

Attachment 3

Services:
General Provisions

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

- 1. Inpatient hospital services other than those provided in an institution for mental diseases.
 Provided: No limitations With limitations*

- 2.a. Outpatient hospital services.
 Provided: No limitations With limitations*

- b. Rural health clinic services and other ambulatory services furnished.
 Provided: 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).
 Provided: No limitations With limitations*

- 3. Other laboratory and x-ray services.
 Provided: No limitations With limitations*

- 4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
 Provided: No limitations 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.
 Provided: No limitations With limitations*

*Description provided on attachment.

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

Provided: No limitations With limitations*

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

Provided: No limitations 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.

Provided: No limitations With limitations*

Not Provided:

b. Optometrists' services.

Provided: No limitations With limitations*

Not Provided:

c. Chiropractor's services.

Provided: No limitations With limitations*

Not Provided:

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

Provided: No limitations With limitations*

Not Provided:

*Description provided on attachment.

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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.
 Provided: No limitations With limitations*
 - b. Home health aide services provided by a home health agency.
 Provided: No limitations With limitations*
 - c. Medical supplies, equipment, and appliance suitable for use in the home.
 Provided: No limitations With limitations*
 - d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.
 Provided: No limitations With limitations*
 - e. Other Medical services, supplies, equipment and appliances.
 Provided: No Limitations With limitations*

- 8. Private duty nursing services.
 Provided: No limitations With limitations*
 Not Provided:

- 9. Clinic services.
 Provided: No limitations With limitations*
 Not Provided:

*Description provided on attachment.

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10. Dental services.

Provided: No limitations With limitations*

Not Provided:

11. Physical therapy and related services.

a. Physical therapy.

Provided: No limitations With limitations*

Not Provided:

b. Occupational therapy.

Provided: No limitations 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).

Provided: No Limitations 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.

Provided: No limitations With limitations*

Not Provided:

b. Dentures.

Provided: No limitations With limitations*

*Description provided on attachment.

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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.

Provided: No limitations With limitations*

Not Provided:

d. Eyeglasses.

Provided: No limitations 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:

b. Screening services.

Provided: No limitations With limitations*

Not Provided:

c. Preventive services.

Provided: No limitations With limitations*

Not Provided:

d. Rehabilitative services.

Provided: No limitations With limitations*

Not Provided:

*Description provided on attachment.

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

a. Inpatient hospital services.

Provided: No limitations With limitations*

Not Provided:

b. Nursing facility services.

Provided: No limitations With limitations*

Not Provided:

c. Intermediate care facility services.

Provided: 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.

Provided: 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:

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

Provided: No limitations With limitations*

Not Provided:

*Description provided on attachment.

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17. Nurse -midwife services.

Provided: No limitations With limitations*

Not Provided:

18. Hospice care (in accordance with section 1903(o) of the Act.

Provided: No limitations 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).

Provided: With limitations*

Not Provided:

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

Provided: With limitations*

Not Provided:

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

*Description provided on attachment.

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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*

*Description provided on attachment.

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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.

Provided: No limitations With limitations*

Not Provided:

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

Provided: No limitations With limitations*

Not Provided:

c. Reserved.

Provided: No limitations With limitations*

Not Provided:

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

Provided: No limitations With limitations*

Not Provided:

e. Emergency hospital services.

Provided: No limitations With limitations*

Not Provided:

*Description provided on attachment.

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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.

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

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.

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Description of Service Limitations

1. 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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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.

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

Early Periodic Screening, Diagnosis and Treatment (EPSDT) is a program providing EPSDT to persons under 21 years of age who are eligible for Medicaid or the Children's Health Program. 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 do not apply other than based on medical necessity.

(1) School-based healthcare services provided to a child with a disability in accordance with the Individuals with Disabilities Education Act (IDEA):

- Address the physical and/or mental disabilities of the child;
- Are prescribed or can be recommended by a physician or another licensed healthcare practitioner within his or her scope of practice under State law; and
- Are included in the child's IEP in accordance with IDEA.

(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 requirements and who operates within the scope of his or her license or certification according to State law and professional practice standards.

- (i) *Physical therapist* – A 'qualified physical therapist' is an individual who meets the requirements set forth in 42 CFR 440.110 (a) and who is licensed according to the Washington State Board of Physical Therapy.
- (ii) *Occupational therapist* – A 'qualified occupational therapist' is an individual who meets the requirements set forth in 42 CFR 440.110 (b) and who is licensed according to the Washington State Occupational Therapy Practice Board. Occupational therapy services may be provided by a Certified Occupational Therapy Assistant under the direction/supervision of a licensed occupational therapist according to professional practice standards.
- (iii) *Speech pathologist* – A 'qualified speech pathologist' is an individual who meets the requirements set forth in 42 CFR 440.110 (c) (2) and who is licensed according to the Washington State Board of Hearing and Speech.
- (iv) *Audiologist* – A 'qualified audiologist' is an individual who meets the requirements set forth in 42 CFR 440.110 (c) (3) and who is licensed according to the Washington state Board of Hearing and Speech.
- (v) *Registered nurse, practical nurse* – A 'qualified registered nurse or practical nurse' is an individual who is licensed according to the Washington State Health Nursing Commission in accordance with 42 CFR 440.60.

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4. b. EPSDT (cont)
- (vi) *Psychologist* – A ‘qualified school psychologist’ is an individual who is licensed according to the Washington State Board of Psychology in accordance with 42 CFR 440.130(d).
 - (vii) *Social worker* – A ‘qualified school social worker’ is an individual who is licensed according to the Washington State Board of Health in accordance with 42CFR 440.130(d).
 - (viii) *Mental health counselor* – A ‘qualified school mental health counselor’ is an individual who is licensed according to the Washington State Board of Health in accordance with 42 CFR 440.130(d).
 - (ix) In those circumstances when a healthcare-related service is provided under the direction or supervision of a federally qualified therapist, the following restrictions apply. Documentation must be kept supporting the federally qualified therapist’s supervision of services and ongoing treatment of services. The supervising therapist must:
 - (A) See the child at the beginning of and periodically during treatment;
 - (B) Be familiar with the treatment plan as recommended by the healthcare practitioner under State law;
 - (C) Have a continued involvement in the care provided; and
 - (D) Review the need for continued services throughout treatment.
- (b) Covered services are provided in accordance with 1905 (a) of the Social Security Act including (4) (B), (6), (11), (13) (28) and sub-section (r) (5).
- (i) *Physical therapy evaluation and treatment services* – Assessing, preventing, or alleviating movement dysfunction and related dysfunctional problems.
 - (ii) *Occupational therapy evaluation and treatment services* – Assessing, improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation, improving ability to perform tasks for independent functioning when functions are lost impaired, preventing through or early intervention, initial or further impairment or loss of function.
 - (iii) *Speech-language therapy evaluations and treatment services* – Assessment of children with speech and/or language disorders, diagnosis and appraisal of specific speech and/or language disorders, referral for medical and other professional attention necessary for the rehabilitation of speech and/or language disorders, provision of speech or language services for the prevention or improvement of communication disorders.

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4. b. EPSDT (cont)
- (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 for medical or other professional attention for restoration or 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 and remedial services either recommended by a physician or determined to be necessary by the licensed registered nurse; treatment services including those that prevent disease, disability, and other health conditions or their progression, and supervision of delegated health care services.
 - (vi) *Psychological assessments and psychotherapy services* – Psychological assessments including testing, and psychotherapy to assist a child to adjust to their disability.
 - (v) *Counseling assessments and therapy services* – Therapeutic intervention services to assist a child to adjust to their disability
- (c) Medicaid beneficiaries have freedom of choice of 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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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.

- For adults: Outpatient psychotherapy and electroconvulsive therapy, in any combination – one hour per day, per client, up to a total of twelve hours per calendar year. Includes family or group psychotherapy.
- For children: Outpatient psychotherapy and electroconvulsive therapy, in any combination – one hour per day, per client, up to a total of twenty hours per calendar year. Includes family or group psychotherapy.
- Psychiatric diagnostic interview examinations – one in a calendar year unless an additional evaluation 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 prescription 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

Short stay procedures also take place in ambulatory surgery settings.

- (1) Non-emergent oral surgeries performed in an inpatient hospital setting are not covered. The exceptions to this are DDD clients and children 18 years of age and under, whose surgery cannot be performed in an office setting (e.g., orthognathic cleft palate bone grafting). Prior written authorization is required. Documentation must be maintained in the client's record.
- (2) Orthodontic treatment is limited to medically necessary treatment, as follows, and only for children with, craniofacial anomalies or cleft lip or palate or severe handicapping malocclusion:
 - (a) Clients in the EPSDT program through age twenty (20);
 - (b) Clients in the children's health program through age eighteen (18);
 - (c) Clients in the CN program through age twenty (20).

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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 an M.D., D.O., or podiatrist.
 - (2) The treatment of flat feet, or non-medically necessary treatment of fungal disease is not covered.
- b. Optometrists' services
- (1) Frames, lenses, and contact lenses must be ordered from the department's contractor.
 - (2) The department covers medically necessary eye examinations, refractions, eyeglasses (frames and glasses), and fitting fees as follows:
 - Every 24 months for asymptomatic adults 21 years or older; and
 - Every 12 months for asymptomatic children 20 years or younger, and clients identified by the Department as developmentally disabled.
 - (3) The department covers medically necessary contact lenses, as defined in chapter 388-544 WAC. Normal replacement for contact lenses is every 12 months.
 - (4) Exceptions to numbers (2) and (3) above will be considered for all individuals based on medical necessity.
 - (5) 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 Department.
6. d. Other practitioners' services
- All other practitioners covered by the department include, but are not limited to, the following licensed practitioners: physician assistants, advanced registered nurse practitioners including certified registered nurse anesthetists, psychologists, dental hygienists, denturists, chiropractors (for EPSDT only), dietitians, nutritionists, radiological technicians, opticians, and licensed non-nurse midwives. These practitioners are limited to services within their scope of practice and specialty area.
- Counselors, social workers, and other practitioners are covered as specified in other sections of the State Plan and as approved by the department.

