day-to-day basis for the child's behavior management, in accordance with each child's specific treatment plan. Care managers coordinate with other agencies to ensure that the child, when returned home, will have adequate supports to enable him/her to remain in the community. Examples of such supports could include ensuring that the child has a medical home, has a community treatment resource for drug and/or alcohol abuse, or has counseling for the treatment of sexually aggressive behavior. Coordination with other agencies depends on the specific problems of a specific child.

Therapeutic interventions are provided by social services staff, care management staff, and subcontracted individuals. All providers must meet the qualifications above, and as required, be licensed or certified by the Department of Health (DOH) according to chapter 18.25 RCW to furnish the service(s) provided by the BRS contractor.

Child Care Staff: Minimum qualifications require that no less than 50% of the childcare staff in a facility have a Bachelor's Degree. Combinations of formal education and experience working with children and families may be substituted for a Bachelor's degree.

Responsibilities include assisting social service staff in providing individual, group, and family counseling; and therapeutic intervention to address behavioral and emotional problems as they arise. Child care staff are responsible for understanding each child's treatment plan and providing day-to-day supervision and behavioral feedback to the child, in accordance with each child's individual treatment plan. These staff may provide input, based on their experience with the child, during case staffing and counseling sessions with the child and/or his/her family.

Master's Level Oversight: In addition to the staffing qualifications listed in this section, the Contractor's program must have Master's level oversight. This requirement may be met through a Master's level Program Director or Social Service staff or by subcontracting with a consultant.

17. Nurse midwife services

Limited to facilities approved by the Medicaid Agency to provide this service, or in the case of home births, to clients and residences approved for this service.

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18. Hospice care in accordance with section 1905(o) of the Act

A. Services
1. All curative treatment, including all related services and related medications, require prior authorization.
2. The Medicaid agency reviews all requests for curative treatment, related services, and related medications for medical necessity.
3. Exception to rule requests for non-covered services are reviewed for medical necessity.
4. Hopsice care is provided in accordance with the State Medicaid Manual at section 4305.
5. Covered services
   a. Covered services are intermittent except during brief periods of acute symptom control.
   b. Core services are provided directly by hospice agency staff or contracted through a hospice agency as necessary, and include:
      - Physician services related to administration of the plan of care.
      - Nursing care provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of an RN.
      - Medical social services provided by a social worker under the direction of a physician.
      - Counseling services provided to a client and the client's family members or caregivers.
   c. Additional services, which must be related to the hospice diagnosis, written in the plan of care, identified by the hospice interdisciplinary team, safe and meet the client's needs within the limits of the hospice program, and made available by the hospice agency on a 24-hour basis:
      - A brief period of inpatient care for general or respite care provided in a Medicare-certified hospice care center, hospital, or nursing facility.
      - Drugs, biologicals, and over-the-counter medications used for the relief of pain and symptom control of a client's terminal illness and related conditions.
      - Home health aide, homemaker, and/or personal care services ordered by the client's physician and documented in the plan of care. (Home health aide services must be provided by a qualified home health aide and are an extension of skilled nursing or therapy services).
      - Interpreter services as necessary for the plan of care.
      - Medical equipment and supplies that are medically necessary for the palliation and management of a client's terminal illness and related conditions.
      - Medical transportation services as required by the plan of care related to the terminal illness.
      - Physical therapy, occupational therapy, and speech-language pathology therapy to manage symptoms or enable the client to safely perform activities of daily living and basic functional skills.
      - Skilled nursing care.
      - Other services or supplies documented as necessary for the palliation and management of the client's terminal illness and related conditions.
      - Bereavement counseling

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18. Hospice care in accordance with section 1905(o) of the Act (cont)

B. Hospice Agency and Practitioner Qualifications

1. Hospice agency requirements:
   - Documentation that it is Medicare, Title XVIII-certified by the State's Department of Health; and
   - Has received written notification from the Medicaid Agency of enrollment as an approved hospice care center.

2. Practitioner requirements:

All practitioners who provide hospice services must be licensed, certified, accredited, or registered according to Washington State's laws and rules, including but not limited to physicians, registered nurses, licensed practical nurses, and social workers.

C. Hospice Election Periods

Hospice coverage is available for two (2) 90-day election periods followed by an unlimited number of 60-day election periods. A client or a client's authorized representative must sign an election statement to initiate or reinstate an election period for hospice care. An election period to receive hospice care continues through the initial election period and subsequent election periods without a break in care as long as the client:

- Remains in the care of a hospice agency; and
- Does not revoke the election

D. Face-to-face Encounters

Hospice agencies must have a face-to-face encounter with every hospice client prior to the one hundred eightieth-day recertification and prior to each subsequent recertification in order to determine continued eligibility of the client for hospice care. These encounters are not covered separately – they are included in the core services.

Concurrent care for children on hospice in accordance with section 2302 of the Affordable Care Act.

A. Hospice clients 20 years of age and under are eligible.

B. The hospice benefit may be elected without foregoing curative services to which the client is entitled for treatment of the terminal condition.

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20. Extended services for pregnant women, through the sixty days postpartum period.

The extended services include:

a. Maternity support services (MSS) by a provider approved by the Department of Health and the department consisting of the following. All staff meet Washington State licensure requirements according to Washington State's law cited in the Revised Code of Washington, RCW 43.24.030.

(1) Nursing assessment and/or counseling visits, provided by licensed registered nurses;
(2) Psychosocial assessment and/or counseling visits, provided by licensed or credentialed behavior health specialists;
(3) Nutrition assessment and/or counseling visit, provided by registered, state-certified dieticians;
(4) Community health worker visit, provided by community health educators; and
(5) Child birth education, provided by licensed or credentialed child birth educators.

b. Outpatient alcohol and drug treatment for pregnant and postpartum women consisting of a chemical dependency assessment by an Alcohol and Drug Abuse Treatment and Services Act assessment center, parenting education, and chemical dependency treatment. These services are provided by Chemical Dependency Counselors approved by the Division of Behavioral and Health Rehabilitation according to Washington State's law cited in the Revised Code of Washington, RCW 43.24.030.

c. Rehabilitation alcohol and drug treatment services, excluding room and board, for pregnant and postpartum women recommended by a physician or licensed practitioner of the healing arts within the scope of their practice under State law. Services are provided in residential treatment facilities with 16 beds or less certified by the Division of Behavioral and Health Rehabilitation.

d. Genetic counseling performed by a genetic counselor approved by Parent-Child Health Services and Washington State's Department of Health according to Washington State's law cited in the Revised Code of Washington, RCW 43.24.030.

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22. Respiratory care services

As defined in rule, the department covers medically necessary oxygen and/or respiratory therapy equipment, supplies and services to eligible clients in nursing facilities, community residential settings, and in their homes. The above is prescribed by a health care practitioner authorized by law or rule in the State of Washington. Prior authorization is required for specified equipment, or when a request falls outside of the defined criteria.

Selected contracted nursing facilities are authorized to provide exceptional care needs to ventilator- and tracheostomy-dependent clients.

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23. a. Transportation

Ambulance transportation is provided as a medical service for emergencies, for scheduled non-emergencies when medically necessary, or as required by state law. Ambulance transportation is not provided through a brokerage system.

See Attachment 4.19-B, IX.C for reimbursement information.

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23. a.(a) Transportation (cont)

Transportation is provided in accordance with 42 CFR 440.170 as an optional medical service, excluding "school-based" transportation.

/ / Not Provided:
/ / Provided without a broker as an optional medical service:

(If state attests "Provided without a broker as an optional medical service" then insert supplemental information.)

Instructions:
Describe how the transportation program operates including types of transportation and transportation-related services provided and any limitations. Describe emergency and non-emergency transportation services separately. Include any interagency or cooperative agreements with other Agencies or programs.

/X/ Non-emergency transportation is provided through a brokerage program as an optional medical service in accordance with 1902(a)(70) of the Social Security Act and 42 CFR 440.170(a)(4).

(If the state attests that non-emergency transportation is being provided through a brokerage program then insert information about the brokerage program.)

Instructions:
/X/ The State assures it has established a non-emergency medical transportation program in accordance with 1902(a)(70) of the Social Security Act in order to more cost-effectively provide transportation, and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36(b)-(i).

See response at ATTACHMENT 3.1-A 24.a.(a) (information about the brokerage program), Page 62___.

(a) Non-governmental entity
(1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a):
/ / (1) state-wideness (indicate areas of State that are covered)
Broker regions covered by SPA 08-028, approved 08/17/2010, effective 10/01/2008:
1A: Chelan, Douglas, and Okanogan counties
3B: Snohomish County
4: King County
5: Pierce County
6B: Grays Harbor, Lewis, Mason-south, Pacific, and Thurston counties
6C: Clark, Cowlitz, Klickitat, Skamania, and Wahkiakum counties

Broker regions covered by SPA 11-11, effective 01/01/2011:
1B: Ferry, Pend Oreille, and Stevens counties
1C: Adams, Grant, and Lincoln counties
1D: Spokane County
1E: Asotin, Garfield, and Whitman counties
2: Benton, Columbia, Franklin, Kittitas, Walla Walla, and Yakima counties
Broker region covered by SPA 11-11, effective 04/01/2011:
6A: Clallam, Jefferson, Kitsap, and Mason-north counties

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23. a.(a) Transportation (cont)

/ / (10)(B) comparability (indicate participating beneficiary groups)

/X/ (23) freedom of choice (indicate mandatory population groups)

(2) Transportation services provided will include:

/X/ Wheelchair van
/X/ Taxi
/X/ Stretcher car
/X/ Bus passes
/X/ Tickets
/X/ Secured transportation
/X/ Other transportation

Instructions:
Describe other transportation: When cost- effective, appropriate, and necessary to ensure access to eligible medical services, will consider using/authorizing gas/fuel vouchers, mileage reimbursement, grouped-ride vehicle, volunteer drivers, parking, tolls, ferries, and air transport, and will provide lodging and meal reimbursement as outlined at 42 CFR 440.170(a)(3)(ii).