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

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

Children's mental health outpatient services may be provided up to twenty hours per calendar year, subject to medical necessity. Prior authorization is required for additional services that are medically necessary.

Mental health payment rate methodology is in accordance with Attachment 4.19-B, page 6.

(1) HRSA does not cover services provided by:

- Acupuncturists
- Christian Science practitioners or theological healers
- Herbalists
- Homeopathists
- Naturopaths
- Masseuses
- Masseurs
- Sanipractors

(2) Licensed non-nurse midwives.

- To participate in home births and in birthing centers, midwives must be a HRSA-approved provider.

(3) Psychologists.

- One psychological evaluation per client's lifetime is covered.
- Neuropsychological testing requires prior authorization.
- Children's mental health outpatient services up to twenty hours per calendar year, including evaluation, subject to medical necessity.

(4) Intentionally left blank.

(5) Dietitians.

Medical Nutrition Therapy is a face-to-face interaction between a licensed/certified dietitian and the client and/or client's guardian for the purpose of evaluating and making recommendations regarding the client's nutritional status. The service must be medically necessary and the client must be 20 years of age or younger with an EPSDT referral.

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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.
 - (5) 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
 Medical supplies, equipment and appliances must be:
 - (1) Medically necessary;
 - (2) Ordered by the treating physician; and
 - (3) In the plan of care.

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:

 - (4) Purchase of equipment and appliances and rental of durable medical equipment require prior approval.
 - (5) Must be billed separately under a DME provider number.
 - (6) Are subject to the requirements in Washington Administrative Code.
 - (7) Specific reusable and disposable medical supplies, prosthetics, orthotics, and non-durable equipment that have set limitations, require prior approval (PA) to exceed those limitations.
 - d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility
 Therapies are limited to:
 - (1) Clients who are not able to access their care in the community; and
 - (2) To 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.

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

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7. Home health care services (cont.)
- e. Other Medical services, supplies, equipment and appliances
- (1) The Oxygen and Respiratory Therapy Services Program provides oxygen and/or respiratory therapy equipment, services, and supplies to eligible clients who reside at home or reside in nursing homes when medically necessary.
 - (2) Home infusion-parenteral nutrition equipment and supplies are provided when medically necessary.
 - One germicide and/or one antiseptic allowed on the same day. Justification for exceeding this limit must be documented in the client's file.
 - (3) 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 EPSDT purposes. Exceptions to these limitations are allowed based on documented medical necessity.

- A licensed and certified dietitian must evaluate all clients 20 years of age and younger within 30 days of initiation of medical nutrition, and periodically (at the discretion of the licensed/certified dietitian) while the client is receiving medical nutrition.
- Initial assessments limited to 2 hours (or 8 units) per year.
- Reassessments limited to no more than 1 hour (or 4 units) per day.
- Group therapy limited to 1 hour (or 4 units) per day.

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8. Private duty nursing services

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

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

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

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9. Clinic services
- a. Freestanding kidney centers
- (1) Description of facility: A center devoted specially to treating End Stage Renal Disease (ESRD)
 - (2) Description of service: Peritoneal dialysis or hemodialysis for ESRD.
 - (3) Program coverage: Covered as an outpatient service when provided by a freestanding renal dialysis center or a freestanding community hemodialysis unit. includes physician services, medical supplies, equipment, drugs, and laboratory tests.
 - (4) Prior authorization: Required for the facility but not the physician. Initial authorization may be granted for up to three months. Reauthorization may be granted for up to twelve months.
 - (5) Reimbursement: This service is reimbursed according to attachment 4.19-B.
- b. Freestanding ambulatory surgery centers
- Allowed procedures are covered when they:
- Are medically necessary; and
 - Are not for cosmetic treatment surgery.
- Some procedures are covered only when they:
- Meet certain limitation requirements; and
 - Have been prior authorized by the department.

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10. Dental services and dentures
- a. Limited to selected medically necessary services for the identification and treatment of dental problems or the prevention of dental diseases. Some of these services may require prior authorization.
 - b. Crowns are covered only for children through age twenty (20) and require prior authorization.
 - c. Orthodontic treatment is limited to medically necessary treatment, as follows, and only for children with craniofacial anomalies or cleft lip or palate or severe handicapping malocclusion. Limits may be exceeded based on medical necessity.
 - (1) Clients in the EPSDT program through age twenty (20);
 - (2) Clients in the CN program through age twenty (20)
 - d. Clients of the Developmental Disability Division may receive additional services
 - e. Dentures

For limitations indicated in (1) below, limits may be exceeded based on medical necessity.

 - (1) For clients through age twenty (20), allowed per client:
 - Complete, immediate, and overdenture dentures - one maxillary and one mandibular denture in a ten year period.
 - Partial dentures - once every five years, subject to limitations.
 - Replacement full or partial dentures - requires prior authorization when requested within one year of the seat date of the previous dentures.
 - Rebase - once every five years and the dentures must be at least three years old
 - Relines and adjustments - included in the reimbursement if done within six months of the seat date. After six months, allowed once every five years.
 - (2) For clients age twenty-one (21) and over, allowed per client:
 - Immediate dentures - one maxillary and one mandibular denture in a lifetime, and requires prior authorization.
 - Complete dentures - one maxillary and one mandibular denture in a ten-year period and requires prior authorization.
 - Resin and cast metal framework partial dentures - once in a ten-year period and requires prior authorization.
 - Replacement resin partial dentures – not allowed within the ten-year period.

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10. Dental services and dentures (continued)
- Replacement cast metal framework partial dentures - once in a ten-year period.
 - Complete and partial denture relines - once in a five-year period.

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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. Prior authorization required to exceed set limits for clients twenty-one (21) years of age and older as follows:
 - (1) Prior Authorization is required for physical therapy (PT) when the client is:
 - 21 years of age and older and requires services beyond one PT evaluation and 48 units PT per year, per client per diagnosis, or
 - 21 years of age and older and has a qualifying diagnosis or has completed an approved inpatient rehab stay, and requires services beyond one PT evaluation and 144 units of PT per year, per client, per diagnosis.
 - (2) Prior Authorization is required for occupational therapy (OT) when the client is:
 - 21 years of age and older and requires services beyond one OT evaluation and 12 OT visits per year, per client; or
 - 21 years of age and older and has a qualifying diagnosis or has completed an approved inpatient rehab stay and requires services beyond one OT evaluation and 36 OT visits per year, per client.
 - (3) Prior Authorization is required for speech therapy (ST) when the client is:
 - 21 years of age and older and requires services beyond one speech evaluation and 12 speech visits per year per client; or
 - 21 years of age and older and has a qualifying diagnosis and requires services beyond one Speech evaluation and 36 speech visits per year per client.
 - d. 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.
 - e. 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.
 - f. 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 January 16, 2004, entitled "State of Washington Supplemental Rebate Contract," has been authorized by CMS.
 - 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

- 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)

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 anorexia, 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:

- Guaifenesin 100mg/5ml liquid or syrup;
- Dextromethorphan 15mg/5ml liquid or syrup;
- Pseudoephedrine 30mg or 60mg tablets;
- Saline nasal spray 0.65%; and
- Generic combination product: dextromethorphan-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:: analgesics/antipyretics, antacids, antibacterial topical preparations, antidiarrheals, antiemetic/antivertigo agents, antiflatulents, antihistamines, antitussives, decongestants, electrolyte replacements, emetics, expectorants, eye antihistamines, fluoride preparations, hyperglycemics, inhalation agents, insulins,

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12. a. Prescribed Drugs (continued)

laxatives, lipotropics, nasal preparations, topical antifungals
topical steroidal anti-inflammatories, topical antiparasitics, topical
nicotine replacement patches and gum after completion of the
nicotine replacement therapy supply available from the Dept. of
Health under their smoking cessation program.

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

X (viii) Barbiturates

X (ix) Benzodiazepines

X (x) Agents when used to promote smoking cessation (drugs not
eligible under Part D and are not covered for dual-eligible
clients):

- FDA-approved prescription drugs to promote smoking
cessation will be covered, consistent with FDA
guidelines, only for clients who are eighteen years of age
or older and participating in a department-approved
smoking cessation program.

 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. 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.
- (B) Chemical dependency professionals (CDP) - chapter 18.205 RCW and chapter 246-924 WAC.
- (C) Mental health counselor, marriage and family therapist, or social worker - chapter 18.225 RCW and chapter 246-809 WAC.
- (D) Physician (MD) - chapter 18.71 RCW and chapter 246-919 WAC.
- (E) Physician assistant (PA) - chapter 18.71A RCW and chapter 246-918 WAC.
- (F) Psychologist - chapter 18.83 RCW and chapter 246-924 WAC.

(iii) Settings

Services may be delivered in the following settings: hospitals, residential facilities, outpatient facilities, health care clinics, FQHCs, and Indian Health Service facilities.

(b) 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).