[Note: Grouped or shared ride vehicles are a cost-effective method to transport groups of clients with similar trip origins and destinations, or more than one client in a locale similar to an airport shuttle. Brokers pay transportation subcontractors on a contracted mileage-based or time-based system; costs are allocated equitably to the clients' specific medical program account codes.]

See response at ATTACHMENT 3.1-A, 24.a.(a)(2) (Transportation services provided will include), Page 62___.

(3) The State assures that transportation services will be provided under a contract with a broker who:
(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, qualifications, and costs;

(ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transportation is timely and transport personnel are licensed, qualified, competent, and courteous;

(iii) is subject to regular auditing and oversight by the State in order to ensure the quality and timeliness of the transportation services provide and the adequacy of beneficiary access to medical care and services;

(iv) complies with such requirements related to prohibitions on referral and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under Section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate.)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

23. a. Transportation (cont)

(4) The broker contract will provide transportation to the following medically needy populations:

/X/ Children under age 21, or under age 20, 19, or 18 and reasonable classifications as the State may choose.
/ / Parents or other caretaker relatives with whom a child is living if child is a dependent child.
/X/ Aged (65 years of age or older)
/X/ Blind
/X/ Disabled
/X/ Permanently or totally disabled individuals 18 or older, under title XVI
/X/ Persons essential to recipients under title I, X, XIV, or XVI
/X/ Blind or disabled as defined in section 1614 with respect to States not eligible to participate in the State plan program under title XVI
/X/ Pregnant women
/X/ Newborns

(5) Payment Methodology

(A) The State will pay the contracted broker by the following method:

/ / (i) Risk capitation
/ / (ii) Non-risk capitation
/X/ (iii) Other (e.g., brokerage fee and direct payment to providers)

(B) Who will pay the transportation provider?

/X/ (i) Broker
/ / (ii) State
/ / (iii) Other

Instructions:
Describe who will pay the transportation provider.

See response at ATTACHMENT 3.1-A, 24.a.(a) (6) Payment Methodology, Page 62___.

(C) What is the source of the non-Federal share of transportation payments?

Instructions:
Describe the source of the non-Federal share of the transportation payments proposed under this State plan amendment. If more than one source exists to fund the non-Federal share of the transportation payments, please separately identify each source of non-Federal share funding.

The source of the non-Federal share of the transportation payments is State general funds.

(D) The State assures that no agreement (contractual or otherwise) exists between the State or any form of local government and the transportation broker to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly). This assurance is not intended to interfere with the ability of a transportation broker to contract for transportation services at a lesser rate and credit any savings to the program.

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23. a.(a) Transportation (cont)

(E) The State assures that payment proposed under this State plan amendment will be made directly to transportation providers and that the transportation provider payments are fully retained by the transportation providers and no agreement (contractual or otherwise) exists between the State or local government and the transportation provider to return or redirect any of the Medicaid payment to the State or form of local government (indirectly or directly).

/X/ (6) The broker is a non-governmental entity:

/X / The broker is not itself a provider of transportation nor does it refer to or subcontract with any entity with which it has a prohibited financial relationship as described at 45 CFR 440.170(4)(ii).

/ / The broker is itself a provider of transportation or subcontracts with or refers to an entity with which it has a prohibited financial relationship and:

(i) / / Transportation is provided in a rural area as defined at 412.62(f) and there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

(ii) / / Transportation is so specialized that there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

(iii) / / The availability of other non-governmental Medicaid participating providers or other providers determined by the State to be qualified is insufficient to meet the need for transportation.

/ / (7) The broker is a governmental entity and provides transportation itself or refers to or subcontracts with another governmental entity for transportation. The governmental broker will:

/ / Maintain an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the Medicaid brokerage will be completely separate from any other program.

/ / Document that with respect to each individual beneficiary's specific transportation needs, the governmental provider is the most appropriate and lowest cost alternative.

/ / Document that the Medicaid program is paying no more for fixed route public transportation than the rate charged to the general public and no more for public paratransit services than the rate charged to other State human services agencies for the same service.

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23. a.(a) Transportation (cont)

(8) /X/ Please describe how the NEMT brokerage program operates.

Instructions:
Describe how the Brokerage program will operate. Include the services that will be provided by the broker. If applicable, describe any services that will not be provided by the broker and name the entity that will provide these services.

Non-governmental brokers serving the following contract regions are all private non-profit 501(c)3 organizations: Regions:

1. 1A, 3B, 4, 5, 6B and 6C (approved in SPA 08-028, effective 10/01/2008)
2. 1B, 1C, 1D, 1E, and 2 (effective 01/01/2011)
3. 6A (effective 04/01/2011)

For additional information see “Description” at ATTACHMENT 3.1-A, 24.a.(a) (9) (how the NEMT brokerage program operates), Page 62 ___.

(b) Governmental entities

(1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a):

/X/ (1) state-wideness (indicate areas of State that are covered)
Broker region (approved in SPA 08-028, effective 10/01/2008): 3A:Island, San Juan, Skagit, and Whatcom counties

/ / (10)(B) comparability (indicate participating beneficiary groups)

/X/ (23) freedom of choice (indicate mandatory population groups)

(2) Transportation services provided will include:

/X/ Wheelchair van
/X/ Taxi
/X/ Stretcher car
/X/ Bus passes
/X/ Tickets
/X/ Secured transportation
/X/ Other transportation

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23. a. Transportation (cont)

Instructions:
Describe other transportation: When cost- effective, appropriate, and necessary to ensure access to eligible medical services, will consider using/authorizing gas/fuel vouchers, mileage reimbursement, grouped-ride vehicle, volunteer drivers, parking, tolls, ferries, and air transport, and will provide lodging and meal reimbursement as outlined at 42 CFR 440.170(a)(3)(ii).

[Note: Grouped or shared ride vehicles are a cost-effective method to transport groups of clients with similar trip origins and destinations, or more than one client in a locale similar to an airport shuttle. Brokers pay transportation subcontractors on a contracted mileage-based or time-based system; costs are allocated equitably to the clients' specific medical program account codes.]

See response at ATTACHMENT 3.1-A, 24.a.(a) (2) (Transportation services provided will include), Page 62___.

(3) The State assures that transportation services will be provided under a contract with a broker who:
(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, qualifications, and costs;
(ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transportation is timely and transport personnel are licensed, qualified, competent, and courteous;
(iii) is subject to regular auditing and oversight by the State in order to ensure the quality and timeliness of the transportation services provided and the adequacy of beneficiary access to medical care and services;
(iv) complies with such requirements related to prohibitions on referral and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under Section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate.

(4) The broker contract will provide transportation to the following medically needy populations:

/X/ Children under age 21, or under age 20, 19, or 18 and reasonable classifications as the State may choose.
/ / Parents or other caretaker relatives with whom a child is living if child is a dependent child.
/X/ Aged (65 years of age or older)
/X/ Blind
/X/ Disabled
/X/ Permanently or totally disabled individuals 18 or older, under title XVI
/X/ Persons essential to recipients under title I, X, XIV, or XVI
/X/ Blind or disabled as defined in section 1614 with respect to States not eligible to participate in the State plan program under title XVI
/X/ Pregnant women
/X/ Newborns

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23. a. (b) Transportation (cont)

(5) Payment Methodology

(A) The State will pay the contracted broker by the following method:
/ / (i) Risk capitation
/ / (ii) Non-risk capitation
/X/ (iii) Other (e.g., brokerage fee and direct payment to providers)

(B) Who will pay the transportation provider?
/X/ (i) Broker
/ / (ii) State
/ / (iii) Other

Instructions:
Describe who will pay the transportation provider.

See response at ATTACHMENT 3.1-A, 24.a.(a) (6) Payment Methodology, Page ___.

(C) What is the source of the non-Federal share of transportation payments?

Instructions:
Describe the source of the non-Federal share of the transportation payments proposed under this State plan amendment. If more than one source exists to fund the non-Federal share of the transportation payments, please separately identify each source of non-Federal share funding.

The source of the non-Federal share of the transportation payments is State general funds.

(D) The State assures that no agreement (contractual or otherwise) exists between the State or any form of local government and the transportation broker to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly). This assurance is not intended to interfere with the ability of a transportation broker to contract for transportation services at a lesser rate and credit any savings to the program.

(E) The State assures that payment proposed under this State plan amendment will be made directly to transportation providers and that the transportation provider payments are fully retained by the transportation providers and no agreement (contractual or otherwise) exists between the State or local government and the transportation provider to return or redirect any of the Medicaid payment to the State or form of local government (indirectly or directly).

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23. a. (b) Transportation (cont)

/ / (7) The broker is a non-governmental entity:

/ / The broker is not itself a provider of transportation nor does it refer to or subcontract with any entity with which it has a prohibited financial relationship as described at 45 CFR 440.170(4)(ii).

/ / The broker is itself a provider of transportation or subcontracts with or refers to an entity with which it has a prohibited financial relationship and:

(i) / / Transportation is provided in a rural area as defined at 412.62(f) and there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

(ii) / / Transportation is so specialized that there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

(iii) / / The availability of other non-governmental Medicaid participating providers or other providers determined by the State to be qualified is insufficient to meet the need for transportation.

/X/ (8) The broker is a governmental entity and provides transportation itself or refers to or subcontracts with another governmental entity for transportation. The governmental broker will:

/X/ Maintain an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the Medicaid brokerage will be completely separate from any other program.

/X/ Document that with respect to each individual beneficiary's specific transportation needs, the governmental provider is the most appropriate and lowest cost alternative.

/X/ Document that the Medicaid program is paying no more for fixed route public transportation than the rate charged to the general public and no more for public paratransit services than the rate charged to other State human services agencies for the same service.

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24. a.(b) Transportation (cont)

(9) /X/ Please describe how the NEMT brokerage program operates.

Instructions:
Describe how the Brokerage program will operate. Include the services that will be provided by the broker. If applicable, describe any services that will not be provided by the broker and name the entity that will provide these services.

Governmental broker serving region 3A.

The broker serving Region 3A is a governmental entity (a council of governments) and serves Island, San Juan, Skagit, and Whatcom counties. This broker does not directly provide trips, but does purchase trips on two public transit systems (in Skagit and Whatcom counties). This broker also authorizes trips using other available modes of transportation as listed in Section (2).

(A) The State pays for direct transportation expenses (e.g., cost of the trips by subcontracted transportation providers, bus tickets, gas vouchers) per detailed report. The State pays separately for the governmental broker's cost of operating the brokerage (call center, etc.), on a set monthly amount basis.

The governmental broker maintains an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the Medicaid brokerage will be completely separate from any other program. The governmental broker maintains an accounting system as required by this authority. The broker is both required by law and committed to assuring that all agency costs are allocated to the appropriate activity and fund source. All costs clearly attributable to a specific activity and fund source are directly charged to that fund source. Activities which benefit all programs operated by the organization are allocated based upon a cost allocation plan (this applies to a portion of the broker's cost of operating the brokerage).

(B) The governmental broker has a procedure related to evaluating each individual beneficiary's specific needs and making a determination related to the most appropriate, lowest cost trip, with a specific focus on the procedure related to governmental providers (i.e., public transit). These determinations are made on a case-by-case basis each month.

(C) For Medicaid beneficiaries, the governmental broker pays the same rate/fare as the general public pays for all fixed route transportation. The cost of the bus pass may not exceed the total cost of all trips a beneficiary would make to Medicaid providers to obtain Medicaid services, were the trips purchased individually. The governmental broker also pays the same rate as the general public for paratransit trips, which is no more than human service agencies pay for the service. The public rates are utilized in determining whether public transit will be the most appropriate low cost service for a specific beneficiary's needs in any given month. In general, public transit trips in the broker's regions are significantly lower in cost than other modes of transportation available.

For additional information see "Description" at ATTACHMENT 3.1-A, 24.a.(b) (9) (how the NEMT brokerage program operates), Page 62___.

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State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

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23. d. Nursing facility services provided for patients under 21 years of age

Admission requires prior approval.

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State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

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29. Licensed or Otherwise State-Approved Freestanding Birthing Center

a. Facilities must:
   (i) Be licensed by the Department of Health (DOH) under chapter 246-349 WAC;
   (ii) Be specifically approved by DOH to provide birthing center services; and
   (iii) Maintain standards of care required by DOH for licensure.

b. Covered practitioners providing services in the freestanding birthing center

   (i) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State Plan.

   The following practitioners may provide birthing center services and must be licensed in the State of Washington as a:
   (a) Physician under chapter 18.57 or 18.71 RCW;
   (b) Nurse midwife under chapter 18.79 RCW; or

   (ii) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birthing center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60.
   (a) Midwife under chapter 18.50 RCW.

   (iii) Other health care professionals recognized by the State to provide these birth attendant services.
   NA

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

HIV/AIDS CASE MANAGEMENT SERVICES

- Target Group

  Clients who have a current medical diagnosis of HIV or AIDS and who are eligible for Title XIX (Medicaid) coverage under the Categorically Needy Program (CNP) or the Medically Needy Program (MNP).

  The clients require assistance obtaining and effectively using necessary medical, social, and educational services or the client's condition is such the client requires 90 days continued monitoring.

- Areas of State in which services will be provided:

  [X] Entire State.

  [ ] Only in the following geographic areas (authority of section 1915 (g) (1)) of the Act is invoked to provide services less than Statewide:

  - Comparability of Services:

  [ ] Services are provided in accordance with section 1902 (a) (10) (B) of the act.

  [X] Services are not comparable in amount, duration, and scope. Authority of section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of section 1902 (a) (10) (B) of the Act.

  - Definition of Services

MAA requires that HIV/AIDS case management providers perform the following functions:

1. Notify HIV positive persons, verbally or by signing a statement, of their choice of available HIV/AIDS case management providers statewide. This requirement does not obligate HIV/AIDS case management providers to accept all clients who request their services. The case management provider will refer the client to another provider.

2. Obtain and maintain a current Authorization to Release/Obtain Information form. The provider must have a valid authorization on file for the months that case management services are billed to MAA. The provider cannot charge the client for services or documents related to covered services.

3. Maintain sufficient contact to ensure effectiveness of ongoing services. MAA requires a minimum of one contact per month between the HIV/AIDS case manager and the client. However, contact frequency must be sufficient to ensure implementation and ongoing maintenance of the Individual Service Plan (ISP).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

HIV/AIDS CASE MANAGEMENT SERVICES (cont.)

D. Definition of Services (continued)

Case management includes services which will assist clients in: living as independently as possible, maintaining and improving their health, reducing behaviors that put themselves and others at risk, and gaining access to needed medical, social, and educational services.

Description of Services:

Case management functions (core and support) are provided under the direction of a qualified case manager and are detailed below.

Core Functions:

Comprehensive Assessment: A comprehensive assessment is an evaluation to determine client's needs for case management services in several areas. This evaluation includes demographic information, physical status, HIV diagnosis, psychological/social/cognitive functioning and mental health history, ability to perform daily activities, financial and employment status, medical benefits and insurance coverage, informal support systems, legal status, and reportable behaviors which could lead to HIV transmission or reinfection.

Service Plan Development: An individual service plan must be developed in conjunction with the comprehensive assessment to identify and document the client's unmet needs and the resources needed to assist in meeting those needs.

Service Plan Implementation: The case manager is responsible for implementation of the service plan, but may delegate specific functions to others, such as the home health nurse, discharge planners, etc.

Service Plan Review: The case manager must review the service plan monthly through in-person contact or by telephone contact with the client.

Narrative Records: Case managers must keep ongoing records, which clearly document case management services. These records must include the reason for the case manager's interaction with the client and the plans in place or to be developed to meet unmet client needs.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

HIV/AIDS CASE MANAGEMENT SERVICES (cont.)

D. Definition of Services (continued)

Support Functions:

Client Advocacy: Intervene with agencies or persons to help individual clients receive appropriate benefits or services.

Assistance: Assist or arrange for the client to obtain a needed service or accomplish a necessary task.

Consultation: Consult with service providers and professionals to utilize their expertise on the client's behalf.

Networking: Help a client to access services through linkages between formal and informal support systems for the purpose of creating an effective continuum of care.

Family Support: Arrange for appropriate referrals to help the family or significant others to deal with stress and changes related to the client's impairments.

E. Qualifications of Providers:

Provider Qualifications – Individual case managers

An HIV/AIDS case manager shall:

1. Be either a professional or a paraprofessional (HIV/AIDS case manager assistant) under the direct supervision of a professional;

i. Be employed and enrolled as an HIV/AIDS case manager by a public or private health, social service, or education agency.

ii. Have demonstrated skills and knowledge necessary to perform his/her job responsibilities at the time of employment or have the potential of achieving the required skills and knowledge through training;

iii. Have a general knowledge of HIV/AIDS-related conditions and diseases, the AIDSNET service delivery system, and other service delivery systems in his/her community;

iv. Meet at least the following requirements for education and experience:

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

HIV/AIDS CASE MANAGEMENT SERVICES (cont.)

E. Qualifications of Providers (continued)

(a) Master's degree in behavioral or health sciences (e.g. social work, clinical psychology, sociology, guidance counseling, nursing, and public health) and one year of paid social service experience;

(b) Bachelor's degree in behavioral or health sciences and two years of paid social services experience;

(c) Bachelor's degree and three years of paid social services experience.

HIV Client Services, Department of Health may make exceptions to the above requirements when the service population is geographically or culturally isolated, or has limited English speaking ability.

Provider qualification – Case management agencies

An HIV/AIDS case management agency must:

1. Be a public or private social service, health, or education agency employing staff with HIV/AIDS case manager qualifications;

2. Demonstrate linkage and referral ability with social and health service agencies and individual practitioners;

3. Have experience working with persons living with HIV/AIDS;

4. Meet applicable state and federal laws and regulations governing the participation of providers in the Medicaid program;

5. Have caseload size standards that allow HIV/AIDS case management staff to perform the duties established in the Title XIX HIV/AIDS case management standards;

6. Have supervisors who meet the HIV/AIDS case manager qualifications and have:

(a) A master's degree and two years of paid social service experience; or

(b) A bachelor's degree and three years of paid social service experience, including one supervisory year.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

HIV/AIDS CASE MANAGEMENT SERVICES (cont.)