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13. d. Rehabilitative Services (cont)
- (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 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; and
 - (V) Resident discharge or transfer criteria.
- (vi) 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:
- (A) Advanced registered nurse practitioner (ARNP): provides screening, detoxification, and referral. Meets requirements of chapter 18.79 RCW and chapter 246-840 WAC.
 - (B) Chemical dependency professionals (CDP): provides screening and referral. Meets requirements of chapter 18.205 RCW and chapter 246-924 WAC.
 - (C) Licensed practical nurse (LPN): provides screening, detoxification, and referral. Meets requirements of chapter 18.79 RCW and chapter 246-840 WAC.
 - (D) Mental health counselor, marriage and family therapist, or social worker: provides screening and referral. Meets requirements of chapter 18.225 RCW and chapter 246-809 WAC.
 - (E) Physician (MD): provides screening, detoxification, and referral. Meets requirements of chapter 18.71 RCW and chapter 246-919 WAC.
 - (E) Physician assistant (PA): provides screening, detoxification, and referral. Meets requirements of chapter 18.71A RCW and chapter 246-918 WAC.
 - (F) Psychologist: provides screening and referral. Meets requirements of chapter 18.83 RCW and chapter 246-924 WAC.
 - (G) Registered nurse (RN): provides screening, detoxification, and referral. Meets requirements of chapter 18.79 RCW and chapter 246-840 WAC.
- (v) Counseling services for persons admitted must be performed by a Chemical Dependency Professional certified in chemical dependency counseling by DOH according to DOH RCW and WAC.

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13. d. Rehabilitative Services (cont)

- (vi) Alcohol and drug detoxification is provided 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.
- (vii) 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) The persons providing the evaluation and treatment services in outpatient and residential treatment centers must be Chemical Dependency Professionals (CDPs) certified in chemical dependency counseling by DOH according to DOH WAC and RCW.

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(3) Adult Day Health (ADH) is a supervised daytime program providing nursing and rehabilitative therapy services. Adult Day Health services are only appropriate for adults with medical or disabling conditions that require the intervention or services of a registered nurse or licensed rehabilitative therapist acting under the supervision of the client's physician. The coverage of Adult Day Health services will end on December 31, 2009.

(a) Provider Qualifications

The Adult Day Health Center must be certified per state law and have a core provider agreement with State Medicaid Agency. Minimum staffing requirements for Adult Day Health Centers include an administrator, program director, registered nurse, activity coordinator, a PT/OT or speech therapist, and a social worker. The administrator and program director may be the same person. Adult Day Health Center staff must meet employee qualifications outlined in state law.

(b) Settings

Adult Day Health is a site-based service located in community settings. Adult Day Health Centers must meet facility and physical environment requirements outlined in state law.

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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. 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.

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;

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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:

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.

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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.

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13. d. 9. Behavior Rehabilitation Services.

Behavior rehabilitative are services provided to children to remediate debilitating disorders, upon the certification of a physician or other licensed practitioner of the healing arts within the scope of their practice within state law. Prior approval is required.

Service Description

Specific services include milieu therapy, crisis counseling and regularly scheduled counseling and therapy, as well as medical treatment.

Milieu therapy refers to those activities performed with children to normalize their psycho-social development and promote the safety of the child and stabilize their environment. The child is monitored in structured activities which may be recreational, rehabilitative, academic, or a variety of productive work activities. As the child is monitored, intervention is provided to remediate the dysfunctional behaviors and encourage appropriate responses in a broad range of settings.

Crisis counseling is 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.

Regularly scheduled counseling and therapy, as well as psychological testing, is provided. The purpose of which is to remediate specific dysfunctions which have been explicitly identified in a continually updated formal treatment plan. Therapy may be in an individual or group setting. It may be directed toward the child alone, the child within his/her biological or the adopted family, or the child within his/her peer group.

Medical treatment may also be provided. Twenty-four hour nursing is provided for children who are medically compromised to such an extent that they are temporarily unable to administer self care and are impaired medically/developmentally immediate the caretaker's ability to provide medical/remedial care.

Population to be Served

Children who receive these services suffer from developmental disabilities and behavioral/emotional disorders that prevent them from functioning normally in their homes, schools, and communities. They exhibit such symptoms as drug and alcohol abuse; anti-social behaviors that require an inordinate amount of intervention and structure; sexual behavior problems; victims of severe family conflict; behavioral disturbances often resulting from psychiatric disorders of the

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

parents; medically compromised and developmentally disabled children who are not otherwise served by the state agency's Division of Developmental Psychological Disabilities; and impairments.

Provider Qualifications

Service include Social Staff: Responsibilities development of service plans; individual, group, and family counseling; and assistance to child care staff in providing appropriate treatment for clients. The minimum qualification is a Masters Degree in social work or a closely allied field.

Child Care Staff: 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.

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

Program Coordinator: Responsibilities include supervising staff, providing overall direction to the program and assuring that contractual requirements and intents are met.

Minimum qualifications are to be at least 21 years of age with a Bachelors Degree, preferably with major in study psychology, sociology, social work, social sciences, or a closely allied field, and two years experience in the supervision and management of the group care program for adolescents.

Counselor: 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.

Minimum qualifications are to be at least 21 years of age possessing a Master's Degree with major study in social one year work or a closely allied field and of experience in the care of troubled adolescents or, a Bachelor's Degree with major study in social work, psychology, and experience in the care of troubled adolescents.

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17. Nurse midwife services

Limited to facilities approved by the department to provide this services, or in the case of home births, to clients and residences approved for this service. To participate in home births, midwives must be a MAA-approved provider.

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18. Hospice care (in accordance with section 1903(o) of the Act.)
- Also includes pediatric palliative care services that are provided for approved clients 20 years old and younger who have a life limiting diagnosis.

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20. Extended services for pregnant women, through the sixty days postpartum period. The extended services include:
- a. Maternity support services, by a provider approved by the Department of Health and the department, consisting of:
 - (1) Nursing assessment and/or counseling visits, provided by licensed registered nurses;
 - (2) Psychosocial assessment and/or counseling visits, provided by licensed or credentialed behavioral health specialists;
 - (3) Nutrition assessment and/or counseling visit, provided by registered, state-certified dietitians;
 - (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 ventilator- and tracheostomy-dependent clients.

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24. a. Transportation
- (1) Ambulance transportation is provided as an optional service for emergencies or as required by state law.
 - (2) All non-emergency transportation services, to assure clients have access to and from covered services, are provided using administrative matched dollars in accordance with Section 42 CFR 431.53, and are not considered a medical service described in the coverage section of the State Plan.
 - (3) Transportation for clients who also have Medicare Part D is provided at the same level of service as, and under the same restrictions for, prescription drug pickups.

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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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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
 Not provided

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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, children's group care facility 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 Department. Home health agencies providing personal care services do not require Medicaid 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 Department.

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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.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
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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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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:

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.

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 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).

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. 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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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) COMPARABILITY
1902 (a) (1)

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) FREEDOM OF CHOICE
1902 (a) (23)

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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State WASHINGTON

(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 for 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 for 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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State WASHINGTON

(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

A. 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:

1. The infant's natural or adoptive parent(s);
2. A person other than a foster parent who has been granted legal custody of the infant; or
3. 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.

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 subparagraph 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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CASE MANAGEMENT SERVICES

A. Target Group:

All Medicaid recipients under age 21 whose family or caretaker needs assistance in accessing necessary medical, social, educational, and other services.

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

Entire State

This service will be offered on a statewide basis as service delivery systems are developed and become available.

C. Comparability of Services:

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 the recipient(s) to obtain and effectively utilize necessary medical, social, educational and other services.

Description of Service:

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

Linkage: Help recipient(s) to access services through linkages between support systems to avoid duplication of services. Identify recipient needs in physical, environmental, psychosocial, developmental, educational, behavioral, emotional, and mobility areas.

Planning: Prepare a service plan that reflects the recipient's need as identified through the assessment process.

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(Case Management, Under Age 21, cont)

Implementation: Assure that the recipients) receives services as indicated in the service, plan and regular contacts to encourage cooperation, and resolve problems which may create barriers.

Advocacy: Assist the recipient(s) to follow through on recommendations.

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

E. Any qualified provider may contract with DCFS, which is a unit within DSHS, the single state Medicaid agency.

1. Case Managers

- a. A case manager will be either a professional or a paraprofessional under the direct supervision of a professional.
- b. Case managers will have a minimum of one year of on-the-job experience involving contact with the public in a client-service setting.
- c. In addition, the following are the specific minimum requirements for each category of case managers:
 - (1) Nurse - B.S.N. with course work in public health; or a registered nurse with two years of experience in parent-child nursing.
 - (2) Social service worker - Master's Degree in Social Work in Behavioral Science or related, field, with one year of experience in community social services or public health services or related field. Other Master's or, Bachelor's Degree may be substituted with two years closely-related work experience in community social services, public health services, or related field.

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(Case Management, Under Age 21, cont)

- (3) Certificated teachers - Specialized training and experience in parenting education, child development, nutrition, family resource management, health, intervention, and one year on-the-job experience.
 - (4) Educational Staff Associate - Certification as a school counselor, school psychologist, school nurse, school social worker, or physical or speech or occupational therapist and one year on-the-job experience.
 - (5) Substance Abuse Counselor - Meet the requirements of a Qualified or Certified Counselor as defined in WAC 275-19-145(1) and one year on-the-job experience.
 - (6) Paraprofessional - Under direct supervision of a registered nurse or social service worker case management provider, a paraprofessional may conduct case management activities. Associate Degree in Behavioral Health Sciences related field and two years of closely related work experience. Two additional years of appropriate experience could be substituted for the degree.
- d. Foster parents may not serve as case managers for foster children.

2. Case Management Agencies

- a. Public or private social, health or education agencies employing staff with case manager qualifications. This includes state DSHS staff.
- b. Demonstrate linkages and referral ability with essential social and health service agencies and individual practitioners.
- c. Has experience working with low-income families, especially children.
- d. Meets applicable federal and state laws and regulations governing the participation of providers in the Medicaid program.