F. Choice of Providers

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902 (a) (23) of the Act. Eligible recipients will have free choice of the providers of:

1. HIV/AIDS case management services; and

2. Other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

CASE MANAGEMENT SERVICES

A. Target Group:
Persons who are Medicaid recipients (clients) and alcohol- or other drug-dependent who need assistance in obtaining necessary medical, social, educational, vocational, and other services.

B. Areas of State in which services will be provided:

[XX] Entire State

C. Comparability of Services:

[XX] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902 (a)(10)(B) of the Act.

D. Definition of Services:
Case management is an ongoing process to assist eligible clients gain access to and effectively use necessary health and related social services.

Description of Services:
Case management will be used to either involve eligible clients in chemical dependency treatment or to support them as they move through stages of chemical dependency treatment within or between separate treatment agencies.

Core Functions:
The core functions of the case manager are to provide or assist in providing:

Identification of Needs
Complete a comprehensive and on-going assessment of the client's needs for medical, social, educational, and other related services. Address the barriers to accessing or utilizing chemical dependency treatment services and other services.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

CASE MANAGEMENT SERVICES (cont.)

D. Definition of services (continued)

Planning
Prepare and implement a written service plan that reflects the client's needs and the resources available to meet those needs in a coordinated, integrated fashion.

Linkage
Facilitate access to needed services through linkages between support systems to avoid duplication of services. These services will augment/reinforce the treatment for chemical dependency.

Advocacy
Intervene with agencies/persons to help clients receive appropriate benefits or services. Also, help the client obtain a needed service or accomplish a necessary task. Be available to help problem-solve when there is a crisis in the client's treatment plan. Advocate for the client's treatment needs with treatment providers.

Accountability
Retain documentation of case management plan and services provided. Submit data as required.

E. Qualifications of Providers:
Case management services will be provided through contracts between the Medicaid agency and chemical dependency treatment agencies certified under Chapter 388-805 WAC in order to ensure that the case managers for these clients are capable of providing the full range of services needed by these targeted clients.

Case management services will be provided by a Substance Abuse counselor who meets the requirements of a certified Chemical Dependency Professional or a Chemical Dependency Professional Trainee as defined in WAC 388-805.

F. The state assures that the provision of case management services will not restrict a client's free choice of providers in violation of Section 1902 (a)(23) of the Act.

1. Eligible clients will have free choice to receive or not receive case management services.

2. Eligible clients will have free choice of the providers of other medical care under the plan.

Payment for case management services under the plan will not duplicate payments made to public agencies or private entities under other program authorities this same purpose.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

The Standards Established and the Methods Used to Assure High Quality Care

I. The State plan for medical assistance provides that the range of medical services included in the plan is available as determined necessary by qualified physicians and other practitioners. All of the medical services included in the plan are provided without delay attributable to administrative processes required under the plan. Medical services of a high level of quality are made available and this level of quality is affected by administrative procedures or requirements. The decision to provide medical care is always made by a qualified physician or other practitioner. To the greatest extent possible, the physicians and other practitioners take into account the social situation of the individual. Such supervision of professional services rendered as may be required is provided by professional persons in the field.

II. The State program for medical assistance includes reasonable and definite standards for determining that the medical services furnished were necessary and were supplied in an amount and variety consistent with accepted norms of professional practice. The administration of these standards is handled on a continuing basis by the local medical consultants and the local nursing care consultants; these standards are also subject to continuing review at the State office level.

III. To the greatest extent possible the administrative mechanisms required in this plan to insure prompt receipt of medical assistance are kept simple and clearly defined and in the best interests of the recipient. To this end, realistic schedules of compensation for all medical services included in the State plan are maintained and updated within the limits of federal regulations and available appropriations. Routine prior authorizations of medical care and services are kept at a minimum. In order that applicants, recipients, the general public, and the various providers of medical services involved be kept informed as fully as possible regarding the content of the medical care available and the circumstances under which it is provided, an ongoing program of public information, including the use of pamphlets and brochures, is carried out.

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Pages 2 – 15 removed via SPA 13-07 effective April 1, 2013

Superseded TN# 11-04

Pages 16 – 28 removed via SPA 13-20 effective Oct. 1, 2013

Superseded SPA 10-008

Pages 29 – 43 removed via SPA 13-07 effective April 1, 2013

Superseded TN# 09-011

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

METHODS OF ASSURING TRANSPORTATION

Non-emergency medical transportation is provided as an optional medical service in accordance with 42 CFR 440.170(a)(4) in all areas of the State of Washington with the exception of Region 6A (Clallam, Jefferson, Kitsap, and Mason-north counties) which was provided as an administrative activity until 3/31/2011. After 4/1/11 see Attachment 3.1-A, 24(a) Non-governmental entities.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

The Consolidated Omnibus Budget Reconciliation Act of 1985 (signed by the President April 7, 1986) requires written standards for the provision of organ transplants. State Plans must provide for standards that treat similarly situated individuals alike, identify restrictions on the facilities or practitioners providing organ transplantation procedures, and are consistent with the accessibility of high quality care to those individuals eligible for the procedures under the State Plan. Heart-lung, lung, pancreas-kidney, pancreas, heart, liver and bone marrow transplants (in addition to cornea and kidney) are medically necessary and reasonable when patient selection criteria are observed and when performed at a facility that meets certain criteria. Compound transplants of three or more organs are viewed as experimental.

STANDARDS

I. Patient Selection

Policy Statement. In general, the Medical Assistance recipient must have end stage organ disease, a poor prognosis (for example, in the case of heart disease, less than 25 percent likelihood of survival for six months or more) as a result of poor organ functional status; .the pancreas is an exception to this. All other medical and surgical therapies that might be expected to yield both short- and long-term survival (for example, three to five years) comparable to that of organ transplantation must have been tried or considered. Standards are designed to ensure that patients are selected so that organ transplantation as a therapy will have a successful clinical outcome.

Factors to be considered in the patient selection process include the following conditions:

1. Advancing age (the selection of a recipient for [not pancreas] transplantation beyond age 60 must be done with particular care to ensure an adequately young "physiologic" age and the absence or insignificance of coexisting disease); beyond age 40 for pancreas transplants will be reviewed with special care.

2. Severe pulmonary hypertension (because of the limited work capacity of the typical donor's right ventricle in case of heart transplantation).

3. Other organ dysfunction; e.g., renal or hepatic in the case of cardiac transplantation not explained by the underlying heart failure; (where multiple organ transplant is not proposed and/or will not solve this problem).

4. Acute, severe hemodynamic compromise at the time of transplantation if accompanied by compromise or failure of a vital end organ.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES (cont)

5. Symptomatic peripheral or cerebrovascular disease; is an absolute contraindication to participation in all transplants.

6. Chronic obstructive pulmonary disease or chronic bronchitis.

7. Active systemic infection.

8. Recent or unresolved pulmonary infarction or x-ray evidence of infection or of abnormalities of unclear etiology.

9. Systemic hypertension that requires multi-drug therapy for control; an exception may be considered in renal transplants.

10. Other systemic disease considered likely to limit or preclude survival and rehabilitation after transplantation.

11. Cachexia.

12. The need for prior transplantation of a second organ; i.e., lung, liver, kidney, heart or marrow (because this represents the coexistence of significant disease); exception pancreas after kidney.

13. A history of a behavior pattern or psychiatric illness considered likely to interfere significantly with compliance with a disciplined medical regimen (because a life long medical regimen is necessary, requiring multiple drugs several times a day, with serious consequences in the event of their interruption or excessive consumption).

13A. Noncompliance is the No. 1 cause of transplantation failure; patients with behavior patterns that may lead to interference must present evidence of compliance for one year and voluntary treatment program participation.

14. Other factors given less weight but still considered important include:

   a. Diabetes mellitus requiring insulin (because the diabetes is often accompanied by occult vascular disease and because the diabetes and its complications are exacerbated by chronic corticosteroid therapy); exceptions will be considered in combined pancreas/kidney in the young.

   b. Asymptomatic severe peripheral or cerebral vascular disease (because of accelerated progression in some patients after organ transplantation and chronic corticosteroid treatment).

   c. Peptic ulcer disease (because of the likelihood of early postoperative exacerbation); must be well controlled.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES (cont)

d. Current or recent history of unresected diverticulitis or other chronic infectious process (considered as a source of active infection which may be exacerbated with the initiation of an immunosuppressant).

The existence of one or more of these factors could lead to the disqualification of a Medical Assistance recipient as a candidate for organ transplantation.

II. Facilities and Practitioners

Organ transplantation procedures will be covered in centers approved by the Medical Director and on entering special agreements with the Division of Medical Assistance. Documentation that the center meets or exceeds these standards is required for approval.

1. The center has board certified/eligible practitioners in the fields of cardiology, hemodynamics and pulmonary function, cardiovascular surgery, anesthesiology, hepatology, hematology, immunology and infectious disease. Nursing, social services, and organ procurement services must complement the team. Specified team specific transplant coordinators are required for each organ.

2. The center has an active cardiovascular medical and surgical program with regard to heart transplants as evidenced by a minimum of 500 cardiac catherizations and coronary arteriograms and 250 open heart procedures per year.

3. The center has an anesthesia team that is available at all times.

4. The center has infectious disease services with both the professional skills and the laboratory resources that are needed to discover, identify, and manage a whole range of organisms.

5. The center has a nursing service team trained in the hemodynamic support of the patient and in managing immunosuppressed patients.

6. The center has pathology resources that are available for studying and reporting the pathological responses of transplantation.

7. The center has legal counsel familiar with transplantation laws and regulations.

8. Transplant surgeons and other responsible team members must be experienced, board certified or board eligible in their respective disciplines; organ specific transplant physicians are required for each organ/team.

9. Component teams must be integrated into a comprehensive transplant team with clearly defined leadership and responsibility.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES (cont)

10. The center has social services resources.

11. The transplant center must safeguard the rights and privacy of patients.

12. The transplant center must have patient management plans and protocols.

13. The center participates in a donor procurement program and network (the National Organ Procurement and Transplantation Network - OPTN).

14. The center systematically collects and shares data on its transplant program.

15. The center has an interdisciplinary body to determine the suitability of candidates for transplantation on an equitable basis and submits its recommendation regarding Medical Assistance recipients to the Division of Medical Assistance.

15A. **Recipient Selection**

The center must have procedures in place and document selection of transplant candidates and distribution of organs in a fair and equitable manner conducive to optimal recipient outcome.

16. The center has extensive blood bank support.

17. The center must have an established organ transplantation program with documented evidence of 12 or more heart transplants, or 25 or more kidney transplants or 12 or more liver transplants annually. Centers within the state of Washington that fail to meet volume requirement may request conditional approval.

18. The center performing heart transplants must demonstrate actuarial survival rates of 73 percent for one year and 65 percent for two years or greater.

19. The center performing transplants must have UNOS approval - also concerning survival rate.

20. In-state centers granted conditional approval on an exception basis must meet criteria standards within one year.

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CRITERIA FOR PANCREAS TRANSPLANTATION
January 19, 1990

TRANSPLANT CRITERIA

A. PANCREAS TRANSPLANTATION

Indications:

1. Insulin-dependent diabetics with renal failure who will undergo a renal **and** pancreas transplant.

2. The insulin-dependent diabetic with prior kidney transplant to undergo a pancreas transplant.

3. The insulin-dependent diabetic with nonrenal complications, such as retinopathy, neuropathy, or early vascular changes, and those patients with poorly controlled diabetes who will undergo a pancreas-only transplant.

B. HEART - LUNG TRANSPLANT

Indications:

1. Primary Pulmonary Hypertension resulting from elevated pulmonary vascular resistance with poor survival prognosis for over 12 to 18 months.

2. Eisenmenger's Syndrome with same prognosis as above number 1.

3. Core Pulmonale with same prognosis as number 1.

4. Cystic Fibrosis with same prognosis as above number 1.

Contraindications:

1. Contraindications with the exception of pulmonary hypertension are otherwise the same as for heart transplant patients.

2. Given the scarcity of heart lung donors, priority will be given to patients under the age of 50.

3. Particular attention must be given in the selection of patients with previous thoracic surgery and patients with liver dysfunction as these factors significantly affect mortality in heart-lung transplantation:

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C. SINGLE LUNG TRANSPLANTATION

Indications:

1. Terminal restrictive lung disease with life expectancy less than 18 months.

2. Primary Pulmonary Hypertension.

3. Patient over the age of 60 must be selected with particular care because of the shortage of donor material.

4. Patients with severe obstructive lung disease (and air trapping) are not considered optimal candidates; this is considered a weak indication.

Contraindications:

1. Acute or chronic pulmonary infectious process.

2. Ventilator dependence.

3. Cachexia.

4. Severe right ventricular failure.

5. Multi-organ system failure.

6. Systemic disease that may affect long term graft function/survival and recipient survival.

7. The presence of a malignancy, or significant history thereof.

8. Severe obstructive lung disease where air trapping is a moderate contraindication.

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Citation	Condition or Requirement
1932(a)(1)(A)	A. Section 1932(a)(1)(A) of the Social Security Act. The State of Washington enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries described in 42 CFR 438.50(d). Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place check mark to affirm such compliance.
1932(a)(1)(B)(i) 1932(a)(1)(B)(ii) 42 CFR 438.50(b)(1)-(2)	B. <u>Managed Care Delivery System.</u> The State will contract with the entity(ies) below and reimburse them as noted under each entity type. 1. ☐MCO a. ☐ Capitation 2. ☐PCCM (individual practitioners) a. ☐ Case management fee b. ☐ Bonus/incentive payments c. ☐ Other (please explain below) 3. ☒PCCM (entity based) a. ☒ Case management fee b. ☐ Bonus/incentive payments c. ☐ Other (please explain below) For states that elect to pay a PCCM a bonus/incentive payment as indicated in B.2.b. or B.3.b, place a check mark to affirm the state has met ***all*** of the following conditions (which are representative of the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).
Back to TOC	☐a. Incentive payments to the PCCM will not exceed 5% of the total

State WASHINGTON

Citation	Condition or Requirement
	FFS payments for those services provided or authorized by the PCCM for the period covered.
	☐b. Incentives will be based upon a fixed period of time.
	☐c. Incentives will not be renewed automatically.
	☐d. Incentives will be made available to both public and private PCCMs.
	☐e. Incentives will not be conditioned on intergovernmental transfer agreements.
	☐f. Incentives will be based upon specific activities and targets.
CFR 438.50(b)(4)	C. Public Process.
	Describe the public process including tribal consultation, if applicable, utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)*
	The State's PCCM program is provided only through tribal clinics and urban Indian health organizations (FQHCs). The program was implemented in the early 1990s, and, as the program has evolved, the state has collaborated with external stakeholders and tribal governance boards and clinic staff regarding any changes in the program.
	The State maintains a website which provides information about Apple Health managed care and PCCM updates and program changes. Users of the website are free to comment or ask questions whenever they wish to.
	The State consults with American Indian/Alaska Native tribal (AI/AN) organizations and clinics on all PCCM program changes, including the Department of Social and Health Services' Indian Policy Advisory Committee (IPAC) and the American Indian Health Commission (AIHC).
	D. State Assurances and Compliance with the Statute and Regulations.
	If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.
1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)	1. ☐The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.
1932(a)(1)(A)(i)(I) 1905(t)	2. ☒The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.

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Citation		Condition or Requirement
42 CFR 438.50(c)(2) 1902(a)(23)(A)		
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3.	☐The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring Beneficiaries to receive their benefits through managed care entities will be met.
1932(a)(1)(A) 42 CFR 431.51 1905(a)(4)(C)	4.	☒The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A)	5.	☒The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i).
1932(a)(1)(A) 42 CFR 438 1903(m)	6.	☒The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	7.	☐The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) CFR 447.362 42 CFR 438.50(c)(6)	8.	☒The state assures that all applicable requirements of 42 CFR 447.362 for 42 payments under any non-risk contracts will be met.
45 CFR 92.36	9.	☐The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

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Citation | Condition or Requirement

1932(a)(1)(A)
1932(a)(2)

E. Populations and Geographic Area

1. Included Populations. Please check which eligibility populations are included, if they are enrolled on a mandatory (M) or voluntary (V) basis, and the geographic scope of enrollment. Under the geography column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions.

Population	M	Geographic Area	V	Geographic Area	Excluded
Section 1931 Children & Related Populations – 1905(a)(i)			X	Benton, Clallam, Douglas, Ferry, Grant, Grays Harbor, Jefferson, King, Kitsap, Klickitat, Lincoln, Okanogan, Pacific, Pierce, Skamania, Snohomish, Spokane, Stevens, Whatcom and Yakima Counties	
Section 1931 Adults & Related Populations1905(a)(ii)			X	Please see above	
Low-Income Adult Group			X	Please see above	
Former Foster Care Children under age 21			X	Please see above	
Former Foster Care Children age 21-25			X	Please see above	
Section 1925 Transitional Medicaid age 21 and older			X	Please see above	
SSI and SSI related Blind Adults, age 18 or older* - 1905(a)(iv)			X	Please see above	
Poverty Level Pregnant Women – 1905(a)(viii)			X	Please see above	
SSI and SSI related Blind Children, generally under age 18 – 1905(a)(iv)			X	Please see above	
SSI and SSI related Disabled children under age 18			X	Please see above	
SSI and SSI related Disabled adults age 18 and older – 1905(a)(v)			X	Please see above	
SSI and SSI Related Aged Populations age 65 or older- 1905(a)(iii)			X	Please see above	
SSI Related Groups Exempt from Mandatory Managed Care under 1932(a)(2)(B)			X	Please see above	

Population	M	Geographic Area	V	Geographic Area	Excluded
Recipients Eligible for Medicare			X	Please see above	
American Indian/Alaskan Natives			X	Please see above	
Children under 19 who are eligible for SSI			X	Please see above	
Children under 19 who are eligible under Section 1902(e)(3)			X	Please see above	
Children under 19 in foster care or other in-home placement			X	Please see above	
Children under 19 receiving services funded under section 501(a)(1)(D) of title V and in accordance with 42 CFR 438.50(d)(v)			X	Please see above	
Other Families or individuals eligible for an Alternative Benefit Plan (ABP) as the result of the federal Affordable Care Act Children enrolled under the Children's Health Insurance Program (CHIP)			X	Please see above.	