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(Case Management, Under Age 21, cont)

- F. The state assures that there will be no restrictions on a recipient's free choice of providers in violation of Section 1902 (a) (23) of the Act.
1. Eligible recipients will have free choice to receive or not receive case management services.
 2. Eligible recipients will have free choice of the providers of case management services.
 3. Eligible recipients will have free choice of the providers of 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

(Case Management, LES, cont)

C. Comparability of Services:

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

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

D. Definition of Service:

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

Core Functions:

1. *Comprehensive Assessment and follow up-* This service includes an intake interview and assessment of client's needs for medical, educational, social and other related services deemed appropriate by the case manager. The case manager will prepare a detailed plan of services needed to help the client overcome barriers to self-sufficiency. The focus of this service is client referral and access to needed services. Follow-up on this plan is essential to insure that appropriate services are received.
2. *Self-Sufficiency Service:* This service is provided to inform each client about, and gain access to, needed services, such as health, social and educational opportunities (English as a Second Language (ESL), Vocational Training, etc. ,). Access to services is accomplished by setting, on an individual basis, personal goals for self-sufficiency, and designing realistic plans for the individual client related to access to specific services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

(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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State WASHINGTON

(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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State WASHINGTON

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

(Case Management, Alcohol/Drug Dependent, cont)

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

1. Eligible clients will have free choice to receive or not receive case management services.
2. Eligible clients will have free choice of the providers of other medical care under the plan.

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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):

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

- b. _____ Eligibility is limited by the severity of disease or condition, as specified in Appendix B.
- c. _____ Eligibility is limited to individuals who have been shown to have a need for one or more of the services elected by the State under this benefit.
5. Standards for financial eligibility are set forth in Appendix A. Each individual served shall meet applicable standards for financial eligibility.
6. Each individual served will meet the test of functional disability set forth in Appendix B.
7. The State will provide for a comprehensive functional assessment for a financially eligible individual who meets the targeting requirements set forth in item 3 of this Supplement. This assessment will be provided at the request of the individual or another person acting on such individual's behalf. The individual will not be charged a fee for this assessment.
8. The comprehensive functional assessment will be used to determine whether the individual is functionally disabled, as defined in Appendix B. Procedures to ensure the performance of this assessment are specified in Appendix D.
9. The comprehensive functional assessment is based on the uniform minimum data set specified by the Secretary. Check one:
- a. _____ The State will use the assessment instrument designed by HCFA.
- b. _____ The State will use an assessment instrument of its own designation. The assessment instrument to be used is consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by HCFA. A copy of the assessment instrument can be found at Appendix D.
10. The comprehensive functional assessment will be reviewed and revised .not less often than every 12 months. Procedures to ensure this review and revision are specified in Appendix D.
11. The comprehensive functional assessment and review will be conducted by an interdisciplinary team designated by the State. Qualifications of the interdisciplinary team are specified in Appendix D.
12. Based on the comprehensive functional assessment or review, the interdisciplinary team will:
- a. identify in each such assessment or review each individual's functional disabilities and need for home and community care, including information about the individual's health status, home and community environment, and informal support system; and

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State WASHINGTON

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

- 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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State WASHINGTON

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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State WASHINGTON

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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State WASHINGTON

ASSESSMENT

- a. The State will provide for a comprehensive functional assessment for a financially eligible individual who meet the targeting requirements set forth in items 3 and 4 of Supplement 2.
- b. This assessment will be provided at the request of the individual, or another person acting on the individual's behalf.
- c. The individual will not be charged a fee for this assessment.
- d. Attached to this Appendix is an explanation of the procedures by which the state will ensure the performance of the assessment.
- e. The assessment will be reviewed and revised not less often than (check one):
 1. Every 12 months
 2. Every 6 months
 3. Other period not to exceed 12 months (Specify): _____
- f. Check one:
 1. The State will use an assessment instrument specified by HCFA.
 2. The State will use an assessment instrument of its own specification. A copy of this instrument is attached to this Appendix. The State certifies that this instrument will measure functional disability as specified in section 1929(b) and (c) of the Act. The State requests that HCFA approve the use of this instrument, and certifies that at such time as HCFA may publish a minimum data set (consistent with section 1929(c)(2) of the Act), the assessment instrument will be revised, as determined necessary by HCFA, to conform to the core elements, common definitions, and uniform guidelines which are contained in the minimum data set.
- g. In conducting the assessment (or the periodic review of the assessment), the interdisciplinary team must:
 1. Identify in each such assessment or review each individual's functional disabilities; and
 2. Identify in each such assessment or review each individual's need for home and community care. This identification shall include:
 - A. Information about the individual's health status;
 - B. Information about the individual's home and community environment; and
 - C. Information about the individual's informal support system.

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State WASHINGTON

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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State WASHINGTON

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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State WASHINGTON

INTERDISCIPLINARY TEAM (con't)

Interdisciplinary teams may utilize data gathered by other professionals, and may consult with service providers in conducting periodic reviews of the individuals' comprehensive functional assessments.

When periodic reviews of assessments are provided under contract with an agency or organization which is not part of the Medicaid agency, the Medicaid agency will specify, as part of the contract, that the contracting agency or organization may not subcontract with another entity for the performance of the periodic reviews without the prior written approval of the Medicaid agency.

c. The interdisciplinary teams conducting initial assessments shall consist, at a minimum, of (check all that apply, but at least 2):

1. _____ Registered nurse, licensed to practice in the State
2. _____ Licensed Practical or Vocational nurse, acting within the scope of practice under State law
3. _____ Physician (M.D. or D.O.), licensed to practice in the State
4. _____ Social Worker (qualifications attached to this Appendix)
5. _____ Case manager
6. _____ Other (specify): _____

d. The interdisciplinary teams conducting periodic reviews of assessments shall consist, at a minimum, of (check all that apply, but at least 2):

1. _____ Registered nurse, licensed to practice in the State
2. _____ Licensed Practical or Vocational nurse, acting within the scope of practice under State law
3. _____ Physician (M.D. or D.O.), licensed to practice in the State
4. _____ Social Worker (qualifications attached to this Appendix)
5. _____ Case manager
6. _____ Other (specify): _____

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State WASHINGTON

INDIVIDUAL COMMUNITY CARE PLAN (ICCP)

- a. A written individual community care plan (ICCP) will be developed for each individual who has been determined, on the basis of a comprehensive functional assessment performed in accordance with Appendix D, to be a functionally disabled elderly individual, according to the criteria set forth in Appendices A and B.
- b. The ICCP will be established, and periodically reviewed and revised, by a Qualified Community Care Case Manager after a face-to-face interview with the individual or primary caregiver.
- c. The ICCP will be based on the most recent comprehensive functional assessment of the individual conducted according to Appendix D.
- d. The ICCP will specify, within the amount, duration and scope of service limitations set forth in Appendix C, the home and community care to be provided to such individual under the plan.
- e. The ICCP will indicate the individual's preferences for the types and providers of services.
- f. The ICCP will specify home and community care and other services required by such individual. (Check one):
1. Yes 2. No
- g. The ICCP will designate the specific providers (who meet the qualifications specified in Appendix C-2) which will provide the home and community care. (Check one):
1. Yes 2. No
- h. Neither the ICCP, nor the State, shall restrict the specific persons or individuals (who meet the requirements of Appendix C-2) who will provide the home and community care specified in the ICCP.

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State WASHINGTON

QUALIFIED COMMUNITY CARE CASE MANAGERS

a. "Qualified Community Care Case Manager" will meet each of the following qualifications for the provision of community care case management.

1. Be a nonprofit or public agency or organization;
2. Have experience or have been trained in:
 - A. Establishing and periodically reviewing and revising ICCPs; and
 - B. The provision of case management services to the elderly.

The minimum standards of experience and training which will be employed by the State are attached to this Appendix;

3. Have procedures for assuring the quality of case management services. These procedures will include a peer review process.

4. The State will assure that community care case managers are competent to perform case management functions, by requiring the following educational or professional qualifications be met. (Check all that apply):

- A. Registered nurse, licensed to practice in the State
- B. Physician (M.D. or D.O.), licensed to practice in the State
- C. Social Worker (qualifications attached to this Appendix)
- D. Other (specify): _____

b. When community care case management is provided by a nonprofit, nonpublic agency, the agency providing the community case management will not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides home and community care or nursing facility services and will not furnish home and community care or nursing facility services itself. (Check one):

1. Yes
2. Not applicable. The State will not use nonprofit, nonpublic agencies to provide community care case management.

c. The State will employ procedures to assure that individuals whose home and community care is managed by qualified community care case managers are not at risk of financial exploitation due to such managers. An explanation of these procedures is attached to this Appendix

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State WASHINGTON

QUALIFIED COMMUNITY CARE CASE MANAGERS (cont)

- d. The State requests that the requirements of item E-2-b be waived in the case of a nonprofit agency located in a rural area. The State's definition of "rural area" is attached to this Appendix. (Check one):

1. Yes 2. No
3. Not applicable. The State will not use nonprofit nonpublic agencies to provide community care case management.