2. **Excluded Groups.** Within the populations identified above as Mandatory or Voluntary, there may be certain groups of individuals who are excluded from the managed care program. Please indicate if any of the following groups are excluded from participating in the program:

☒Other Insurance--Medicaid beneficiaries who have other health insurance.

☒Reside in Nursing Facility or ICF/MR--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

☒Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program

☒Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

☐Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

State WASHINGTON

PRIMARY CARE CASE MANAGEMENT (PCCM)

Citation | Condition or Requirement

X Retroactive Eligibility–Medicaid beneficiaries for the period of retroactive eligibility.

☐ Other (Please define):

1932(a)(4) F. Enrollment Process.

1. Definitions.

a. Auto Assignment- assignment of a beneficiary to a health plan when the beneficiary has not had an opportunity to select their health plan.

b. Default Assignment- assignment of a beneficiary to a health plan when the beneficiary has had an opportunity to select their health plan.

2. Please describe how the state effectuates the enrollment process. Select an enrollment methodology from the following options and describe the elements listed beneath it:

a. ☒ The applicant is permitted to select a health plan at the time of application.

i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

The PCCM program is voluntary. PCCM clinics available in the beneficiaries' service area are shown on the screen of the state's online eligibility and enrollment system through the Health Benefit Exchange. Most beneficiaries who are eligible for PCCM are already seeing a PCCM provider so select the clinic where they receive services.

ii. What action the state takes if the applicant does not indicate a plan selection on the application.

PCCM is a voluntary program. The state sends eligible beneficiaries a copy of the "Welcome to Apple Health" booklet, which provides information about the Apple Health/Medicaid program and presents the PCCM options available to the beneficiary. If the beneficiary is not otherwise mandatorily enrolled into managed care via a different authority, he or she may choose to enroll in PCCM, an MCO or remain in the fee-for-service system.

iii. If action includes making a default assignment, describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

iv. The state's process for notifying the beneficiary of the default assignment. (Example: *state generated correspondence*.)

State WASHINGTON

PRIMARY CARE CASE MANAGEMENT (PCCM)

Citation		Condition or Requirement

b. ☐ The beneficiary has an active choice period following the eligibility determination.

a. How the beneficiary is notified of their initial choice period, including its duration.

b. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

c. Describe the algorithm used for default assignment and describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

d. The state's process for notifying the beneficiary of the default assignment.

c. ☐ The beneficiary is auto-assigned to a health plan immediately upon being determined eligible.

i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

ii. The state's process for notifying the beneficiary of the auto-assignment. (Example: state generated correspondence.)

iii. Describe the algorithm used for auto-assignment and describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

The state does not auto-enroll to the PCCM program.

1932(a)(4)
42 CFR 438.50

3. State assurances on the enrollment process.

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

a. ☐The state assures it has an enrollment system that allows Beneficiaries who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

b. ☒The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid Beneficiaries enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

c. ☒ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs in accordance with 42 CFR 438.52(b). Please list the impacted rural counties

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Citation	Condition or Requirement
	Impacted Rural Counties are: Clallam, Douglas, Ferry, Grant, Grays Harbor, Jefferson, Kitsap, Klickitat, Lincoln, Okanogan, Pacific, Skamania, Stevens, and Whatcom Counties
	☐This provision is not applicable to this 1932 State Plan Amendment.
	d. ☒ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.
	☐This provision is not applicable to this 1932 State Plan Amendment.
1932(a)(4) 42 CFR 438.56	G. Disenrollment.
	1. The state will☐/will not☒ limit disenrollment for managed care.
	2. The disenrollment limitation will apply for twelve months (up to 12 months).
	3. ☒The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).
	4. Describe the state's process for notifying the Medicaid Beneficiaries of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*
	The state sends eligible beneficiaries a copy of the "Welcome to Apple Health" booklet, which provides information about the Apple Health/Medicaid program and presents the PCCM options available to the beneficiary, including the beneficiary's ability to disenroll without cause. Because PCCM is a voluntary program, enrollees may end their enrollment, or may change from a PCCM provider to an MCO at any time, without cause.
	Describe any additional circumstances of "cause" for disenrollment (if any).
	H. Information Requirements for Beneficiaries
1932(a)(5)(c) 42 CFR 438.50 42 CFR 438.10	☒The state assures that its state plan program is in compliance with 42 CFR 438.10(e) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments.
1932(a)(5)(D)(b) 1903(m) 1905(t)(3)	I. List all benefits for which the MCO is responsible.
	PCCM clinics provide or coordinate all covered services for enrollees and these services are covered through the State's fee-for-service system.
1932(a)(5)(D)(b)(4) 42 CFR 438.228	J. ☐The state assures that each managed care organization has established an internal grievance procedure for enrollees

State WASHINGTON

Citation	Condition or Requirement
1932(a)(5)(D)(b)(5) 42 CFR 438.206 42 CFR 438.207	K. Describe how the state has assured adequate capacity and services. *The state assures adequate capacity and services through the complaints system; we have received no complaints about access to care through any tribal clinic or urban Indian health organizations.*
1932(a)(5)(D)(c)(1)(A) 42 CFR 438.240	L. ☐The state assures that a quality assessment and improvement strategy has been developed and implemented.
1932(a)(5)(D)(c)(2)(A) 42 CFR 438.350	M. ☐The state assures that an external independent review conducted by a qualified independent entity will be performed yearly.
1932 (a)(1)(A)(ii)	N. Selective Contracting Under a 1932 State Plan Option To respond to items #1 and #2, place a check mark. The third item requires a brief narrative. 1. The state will☒/will not☐ intentionally limit the number of entities it contracts under a 1932 state plan option. 2. ☒The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services. 3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)* *All tribal clinics and urban Indian health organizations are eligible to participate in the PCCM program, and may submit a contract request at any time. The tribal entity or urban Indian health organization is required to submit information about their organization and State staff makes a site visit prior to contracting for services. The State's Administrator of Tribal Affairs and Analysis plays an integral role in this process.* *AI/ANs have a federal right to exempt themselves from Medicaid managed care, in part because tribal clinics and urban Indian health organizations already have the responsibility to manage the care of their AI/AN clients. In respect of this federal trust responsibility and of the relationship between tribal clinics/urban Indian health organizations and their clients, the State has offered the PCCM program through tribal clinics and urban Indian health organizations since it offered Medicaid managed care to non-AI/ANs. With a nominal monthly payment, the PCCM program supports care coordination by tribal clinics and urban Indian health organizations for clients who are not participating in Medicaid managed care and therefore not receiving care coordination from Medicaid managed care organizations.* *4.* ☐The selective contracting provision in not applicable to this state plan..

State WASHINGTON

Citation	Condition or Requirement
	According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0933. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850 CMS-10120 (exp. 3/31/2014)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

APPLE HEALTH MANAGED CARE

Citation	Condition or Requirement

1932(a)(1)(A) **A. Section 1932(a)(1)(A) of the Social Security Act**

The State of Washington enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230).

This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries described in 42 CFR 438.50(d).

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state will place a check mark to affirm such compliance.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)-(2)

B. Managed Care Delivery System

The State will contract with the entity(ies) below and reimburse them as noted under each entity type.

1. ☒MCO
   a. ☒Capitation

2. ☐PCCM (individual practitioners)
   1. ☐ Case management fee
   2. ☐ Bonus/incentive payments
   3. ☐ Other (please explain below)

3. ☐PCCM (entity based)
   1. ☐ Case management fee
   2. ☐ Bonus/incentive payments
   3. ☐ Other (please explain below)

For states that elect to pay a PCCM a bonus/incentive payment as indicated in B.2.b. or B.3.b, place a check mark to affirm the state has met ***all*** of the following conditions (which are representative of the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

APPLE HEALTH MANAGED CARE

Citation | Condition or Requirement

☒a. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.

☐b. Incentives will be based upon a fixed period of time.

☐c. Incentives will not be renewed automatically.

☐d. Incentives will be made available to both public and private PCCMs.

☐e. Incentives will not be conditioned on intergovernmental transfer agreements.

☐f. Incentives will be based upon specific activities and targets.

CFR 438.50(b)(4) **C. Public Process**

Describe the public process including tribal consultation, if applicable, utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)*

The state utilizes the following processes, meetings and correspondence to invite stakeholder input to managed care activities:

- *Statewide Title XIX committee meetings*
- *Monthly open public meetings focusing on the MCOs that provide Apple Health managed care programs but open to anyone*
- *Public website providing information about Apple Health managed care updates and program changes*
- *Regular consultation with American Indian/Alaska Native tribal organizations and clinics on all program changes*
- *Notification of a comprehensive list of stakeholders about changes in the Apple Health managed care program*
- *Notification of enrollees about all proposed substantive changes to the program regarding benefits, administration of benefits (i.e. grievance and appeals, authorizations and denials), service area, or enrollment*

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

APPLE HEALTH MANAGED CARE

Citation	Condition or Requirement
	D. State Assurances and Compliance with the Statute and Regulations
	If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.
1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)	1. ☒The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2. ☐The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.
1932(a)(1)(A) CFR 438.50(c)(3)	3. ☒The state assures that all the applicable requirements of section 42 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring Beneficiaries to receive their benefits through managed care entities will be met.
1932(a)(1)(A) 42 CFR 431.51 1905(a)(4)(C)	4. ☒The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A)	5. ☒The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i).
1932(a)(1)(A) 42 CFR 438 1903(m)	6. ☒The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	7. ☒The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	8. ☐The state assures that all applicable requirements of 42 CFR 447.362 for payments under any non-risk contracts will be met.
45 CFR 92.36	9. ☒The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

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APPLE HEALTH MANAGED CARE

Citation | Condition or Requirement

1932(a)(1)(A)
1932(a)(2)

E. Populations and Geographic Area

IV. *Included Populations.* Please check which eligibility populations are included, if they are enrolled on a mandatory (M) or voluntary (V) basis, and the geographic scope of enrollment. Under the geography column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions.