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State WASHINGTON

COMMUNITY CARE CASE MANAGEMENT FUNCTIONS

- a. A qualified community care case manager is responsible for:
1. Assuring that home and community care covered under the State plan and specified in the ICCP is being provided;
 2. Visiting each individual's home or community care setting where care is being provided not less often than once every 90 days;
 3. Informing the elderly individual or primary caregiver how to contact the case manager if service providers fail to properly provide services or other similar problems occur. This information will be provided verbally and in writing.
 4. Completes the ICCP in a timely manner; and
 5. Reviews and discusses new and revised ICCPs with elderly individuals or primary caregivers.
- b. Whenever a qualified community care case manager has reason to believe that an individual's assessment or periodic review (conducted under Appendix D) appears to contain inaccuracies, the community care case manager will bring these apparent discrepancies to the attention of the agency which has performed the assessment or review. If the assessors and the community care case manager are unable to resolve the apparent conflict, the case manager shall report the situation to the component of the Medicaid agency which is responsible for monitoring the program.
1. _____ Yes 2. _____ No
- c. Whenever a qualified community care case manager is informed by an elderly individual or primary caregiver that provider(s) have failed to provide services, or that other similar problems have occurred, the community care case manager shall take whatever steps are necessary to verify or disprove the complaint. If a problem is confirmed by this monitoring, the community care case manager shall address the problem in an appropriate and timely manner, consistent with the nature and severity of any deficiencies noted. This may include reporting the situation to the component of the Medicaid agency which is responsible for monitoring the program.
1. _____ Yes 2. _____ No
- d. Whenever a qualified community care case manager is informed by a provider of service (whether paid or unpaid) that there has been a change in the individual's condition, or that a problem may have arisen which is not currently being addressed, the community care case manager shall take whatever steps are necessary to verify or disprove the information. If a problem is confirmed by this monitoring, the community care case manager shall address it in an appropriate and timely manner, consistent with the nature and severity of the situation.
1. _____ Yes 2. _____ No

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State WASHINGTON

COMMUNITY CARE CASE MANAGEMENT FUNCTIONS (con't)

- e. Community care case managers shall verify the qualifications of each individual or agency providing home and community care services prior to the initiation of services, and at such intervals as are specified in Appendix C, thereafter. (Check one):
1. _____ Yes 2. _____ No
- f. Where the provision of services in an individual's ICCP is not governed by State licensure or certification requirements, the community care case manager shall verify the qualifications of the individual or entity furnishing the services, and as necessary, provide or arrange for the training specified in Appendix C-2. (Check one):
1. _____ Yes 2. _____ No
3. _____ Not applicable. All services are governed by State licensure or certification requirements.
- g. Community care case managers shall inform each elderly individual for whom an ICCP is established of the person's right to a fair hearing should the individual disagree with the contents of the ICCP.

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.

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.

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.

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 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.

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.

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 client's 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 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 funds (and a final accounting of such funds) to the individual administering the client's estate.

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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 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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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 client's 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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State WASHINGTON

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.

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.

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 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 WASHINGTON

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 client's 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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 funds (and a final accounting of such funds) to the individual administering the client's estate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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 in section 1124(a)(3) of the Social Security Act) in the setting.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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 client's 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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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State WASHINGTON

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

- 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. 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)

- (2) Medical and remedial care expenses in 42 CFR 435.726.

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State WASHINGTON

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

- 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON**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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If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

II. 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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State WASHINGTON

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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1915(i) State Plan Home and Community Based Services Administration and Operation

The State implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below.

1. Services. (Specify service title(s) for the HCBS listed in Attachment 4.19-B that the State plans to cover):

Adult Day Health

2. State wideness. (Select one):

<input checked="" type="checkbox"/>	The State implements the 1915(i) State plan HCBS benefit statewide, per §1902(a)(1) of the Act.
<input type="checkbox"/>	The State implements this benefit without regard to the state wideness requirements in §1902(a)(1) of the Act. State plan HCBS will only be available to individuals who reside in the following geographic areas or political subdivisions of the State. (Specify the areas to which this option applies):

3 State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. (Select one):

<input checked="" type="checkbox"/>	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program (select one):	
<input type="checkbox"/>	The Medical Assistance Unit (name of unit):	
<input checked="" type="checkbox"/>	Another division/unit within the SMA that is separate from the Medical Assistance Unit (name of division/unit) <i>This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.</i>	Aging and Disability Services Administration
<input type="checkbox"/>	The State plan HCBS benefit is operated by (name of agency)	
	a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.	

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4. Distribution of State plan HCBS Operational and Administrative Functions

(By checking this box the State assures that): When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (check each that applies):

(Check all agencies and/or entities that perform each function):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2 State plan HCBS enrollment managed against approved limits, if any	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Eligibility evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4 Review of participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5 Prior authorization of State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6 Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Execution of Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 Establishment of a consistent rate methodology for each State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Rules, policies, procedures, and information development governing the State plan HCBS benefit	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

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4. Distribution of State plan HCBS Operational and Administrative Functions (cont)

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

The Medicaid agency contracts with Area Agencies on Aging (AAAs) to perform the operational and administrative functions at the local level that are listed in the preceding table. In all cases, the Medicaid agency has a contract that sets forth the responsibilities and performance requirements of the AAA. The contract is available through the Medicaid agency.

(By checking the following boxes the State assures that):

5. **Conflict of Interest Standards.** The State assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
- related by blood or marriage to the individual, or any paid caregiver of the individual
 - financially responsible for the individual
 - empowered to make financial or health-related decisions on behalf of the individual
 - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the State, when such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement):*
6. **Fair Hearings and Appeals.** The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.
7. **No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.
8. **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

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NUMBER SERVED

1. Projected Number of Unduplicated Individuals To Be Served Annually.

(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	January 1, 2010	December 31, 2010	1,769
Year 2			
Year 3			
Year 4			
Year 5			

2. Annual Reporting. (By checking this box the State agrees to): annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

3. Optional Annual Limit on Number Served. (Select one):

<input type="checkbox"/>	The State does not limit the number of individuals served during the year or at any one time. Skip to item #5.																																
<input checked="" type="checkbox"/>	The State chooses to limit the number of (check each that applies):																																
<input checked="" type="checkbox"/>	Unduplicated individuals served during the year. (Specify in column A below):																																
<input type="checkbox"/>	Individuals served at any one time ("slots"). (Specify in column B below):																																
	<table border="1"> <thead> <tr> <th rowspan="2">Annual Period</th> <th rowspan="2">From</th> <th rowspan="2">To</th> <th>A</th> <th>B</th> </tr> <tr> <th>Maximum Number served annually (Specify):</th> <th>Maximum Number served at any one time (Specify):</th> </tr> </thead> <tbody> <tr> <td>Year 1</td> <td>1/1/10</td> <td>12/31/10</td> <td>1769</td> <td></td> </tr> <tr> <td>Year 2</td> <td>1/1/11</td> <td>12/31/11</td> <td>1278</td> <td></td> </tr> <tr> <td>Year 3</td> <td>1/1/12</td> <td>12/31/12</td> <td>923</td> <td></td> </tr> <tr> <td>Year 4</td> <td>1/1/13</td> <td>12/31/13</td> <td>667</td> <td></td> </tr> <tr> <td>Year 5</td> <td>1/1/14</td> <td>12/31/14</td> <td>482</td> <td></td> </tr> </tbody> </table>	Annual Period	From	To	A	B	Maximum Number served annually (Specify):	Maximum Number served at any one time (Specify):	Year 1	1/1/10	12/31/10	1769		Year 2	1/1/11	12/31/11	1278		Year 3	1/1/12	12/31/12	923		Year 4	1/1/13	12/31/13	667		Year 5	1/1/14	12/31/14	482	
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Year 4	1/1/13	12/31/13	667																														
Year 5	1/1/14	12/31/14	482																														
<input type="checkbox"/>	The State chooses to further schedule limits within the above annual period(s). (Specify):																																

4. Waiting List. (Select one only if the State has chosen to implement an optional annual limit on the number served):

<input type="checkbox"/>	The State will not maintain a waiting list.
<input checked="" type="checkbox"/>	The State will maintain a single list for entrance to the State plan HCBS benefit. State-established selection policies: are based on objective criteria; meet requirements of the Americans with Disabilities Act and all Medicaid regulations; and ensure that only individuals enrolled in the State plan HCBS benefit receive State plan HCBS once they leave/are taken off of the waiting list.

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FINANCIAL ELIGIBILITY

1. **Income Limits.** *(By checking this box the State assures that):* Individuals receiving State plan HCBS are in aneligibility group covered under the State’s Medicaid State plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL). Individuals with incomes up to 150% of the FPL who are only eligible for Medicaid because they are receiving 1915(c) waiver services may be eligible to receive services under 1915(i) provided they meet all other requirements of the 1915(i) State plan option. The State has a process in place that identifies individuals who have income that does not exceed 150% of the FPL.

2. **Medically Needy. (Select one):**

X	The State does not provide State plan HCBS to the medically needy.
○	The State provides State plan HCBS to the medically needy <i>(select one)</i> :
○	The State elects to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
○	The State does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III).

NEEDS BASED EVALLUATION/REEVALUATION

1. **Responsibility for Performing Evaluations / Reevaluations.** Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed *(select one)*:

X	Directly by the Medicaid agency
X	By Other <i>(specify State agency or entity with contract with the Medicaid/State agency):</i>
	Revaluations may also be conducted by case managers from Area Agencies on Aging

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Needs Based Evaluation/Reevaluation (cont)

2. Qualifications of Individuals Performing Evaluation/Reevaluation. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. (*Specify qualifications*):

In addition to meeting the following minimum qualifications, staff must pass a background check prior to being hired and receive mandatory training prior to completing any evaluations.

Evaluations are performed by case managers who can be a Registered Nurse (licensed in the State), a Social Worker or a Case Resource Manager.

For Social Workers, minimum qualifications are as follows:

A Master's degree in social services, human services, behavioral sciences, or an allied field and two years of paid social service experience equivalent to a Social Worker 2.

OR

A Bachelor's degree in social services, human services, behavioral sciences, or an allied field, and three years of paid social service experience performing functions equivalent to a Social Worker 2.

NOTE: A two year Master's degree in one of the above fields that included a practicum will be substituted for one year of paid social service experience.

NOTE: Employees must successfully complete the formal training course sponsored by their division within one year of their appointment.

NOTE: Equivalent social service experience would include the previous classes of Caseworker 3 or higher.

OR

For current employees the following experience qualifies for promotion to a Social Worker 3: A Bachelor's degree and three years of experience as a Caseworker 3, Social Worker 1A or B, Social Worker 2, Casework Supervisor Trainee, Casework Supervisor, Juvenile Rehabilitation Supervisor 1 or 2, or Juvenile Rehabilitation Counselor 2 in State service.

For Case/Resource Manager minimum qualifications are as follows:

A Bachelor's degree in social sciences, social services, human services, behavioral sciences or an allied field and two years of experience providing social services to people with developmental disabilities, graduate training in social science, social services, human services, behavioral sciences or an allied field will substitute, year for year, for one year of the experience providing social services to people with developmental disabilities.

Job classification descriptions are available from the Medicaid agency.

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Needs Based Evaluation/Reevaluation (cont)

- 3. Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

Case managers complete Level of Care evaluations using the automated assessment tool (CARE). CARE is used for both initial evaluations and re-evaluations. The re-evaluation process does not differ from the initial evaluation process. Evaluations are completed initially, at annual review, and when a significant change occurs.

Information about the person's support needs is obtained via a face to face interview. Evaluators also obtain and verify information by collateral contacts with formal and informal supports including physicians, home health agencies, caregivers and family.

The CARE assessment collects information pertaining to participant eligibility for HCBS including the need for skilled nursing or rehabilitative therapy and the need for assistance with personal care. Based on this evaluation, case managers determine eligibility for HCBS.

- 4. Needs-based HCBS Eligibility Criteria.** *(By checking this box the State assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs and capabilities and may take into account the individual's ability to perform two or more ADLs, the need for assistance, and other risk factors:
(Specify the needs-based criteria):

To be eligible for State plan HCBS an individual must:

1. Be assessed as having an unmet need for skilled nursing or skilled rehabilitative therapy; and
 - a. There is a reasonable expectation that these services will improve, restore or maintain health status, or in the case of a progressive disabling condition, will either restore or slow the decline of health and functional status or ease related pain or suffering; and
 - b. Be at risk for deteriorating health, deteriorating functional ability, or institutionalization; and
 - c. Have a chronic or acute health condition that you are not able to safely manage due to a cognitive, physical, or other functional impairment.

and

2. Be assessed to have a need for assistance demonstrated by:
 - a. The need for assistance with three ADLs, one of which may be body care (application of lotions/ointments, toenails trimmed, dry bandage changes, or passive range of motion). Or
 - b. Hands on assistance with one ADL which may include body care (application of lotions/ointments, toenails trimmed, dry bandage changes, or passive range of motion).

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Needs Based Evaluation/Reevaluation (cont)

5. **Needs-based Institutional and Waiver Criteria.** *(By checking this box the State assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the State has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/MR (& ICF/MR LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
<p>To be eligible for State plan HCBS an individual must:</p> <p>1. Be assessed as having an unmet need for skilled nursing or skilled rehabilitative therapy; and</p> <p style="padding-left: 40px;">a. There is a reasonable expectation that these services will improve, restore or maintain health status, or in the case of a progressive disabling condition, will either restore or slow the decline of health and functional status or ease related pain or suffering; and</p> <p style="padding-left: 40px;">b. Be at risk for deteriorating health, deteriorating functional ability, or institutionalization; and</p> <p style="padding-left: 40px;">c. Have a chronic or acute health condition that you are not able to safely manage due to a cognitive, physical, or other functional impairment.</p> <p>And</p>	<p>Functional criteria for NFLOC mean one of the following applies.</p> <p>The individual: Needs daily care provided by a nurse. or Needs assistance with three Activities of Daily Living (does not include body care or turning and repositioning). or Needs hands on assistance with 2 ADLs which may include turning and repositioning. or Has a cognitive impairment and needs hands on assistance with 1 ADL which may include turning and repositioning</p>	<p>DDD determines eligibility for ICF/MR level of care when an individual is assessed in the CARE tool as:</p> <p>(1) At age birth through five years old the total of level of care score is five or more; or</p> <p>(2) At age six through fifteen years old the total of level of care score is seven or more.</p> <p>(3)At age sixteen or older, eligibility for ICF/MR level of care requires that scores meet at least one of the following:</p> <p style="padding-left: 40px;">(a) a percentile rank that is over nine percent for three or more of the six subscales in the Support Intensity Scale (SIS) support needs scale;</p> <p style="padding-left: 40px;">(b) a percentile rank that is over twenty-five percent for two or more of the six subscales in the SIS support needs scale;</p>	<p>Washington State does not have a Long Term Care/Chronic Care hospital equivalent.</p> <p>*Long Term Care/Chronic Care Hospital</p>

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5. Needs-Based/Level of Care (LOC) Criteria (cont)

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/MR (& ICF/MR LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
<p>2. Be assessed to have a need for assistance demonstrated by:</p> <p>a. The need for assistance with three ADLs, one of which may be body care (application of lotions/ointments, toenails trimmed, dry bandage changes, or passive range of motion). Or</p> <p>b. Hands on assistance with one ADL which may include body care (application of lotions/ointments, toenails trimmed, dry bandage changes, or passive range of motion).</p>		<p>(c) a percentile rank that is over fifty percent in at least one of the six subscales in the SIS support needs scale;</p> <p>(d) a support score of one or two for any of the questions listed in the SIS exceptional medical support needs scale;</p> <p>(e) a support score of one or two for at least one of the following items in the SIS exceptional behavior support needs scale:</p> <p>(i) Prevention of assaults or injuries to others;</p> <p>(ii) Prevention of property destruction (e.g., fire setting, breaking furniture);</p> <p>(iii) Prevention of self-injury;</p> <p>(iv) Prevention of PICA (ingestion of inedible substances);</p> <p>(v) Prevention of suicide attempts;</p> <p>(vi) Prevention of sexual aggression; or</p> <p>(vii) Prevention of wandering.</p> <p>(f) a support score of two for any of the questions listed in the SIS exceptional behavior support needs scale; or</p> <p>(g) meet or exceed any of the qualifying scores for one or more of the selected SIS questions</p>	

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Needs Based Evaluation/Reevaluation (cont)

(By checking the following boxes the State assures that):

6. **Reevaluation Schedule.** Needs-based eligibility reevaluations are conducted at least every twelve months.
7. **Adjustment Authority.** The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).
8. **Residence in home or community.** The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. *(Specify any residential settings, other than an individual's home or apartment, in which residents who will be furnished State plan HCBS may reside. Describe the criteria by which the State determines that these settings are not institutional in character such as privacy and unscheduled access to food, activities, visitors, and community pursuits outside the facility):*

In addition to living in private homes or apartments, participants may also choose to live in state licensed Adult Family Homes or Boarding Homes with contracts to provide Assisted Living, Adult Residential Care, or Enhanced Adult Residential Care.

Participants residing in these settings have visitors at times convenient to the participant and privacy for visitation is available. Participants have either private rooms or share a room with one other individual, except in Assisted Living settings where participants live in individual apartments. Participants have their own possessions, clothing, and personal items. Service settings are located with access to community resources and activities.

Washington's legislature has codified their intent that choice, participation, privacy, and the opportunity to engage in religious, political, recreational, and other social activities foster a sense of self-worth and enhance the quality of life for long-term care residents. In addition, the statute includes the intent that the resident has the right to a safe, clean, comfortable and homelike environment.

State statute requires that residents who choose to live in these settings be provided with, among others, the right to: choose activities, schedules, and health care consistent with his or her interests; assessments and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. These choices include unscheduled access to food and community activities. In all settings, residents have unrestricted access to food and snack items which they have purchased.

Participants have a choice of any Adult Family Home or Boarding Home with a contract to provide adult residential services. Participants who choose Assisted Living services live in private apartments. Adult Family Homes and Boarding Homes with contracts to provide Adult Residential Care or Enhanced Adult Residential Care offer rooms shared with one other individual or private rooms. When participants share a room, the participant receives notice before the participant's roommate in the facility is changed. A participant has the right to share a double room with his or her spouse or domestic partner when participants who are married to each other or in a domestic relationship with each other live in the same facility and both spouses or both domestic partners consent to the arrangement.

Residential settings are licensed through the State Residential Care Services Division. The State determines that these rights are respected and preserved through the licensing inspection process, which includes observations and interviews that determine compliance with licensing rules and related statutes. In addition to licensing inspections, the State investigates complaints from residents or the public, including those about possible resident rights violations and takes action to ensure that rights are not violated. The Residential Care Services Division handles issues related to roommate choices during inspections or complaint investigations and ensures that the facility addresses these issues to the satisfaction of the residents involved.