NOTE: *Former Foster Care Children under age 21, Former Foster Care Children age 21-25, Children under 19 in foster care or other in-home placement will be eligible for voluntary enrollment in Apple Health Managed Care until March 30, 2016. Effective April 1, 2016, these groups will be eligible for Apple Health Foster Care, a new program for children in foster and for young adults who have aged out of foster care.*

Population	M	Geographic Area	V	Geographic Area	Excluded
Section 1931 Children & Related Populations – 1905(a)(i)	X	Adams, Asotin, Benton, Chelan, Clark, Columbia, Cowlitz, Douglas, Ferry, Franklin, Garfield, Grant, Grays Harbor, Island, Jefferson, King, Kitsap, Kittitas, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Oreille, Pierce, San Juan, Skagit, Snohomish, Spokane, Stevens, Thurston, Wahkiakum, WallaWalla,Whatcom, Whitman, Yakima	X	Klickitat, Skamania, Clallam Counties	
Section 1931 Adults & Related Populations1905(a)(ii)	X	See above list	X	Klickitat, Skamania, Clallam Counties	
Low-Income Adult Group	X	See above list	X	Klickitat, Skamania, Clallam Counties	
Former Foster Care Children under age 21			X	Statewide	
Former Foster Care Children age 21-25			X	Statewide	
Section 1925 Transitional Medicaid age 21 and older	X	See above list	X	Klickitat, Skamania, Clallam Counties	
SSI and SSI related Blind Adults, age 18 or older* - 1905(a)(iv)			X	Statewide	

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Population	M	Geographic Area	V	Geographic Area	Excluded
Poverty Level Pregnant Women – 1905(a)(viii)	X	See above list	X	Klickitat, Skamania, Clallam Counties	
SSI and SSI related Blind Children, generally under age 18 – 1905(a)(iv)			X	Statewide	
SSI and SSI related Disabled children under age 18			X	Statewide	
SSI and SSI related Disabled adults age 18 and older – 1905(a)(v)			X	Statewide	
SSI and SSI Related Aged Populations age 65 or older- 1905(a)(iii)					X
SSI Related Groups Exempt from Mandatory Managed Care under 1932(a)(2)(B)					X
Recipients Eligible for Medicare			X	Statewide	
American Indian/Alaskan Natives			X	Statewide	
Children under 19 who are eligible for SSI			X	Statewide	
Children under 19 who are eligible under Section 1902(e)(3)			X	Statewide	
Children under 19 in foster care or other in-home placement			X	Statewide	
Children under 19 receiving services funded under section 501(a)(1)(D) of title V and in accordance with 42 CFR 438.50(d)(v)			X	Statewide	
Other Families or individuals eligible for an Alternative Benefit Plan (ABP) as the result of the federal Affordable Care Act Children enrolled under the Children's Health Insurance Program (CHIP)	X	See above list	X	Klickitat, Skamania, Clallam Counties	

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2. *Excluded Groups.* Within the populations identified above as Mandatory or Voluntary, there may be certain groups of individuals who are excluded from the managed care program. Please indicate if any of the following groups are excluded from participating in the program:

☒Other Insurance--Medicaid beneficiaries who have other health insurance.

☒Reside in Nursing Facility or ICF/MR--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

☒Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program

☒Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

☐Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

☒ Retroactive Eligibility–Medicaid beneficiaries for the period of retroactive eligibility.

☒ Other (Please define): American Indian/Alaska Natives.

1932(a)(4) **F. Enrollment Process.**

1. Definitions

a. Auto Assignment- assignment of a beneficiary to a health plan when the beneficiary has not had an opportunity to select their health plan.

b. Default Assignment- assignment of a beneficiary to a health plan when the beneficiary has had an opportunity to select their health plan.

2. Please describe how the state effectuates the enrollment process. Select an enrollment methodology from the following options and describe the elements listed beneath it:

a, ☐ The applicant is permitted to select a health plan at the time of application.

i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

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Newly eligible beneficiaries are able to select a plan at the time they become eligible for Medicaid. The beneficiary has the ability to search the state's "HealthPlanFinder" (HPF) for a specific clinic or provider and then determine with which plans that clinic or provider contracts. HPF also provides information about each of the MCOs available in the potential enrollee's service area by way of providing HEDIS information for each plan, as well as client survey information for each plan. Because most beneficiaries select a plan based on whether their primary care provider (PCP) is contracted, this additional information can help support that decision, or can provide direction for those beneficiaries who do not already have a PCP.

ii. What action the state takes if the applicant does not indicate a plan selection on the application.

If the beneficiary does not select a plan during the eligibility process, the state assigns the beneficiary to a plan and sends the beneficiary notice of the assignment, along with the "Welcome to Apple Health" beneficiary handbook and directions on how to change plans if the beneficiary wishes to choose a different plan.

Beneficiaries receive two handbooks - The "Welcome to Apple Health Handbook" that the state sends out and an MCO managed care handbook (based on an HCA-supplied template), which is sent to new enrollees as part of their welcome packet. Beneficiaries do not receive duplicate Welcome to Apple Health Handbooks each time they change MCOs, they would receive the MCO handbook for the new MCO each time they change MCOs.

iii. If action includes making a default assignment, describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

The state default assignment process is based on the state's assignment algorithm, which is based on network adequacy, performance under two HEDIS Clinical Performance measures (Childhood Immunization Combo 2 Status, and Comprehensive diabetes care: retinal eye exam) and one Administrative Measure (Initial Health Screen).

iv. The state's process for notifying the beneficiary of the default assignment. (Example: *state-generated correspondence*.)

The state generates a letter to the beneficiary, notifying him or her of the plan assignment and directions on how to change plans if the beneficiary wishes to choose a different plan.

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b. ☐ The beneficiary has an active choice period following the eligibility determination.

i. How the beneficiary is notified of their initial choice period, including its duration.

ii. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

iii. Describe the algorithm used for default assignment and describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

iv. The state's process for notifying the beneficiary of the default assignment.

c. ☐ The beneficiary is auto-assigned to a health plan immediately upon being determined eligible.

i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

ii. The state's process for notifying the beneficiary of the auto-assignment. (*Example: state-generated correspondence*.)

iii. Describe the algorithm used for auto-assignment and describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

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Citation	Condition or Requirement
1932(a)(4) CFR 438.50	3. State assurances on th enrollment process Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment. a. ☒The state assures it has an enrollment system that allows beneficiaries who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program. b. ☒The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid beneficiaries enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3). c. ☐ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs in accordance with 42 CFR 438.52(b). Please list the impacted rural counties: ☒This provision is not applicable to this 1932 State Plan Amendment. d. ☒ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less. ☐This provision is not applicable to this 1932 State Plan Amendment

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Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.56	**G. Disenrollment**

1. The state will ☐/will not☒ limit disenrollment for managed care.

2. The disenrollment limitation will apply for Choose an item. months (up to 12 months).

3. ☒The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe the state's process for notifying the Medicaid Beneficiaries of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state-generated correspondence, HMO enrollment packets, etc.)*

   Beneficiaries are notified of this ability in the Welcome to Apple Health booklet they receive from the state upon eligibility determination. (Note: Beneficiaries also receive a booklet from their MCO, describing in more detail the information that is provided in the Welcome to Apple Health booklet).

5. Describe any additional circumstances of "cause" for disenrollment (if any).

   Medicaid beneficiaries may disenroll – i.e., change plans, prospectively each month, without cause.

H. Information Requirements for Beneficiaries

1932(a)(5)(c)
42 CFR 438.50
42 CFR 438.10

☒The state assures that its state plan program is in compliance with 42 CFR 438.10(e) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments.

1932(a)(5)(D)(b)
1903(m)

I. List all benefits for which the MCO is responsible

1905(t)(3)

Fully Integrated Managed Care: The State intends to implement Fully Integrated Managed Care (Medical, Mental Health and Substance Use Disorder Services) on a phased in basis, beginning with Clark and Skamania Counties and expanding until 2020, when Fully Integrated Managed Care, provided by Apple Health MCOs will be provided statewide.