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PERSON CENTERED PLANNING AND SERVICE DELIVERY

(By checking the following boxes the State assures that):

1. There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:
 - An objective face-to-face evaluation by an independent agent trained in assessment of need for home and community-based services and supports;
 - Consultation with the individual and others as appropriate;
 - An examination of the individual's relevant history, medical records, care and support needs, and preferences;
 - Objective evaluation of the inability to perform, or need for significant assistance to perform 2 or more ADLs (as defined in § 7702B(c)(2)(B) of the Internal Revenue Code of 1986); and
 - Where applicable, an evaluation of the support needs of the individual (or the individual's representative) to participant-direct.
 - A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.
2. Based on the independent assessment, the individualized plan of care:
 - Is developed by a person-centered process in consultation with the individual, the individual's: treating physician, health care or supporting professional, or other appropriate individuals, as defined by the State, and where appropriate the individual's family, caregiver, or representative;
 - Identifies the State plan HCBS necessary for the individual, and furnishes (or, funds, if the individual elects to participant-direct the purchase of such services), all HCBS which the individual needs and for which the individual meets service-specific additional needs-based criteria (if any);
 - Takes into account the extent of, and need for, any family or other supports for the individual;
 - Prevents the provision of unnecessary or inappropriate care;
 - Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
 - Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.

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Person Centered Planning and Service Delivery (cont)

3. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.

There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. *(Specify qualifications):*

In addition to meeting the following minimum qualifications, staff must pass a background check prior to being hired and receive mandatory training prior to completing any evaluations.

Evaluations are performed by case managers who can be a Registered Nurse (licensed in the State), a Social Worker or a Case Resource Manager.

For Social Workers, minimum qualifications are as follows:

A Master's degree in social services, human services, behavioral sciences, or an allied field and two years of paid social service experience equivalent to a Social Worker 2.

OR

A Bachelor's degree in social services, human services, behavioral sciences, or an allied field, and three years of paid social service experience performing functions equivalent to a Social Worker 2.

NOTE: A two year Master's degree in one of the above fields that included a practicum will be substituted for one year of paid social service experience.

NOTE: Employees must successfully complete the formal training course sponsored by their division within one year of their appointment.

NOTE: Equivalent social service experience would include the previous classes of Caseworker 3 or higher.

OR

For current employees the following experience qualifies for promotion to a Social Worker 3: A Bachelor's degree and three years of experience as a Caseworker 3, Social Worker 1A or B, Social Worker 2, Casework Supervisor Trainee, Casework Supervisor, Juvenile Rehabilitation Supervisor 1 or 2, or Juvenile Rehabilitation Counselor 2 in State service.

For Case/Resource Manager minimum qualifications are as follows:

A Bachelor's degree in social sciences, social services, human services, behavioral sciences or an allied field and two years of experience providing social services to people with developmental disabilities, graduate training in social science, social services, human services, behavioral sciences or an allied field will substitute, year for year, for one year of the experience providing social services to people with developmental disabilities.

Job classification descriptions are available from the Medicaid agency.

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Person Centered Planning and Service Delivery (cont)

- 4. Responsibility for Plan of Care Development.** There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. *(Specify qualifications):*

In addition to meeting the following minimum qualifications, staff must pass a background check prior to being hired and receive mandatory training prior to completing any evaluations.

Evaluations are performed by case managers who can be a Registered Nurse (licensed in the State), a Social Worker or a Case Resource Manager.

For Social Workers, minimum qualifications are as follows:

A Master's degree in social services, human services, behavioral sciences, or an allied field and two years of paid social service experience equivalent to a Social Worker 2.

OR

A Bachelor's degree in social services, human services, behavioral sciences, or an allied field, and three years of paid social service experience performing functions equivalent to a Social Worker 2.

NOTE: A two year Master's degree in one of the above fields that included a practicum will be substituted for one year of paid social service experience.

NOTE: Employees must successfully complete the formal training course sponsored by their division within one year of their appointment.

NOTE: Equivalent social service experience would include the previous classes of Caseworker 3 or higher.

OR

For current employees the following experience qualifies for promotion to a Social Worker 3: A Bachelor's degree and three years of experience as a Caseworker 3, Social Worker 1A or B, Social Worker 2, Casework Supervisor Trainee, Casework Supervisor, Juvenile Rehabilitation Supervisor 1 or 2, or Juvenile Rehabilitation Counselor 2 in State service.

For Case/Resource Manager minimum qualifications are as follows:

A Bachelor's degree in social sciences, social services, human services, behavioral sciences or an allied field and two years of experience providing social services to people with developmental disabilities, graduate training in social science, social services, human services, behavioral sciences or an allied field will substitute, year for year, for one year of the experience providing social services to people with developmental disabilities.

Job classification descriptions are available from the Medicaid agency.

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Person Centered Planning and Service Delivery (cont)

- 5. Supporting the Participant in Plan of Care Development.** Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the plan of care development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

Service plan development always includes the participant and their legal representative (if applicable). Participants may include any other individuals of their choice to participate. ADSA encourages participants to include family and other informal supports as appropriate to the participant's situation.

At the time of assessment, case managers review the "Client's Rights and Responsibilities (DSHS 16-172)" document with participants. This document outlines their right to participate in the development of their plan of care and ensure that their preferences and the services they wish to receive are included in their plan of care.

The Client's Rights and Responsibilities form states:

If you are a client of Aging and Disability Services you have a right to:

- Be treated with dignity, respect and without discrimination;
- Not be abused, neglected, financially exploited, abandoned;
- Have your property treated with respect;
- Not answer questions, turn down services, and not accept case management services you do not want to receive. However, it may not be possible for Aging and Disability

Services Administration to offer some services if you do not give enough information;

- Be told about all services you can receive and make choices about services you want or don't want;
- Have information about you kept private within the limits of the laws and DSHS regulations;
- Be told in writing of agency decisions and receive a copy of your care plan;
- Not be forced to answer questions or do something you don't want to;
- Talk with your social service worker's supervisor if you and your social service worker do not agree;
- Request an Administrative hearing;
- Have interpreter services provided to you free of charge if you cannot speak or understand English well;
- Take part in and have your wishes included in planning your care;
- Choose, fire, or change a qualified provider you want; and
- Receive the results of the background check for any individual provider you choose.

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Person Centered Planning and Service Delivery (cont)

6. Informed Choice of Providers. *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the plan of care):*

Participants are given free choice of all approved qualified providers of Adult Day Health. During the assessment and care planning process, case managers provide participants information about Adult Day Health Centers. Case Managers also provide assistance in locating providers. The case manager authorizes the service after the participant has chosen an ADH provider.

7. Process for Making Plan of Care Subject to the Approval of the Medicaid Agency. *(Describe the process by which the plan of care is made subject to the approval of the Medicaid agency):*

ADSA is an administration within DSHS, the State Medicaid Agency. ADSA sets policy and provides oversight for the development of Plans of Care. All plans are developed using the approved assessment tool CARE (Comprehensive Assessment Report Evaluation).

ADSA determines participant eligibility and requires the use of the department's electronic assessment and service planning tool, CARE. ADSA case managers directly authorize all initial service plans. AAA case managers conduct reevaluations for participants served by Home and Community Services Division of ADSA. ADSA has direct electronic access to all service plans. ADSA Quality Units conduct quality assurance activities on all service plans.

ADSA has a comprehensive quality monitoring process, which begins with either an on-site or off-site file reviews. File reviews are conducted at 18 to 24 month intervals with preliminary data available annually. Reviews assess consumer satisfaction and the accuracy and quality of service plans. Inter-rater reliability reviews are conducted in the participant's home. Monitoring includes file reviews by staff assigned to state quality monitoring units. These reviews are conducted on a randomly selected and statistically valid sample of participant files with a confidence interval of +/- 5% and a confidence level of 95%.

The findings from all reviews are collected, analyzed and recorded. Findings must be resolved within 3 to 40 days. Corrections are monitored by the Quality Units and local regional management. Based on the analysis necessary steps are taken. Quality assurance processes may result in corrective actions, adjustments to training curriculum, policy clarifications, forms revision, revisions to Washington Administrative Code and targeting criteria for the next review cycle.

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Person Centered Planning and Service Delivery (cont)

8. Maintenance of Plan of Care Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following (*check each that applies*):

X	Medicaid agency	<input type="checkbox"/>	Operating agency	<input type="checkbox"/>	Case manager
X	Other (<i>specify</i>):	Local offices maintain written copies of service plans for three years. Electronic copies of the CARE assessment including the service plan are maintained by the Medicaid agency.			

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SERVICES

1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

Service Specifications <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):</i>	
Service Title:	Adult Day Health
Service Definition (Scope):	
Adult day health is a supervised daytime program providing nursing and rehabilitative therapy services to adults with medical or disabling conditions that require the intervention or services of a registered nurse, or a licensed speech therapist, occupational therapist or physical therapist acting under the supervision of the participant's physician when required. Services provided are specified in the participant's service plan and encompass both health and social services needed to ensure the optimal functioning of the participant. Transportation between the participant's place of residence and the adult day health site is included as a component of adult day health services and is reflected in the rate paid to adult day health providers.	
Additional needs-based criteria for receiving the service, if applicable <i>(specify)</i> :	
Specify limits (if any) on the amount, duration, or scope of this service for <i>(chose each that applies)</i> :	
<input checked="" type="checkbox"/>	Categorically needy <i>(specify limits)</i> :
<input type="checkbox"/>	Medically needy <i>(specify limits)</i> :

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Service Title: Adult Day Health (cont)			
Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
Adult Day Health Centers		Certified under Washington Administrative code which defines Adult Day Health Center employee requirements. (WAC 388-71-0702 through 388-71-0826)	<p>The Adult Day Health Center must have a Core provider agreement with State Medicaid Agency.</p> <p>Minimum staffing requirements for adult day health centers include an administrator, program director, registered nurse, activity coordinator, a PT/OT or speech therapist, and a social worker. The administrator and program director may be the same person.</p> <p>Employee qualifications are as follows:</p> <p>The program administrator must have a master's degree and one year of supervisory experience in health or social services (full-time equivalent), or a bachelor's degree and two years of supervisory experience in a social or health service setting. The degree may be in nursing.</p> <p>The program director must have a bachelor's degree in health, social services or a related field with one year of supervisory experience (full-time equivalent) in a social or health service setting. Upon approval by the department, a day health center may request an exception for an individual with an associate's or vocational degree in health, social services, or a related field with four years of experience in a health or social service setting, of which two years must be in a supervisory position.</p> <p>Therapists must have valid state credentials and one year of experience in a social or health setting.</p> <p>Rehabilitative therapeutic assistants must be certified with valid state credentials, have at least one year of applicable experience and meet all statutory requirements.</p> <p>A certified or registered nursing assistant must meet the requirements of RCW 18.88A.020.</p>
Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):			
Provider Type (Specify):	Entity Responsible for Verification (Specify):		Frequency of Verification (Specify):
Adult Day Health Centers	AAAs certify that all requirements outlined in Washington Administrative Code have been met.		Annually
Service Delivery Method. (Check each that applies):			
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed

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Services (cont)

2. Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians. *(By checking this box the State assures that):* There are policies pertaining to payment the State makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the State makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS ; (b) how the State ensures that the provision of services by such persons is in the best interest of the individual; (c) the State's strategies for ongoing monitoring of services provided by such persons; (d) the controls to ensure that payments are made only for services rendered; and (e) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

The State does not make payment to legally responsible individuals, other relatives or legal guardians for furnishing state plan HCBS.