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- *Ambulance transportation - ground ambulance transportation for emergency medical conditions; non-emergency ambulance transportation is provided to transport an enrollee between facilities and to transport an enrollee to receive a covered service when the enrollee must be transported on a stretcher and may need medical addition en route.*
- *Ambulatory Surgery Center*
- *Applied Behavioral Analysis, including initial clinical evaluation*
- *Bilateral cochlear Implants, including implants, including parts, accessories, batteries, chargers, and repairs for enrollees age 20 and younger*
- *Blood, blood components and human blood products: Administration of whole blood and blood components as well as human blood products. In areas where there is a charge for blood and/or blood products, the Contractor will cover the cost of the blood or blood products.*
- *Bone-Anchored Hearing Aids (BAHA)*
- *Comprehensive medication therapy management services*
- *Contraceptives - all Food and Drug Administration (FDA)-approved contraceptive drugs, devices, and supplies, including emergency contraception, all long-acting reversible contraceptives, all over-the-counter (OTC) contraceptives and contraceptive methods which require administration or insertion by a health care professional in a medical setting. Enteral and parenteral nutritional supplements and supplies, including prescribed infant formulas.*
- *Durable medical equipment (DME) and supplies*
- *Early and Periodic Screening, Diagnostic and Treatment (EPSDT) (42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(b), 1396d(r))*
- *Early, elective inductions (before 39 weeks)*
- *Habilitative services: limited to enrollees in the Medicaid expansion population that are eligible for the Alternative Benefit Plan (ABP). Devices for adults and children provided for this purpose are covered under the DME benefit.*
- *Hemophiliac blood product: blood factors VII, VIII, and IX and the anti-inhibitor provided to enrollees with a diagnosis of hemophilia or von Willebrand disease when the enrollee is receiving services in an inpatient setting*
- *Home health services: home health services through state-licensed agencies*
- *Hospice services: includes services for adults and children and provided in skilled nursing facilities/nursing facilities, hospitals, hospice care centers and the enrollee's home*

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- *Laboratory, radiology, and other medical imaging services: screening and diagnostic services and radiation therapy*
- *Monaural and binaural hearing aids, including fitting, follow-up care, batteries, and repair for enrollees age 20 and younger*
- *Neurodevelopmental services: the Contractor may refer children to a Department of Health (DOH)-recognized neurodevelopmental center for the services as long as appointment wait time standards and access to care standards of this Contract are met*
- *Newborn screenings: the Contractor will cover all newborn screenings required by the Department of Health*
- *Occupational therapy, speech therapy, and physical therapy*
- *Outpatient mental health services, including mental health medications and medication management*
- *Pediatric concurrent care*
- *Pediatric palliative care*
- *Pharmaceutical products: prescription and over-the-counter drug products according to the Health Care Authority-approved formulary*
- *Renal failure treatment. Hemodialysis, or other appropriate procedures to treat renal failure, including equipment needed in the course of treatment*
- *Respiratory care: equipment, services and supplies*
- *Screening, Brief Intervention and Referral to Treatment (SBIRT) services for adolescents and adults*
- *Second opinion for children prescribed mental health medications*
- *Services to inmates of city and county jail facilities: the Contractor will provide inpatient hospital services to enrollees who are inmates of a city or county jail facility when an inpatient admission occurs during the first month of the incarceration period and HCA has paid a premium for that month to the Contractor*

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V. Services provided in an inpatient or outpatient (e.g., office, clinic, emergency room, pharmacy or home) setting by licensed professionals including, but not limited to, physicians, physician assistants, advanced registered nurse practitioners, naturopaths, pharmacists, midwives, podiatrists, audiologists, registered nurses, and certified dietitians. Provider services include, but are not limited to:

- *Administering pharmaceutical products*
- *Anesthesia*
- *Bio-feedback training when determined medically necessary*
- *Enrollee health education*
- *Family planning services provided or referred by a participating provider or practitioner*
- *Fitting prosthetic and orthotic devices*
- *Genetic services, other than prenatal diagnosis and genetic counseling including: testing, counseling and laboratory services, when medically necessary for diagnosis of a medical condition*
- *Immunizations, including the varicella zoster (shingles) vaccine for enrollees age sixty (60) and over. For enrollees under age sixty (60), the Contractor may require prior authorization.*
- *Medical examinations, including wellness exams for adults and EPSDT for children*
- *Nutritional counseling by a certified registered dietician for specific conditions such as failure to thrive, feeding problems, cystic fibrosis, diabetes, high blood pressure, and anemia*
- *Performing and/or reading diagnostic tests*
- *Pregnant and postpartum clients receive coverage for TDAP vaccine given in any setting (pharmacy, obstetrical provider, etc.) whether or not ordered by PCP*
- *Private duty nursing for children age seventeen (17) and younger*
- *Rehabilitation services. Services to correct defects from birth, illness, or trauma, and mastectomy reconstruction*
- *Surgical services*
- *Telemedicine*
- *Smoking cessation services without primary care provider referral or Contractor prior authorization*
- *Surgical procedures for weight loss or reduction*
- *Tissue and organ transplants: heart, kidney, liver, bone marrow, lung, heart-lung, pancreas, kidney-pancreas, cornea, small bowel, and peripheral blood stem cell*

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Citation Condition or Requirements

- *Vision care: eye examinations for visual acuity and refraction once every twenty-four (24) months for adults and once every twelve (12) months for children under age twenty-one (21)*

In regions of the state in which a Fully Integrated Managed Care program has been implemented, the MCO will be responsible for the following services in addition to those provided above:

- *Inpatient and outpatient Mental Health Services including:*
  - *Brief Intervention*
  - *Day Support*
  - *Family Treatment*
  - *Group Treatment Services*
  - *High Intensity Treatment*
  - *Individual Treatment Services*
  - *Inpatient Hospital Services*
  - *Intake evaluation, including Special Population evaluation, if appropriate*
  - *Medication Management*
  - *Medication Monitoring*
  - *Peer Support*
  - *Psychological Assessment*
  - *Rehabilitation Case Management*
  - *Residential Treatment, including Freestanding Evaluation and Treatment services*
  - *Therapeutic Psychoeducation*
- *Substance Use Disorder Treatment provided in accordance with the American Society of Addiction Medicine (ASAM) Patient Placement Criteria 2-Revised (ASAM PPC2-R), including screening and assessment and referral to services. Services include:*
  - *Acute and sub-acute alcohol/drug detoxification services*
  - *Outpatient treatment services including Medication Assisted Therapy*
  - *Residential Treatment services in a 24/hour a day supervised facility*

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Citation	Condition or Requirements
1932(a)(5)(D)(b)(4) 42 CFR 438.228	**J.** ☒The state assures that each managed care organization has established an internal grievance procedure for enrollees.
1932(a)(5)(D)(b)(5) 42 CFR 438.206 42 CFR 438.207	**K.** Describe how the state has assured adequate capacity and services. *The state's contracted plans submit quarterly network submissions which are evaluated for compliance with distance standards for six critical provider types: hospital, pharmacy, primary care providers, pediatricians, OB/GYN and mental health. Assignments are based, in part, on this network evaluation.*
1932(a)(5)(D)(c)(1)(A) 42 CFR 438.240	**L**. ☒The state assures that a quality assessment and improvement strategy has been developed and implemented.
1932(a)(5)(D)(c)(2)(A) 42 CFR 438.350	**M.** ☒The state assures that an external independent review conducted by a qualified independent entity will be performed yearly
1932 (a)(1)(A)(ii)	**N**. Selective Contracting Under a 1932 State Plan Option To respond to items #1 and #2, place a check mark. The third item requires a brief narrative. 1. The state will☒/will not☐ intentionally limit the number of entities it contracts under a 1932 state plan option. 2. ☒The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services. 3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)* *The state's process for adding new Managed Care Organizations (MCOs) for the Apple Health Managed Care program is as follows:* • *The MCO that wishes to participate in Apple Health Managed Care may submit a letter of interest to the state along with all of the following documentation:* ○ *Certificate of registration from the Washington Office of the Insurance Commissioner (OIC) that allows the MCO to provide health care services under a risk-based contract*

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- *Acceptance of the terms and conditions of the Apple Health Managed Care contract*

- *Proof of network adequacy in the service areas in which the MCO wishes to participate*

- *Attestation that the MCO meets the quality standards for Apple Health Managed Care that have been established by the state for the currently participating Apple Health Managed Care MCOs.*

If the state determines that there is a need for an additional MCO in the proposed service areas, the state conducts and onsite readiness review of the applicant's operations, including:

- *Customer service*
- *Grievance and appeal processes*
- *Subcontracting*
- *Quality and Performance Improvement (QAPI)*
- *Care coordination*

Network adequacy is validated in a separate process, as is financial viability to provide these services.

If the applicant meets the contract standards reviewed at the readiness review, the state issues an Apple Health Managed Care contract.

4. ☒The selective contracting provision in not applicable to this state plan.

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COORDINATION OF TITLE XIX WITH PART B OF TITLE XVIII

The following method is used to provide the entire range of benefits under Part B of title XVIII to the groups of Medicare-eligible individuals indicated:

[X] A. Buy-in agreements with the Secretary of HHS. This agreement covers:

1. [ ] Individuals receiving SSI under title ZVI or State supplementation, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

   [ ] Yes [ ] No

2. [ ] Individuals receiving SSI under title XVI, State supplementation, or a money payment under the State's approved title IV-A plan, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

   [ ] Yes [ ] No

3. [X] All individuals eligible under the State's approved title XIX plan.

[ ] B. Group premium payment arrangement entered into with the Social Security Administration. This arrangement covers the following groups:

[X] C. Payment of deductible and coinsurance costs. Such payments are made in behalf of the following groups:

All Medicare-Eligible individuals who are also eligible under this Title XIX Plan.

This relates only to comparability of devices - benefits under XVIII to what groups- not how XIX pays. ... if State has buy-in (which covers premium), it does not check #3 for same group-only if it does #3 for another group; e.g. does #1 for money payment receipts and #3 for non-$-receipts. How it handles deductibles and coinsurance for money payment receipts is a matter for reimbursement attachment.

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