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PARTICIPANT-DIRECTION OF SERVICES

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. *(Select one):*

X	The State does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the State. <i>(Specify criteria):</i>

2. Description of Participant-Direction. *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

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3. Limited Implementation of Participant-Direction. *(Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewide requirements. Select one):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the State. Individuals who reside in these areas may elect self-directed service delivery options offered by the State, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. <i>(Specify the areas of the State affected by this option):</i>

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	□	□
	□	□

5. Financial Management. *(Select one):*

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

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Participant-Direction of Services (cont)

6. **Participant-Directed Plan of Care.** *(By checking this box the State assures that):* Based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Is directed by the individual or authorized representative and builds upon the individual's preferences and capacity to engage in activities that promote community life;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual or representative;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques.

7. **Voluntary and Involuntary Termination of Participant-Direction.** *(Describe how the State facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

--

8. Opportunities for Participant-Direction

a. Participant-Employer Authority (individual can hire and supervise staff). *(Select one):*

X	The State does not offer opportunity for participant-employer authority.
○	Participants may elect participant-employer Authority <i>(Check each that applies):</i>
<input type="checkbox"/>	Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
<input type="checkbox"/>	Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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Participant-Direction of Services (cont)

8. b. Participant–Budget Authority (individual directs a budget). (*Select one*):

<input checked="" type="checkbox"/>	The State does not offer opportunity for participants to direct a budget.
<input type="checkbox"/>	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. (<i>Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the plan of care</i>):
	Expenditure Safeguards. (<i>Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards</i>):

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QUALITY IMPROVEMENT STRATEGY

(Describe the State's quality improvement strategy in the tables below):

Discovery Activities					Remediation	
Requirement	Discovery Evidence (Data Metrics)	Discovery Activity (Source of Data)	Monitoring Responsibilities (agency or entity that conducts discovery activities)	Frequency	Monitoring Responsibilities (Who analyzes and aggregates remediation activities)	Frequency of Analysis and Aggregation
Service plans address assessed needs of enrolled participants, are updated annually, and document choice of services and providers.	1. Quality Monitoring Units Monitoring reports	1. Recipient Record Reviews	1. ADSA Quality Units	1. 18-24 month review cycle	1. ADSA Quality Monitoring Units. Findings must be resolved within 3 to 40 days. 2. ADSA management and Regional management	1. 18-24 month review cycle with preliminary data available annually 2. Monthly, quarterly, annually
	2. CARE Management Reports	2. CARE administrative data	2. ADSA management and local offices	2. Continuous and ongoing		
Providers meet required qualifications.	Contract monitoring reports	Provider contract monitoring	AAA contract staff	Initially and annually	ADSA Program Manager for Adult Day Health. Findings must be resolved within 3 to 40 days.	Continuous and on-going
The SMA retains authority and responsibility for program operations and oversight.	Fiscal/contract Monitoring Reports	AAA contract monitoring	ADSA State Unit on Aging	1. Desk monitoring occurs monthly	ADSA SUA A Corrective Action Plan addressing all findings must be submitted within 45 days after the completion of monitoring activities.	1. Annually 2. 18 months
				2. On site monitoring occurs annually		

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Quality Improvement Strategy (cont)

Discovery Activities (cont)					Remediation (cont)	
The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to enrolled participants by qualified providers.	<ol style="list-style-type: none"> ADSA Quality Monitoring Units monitoring reports Medicaid social service payment system reports Payment Review Process Reports 	<ol style="list-style-type: none"> Record reviews Medicaid social service payment system Review of payment data 	<ol style="list-style-type: none"> ADSA Quality Monitoring Units Medicaid social service payment system ADSA management and local offices 	<ol style="list-style-type: none"> 18-24 month review cycle Continuously and ongoing Continuously and ongoing 	<ol style="list-style-type: none"> ADSA Quality Units, local management. Findings must be resolved within 3 to 40 days. Medicaid social service payment system ADSA management 	<ol style="list-style-type: none"> 18-24 month review cycle with preliminary data available annually Monthly, Quarterly, Annually Quarterly, Annually
The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	<ol style="list-style-type: none"> ADSA Quality Monitoring Units Monitoring Reports APS QA monitoring reports APS reports DDD incident reports 	<ol style="list-style-type: none"> Record Review APS record review APS administrative data DDD incident reports/data 	<ol style="list-style-type: none"> ADSA Quality Monitoring Units APS Supervisors/Managers ADSA management and local offices DDD incident manager 	<ol style="list-style-type: none"> 18 to 24 month review cycle Annually Continuously and ongoing Continuously and ongoing 	<ol style="list-style-type: none"> ADSA Quality Monitoring Units Findings must be resolved within 3 days. ADSA APS Managers and local supervisors/managers ADSA APS Managers, Executive management, Regional APS management DDD Waiver Oversight Committee 	<ol style="list-style-type: none"> 18-24 month review cycle with preliminary data Annually Quarterly/Annually Annually Annually

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System Improvement: <i>(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)</i>			
Methods for Analyzing Data and Prioritizing Need for System Improvement	Frequency	Roles and Responsibilities	Method for Evaluating Effectiveness of System Changes
<p>ADSA uses a discovery and monitoring process to analyze the effectiveness of current systems. Performance is measured in terms of outcomes. Data from multiple data sources is analyzed to discover whether trends and patterns meet expected outcomes. The goal of quality monitoring in ADSA is to promote, encourage, empower and support continuous quality improvement.</p> <p>ADSA Quality Monitoring Units use a statistically valid sample with a confidence interval of +/- 5% and a confidence level of 95%. A random sample is pulled and monitored over a statewide 18-24 month review cycle with preliminary data available annually.</p> <p>During the review cycle each of the 13 AAA and 6 ADSA Regions are monitored based on an established schedule. Findings must be resolved in 3 to 40 days. Corrections are monitored by the Quality Monitoring Units and local regional/AAA management. Findings are analyzed by management. Based on the analysis necessary steps are taken. Quality assurance processes may result in corrective actions, adjustments to training curriculum, policy clarifications, forms revision, WAC revisions and targeting criteria for the next review cycle.</p>	<p>18-24 month review cycle with preliminary results available annually.</p> <p>Training is conducted at regular intervals throughout the year.</p>	<p>The ADSA quality process monitors consumer satisfaction, program eligibility, accuracy and quality of file documents, and if policy & procedures, state and federal statutes including waiver requirements are met. Quality monitoring responsibility covers six state regional areas and 13 Areas on Aging each review cycle. Entrance and exit conferences are held as well as technical assistance throughout the process. Detailed reports are produced and discussed with regional offices and AAAs.</p> <p>Quality Monitoring Units verify that corrections have been made to critical areas (health & safety, eligibility, payment).</p> <p>All issues identified by the monitoring activities are addressed in the remediation plans developed by the Regional or AAA offices.</p>	<p>At a statewide level, evaluating the effectiveness of the 1915(i) option is an ongoing process performed by the program manager and other staff responsible for the administration of the 1915(i) option. Data related to 1915(i) option is available from a variety of resources. Numerous reports and aggregate data generated by the Quality monitoring process are available on a continuous basis for use by managers, supervisors and the Quality Unit staff. Reports are used for discovery, remediation and to identify strengths and areas of improvement, training needs, areas of deficiencies and identify corrective action plans. There is continuity and integration of report review throughout ADSA.</p> <p>Ongoing analysis of data is reviewed. If a trend becomes evident action is taken at the headquarters level without waiting for the completion of the review cycle.</p> <p>At the completion of each area's monitoring, data is analyzed and used to develop local corrective action plans, policy /procedural changes and training or guidance at the regional/AAA, unit, and/or worker level.</p> <p>Upon completion of the review cycle, statewide systemic data is analyzed for trends and patterns by managers, and executive staff. Decisions for action are made based on analysis and prioritization. These activities may include statewide training initiatives, policy and/or procedural changes and identification of quality improvement activities/projects.</p> <p>ADSA staff are responsible for:</p> <ul style="list-style-type: none"> • Oversight of Area Agency on Aging (AAA) operations including implementation and compliance with contract requirements, state and federal laws and regulations, policies and procedures; approval and oversight of program budgets, billing for services provided, and Area Plan development and implementation; review of remediation (corrective action) plans submitted by AAAs to correct deficiencies in AAA operations and monitoring implementation of corrective actions; and review of monitoring reports submitted by AAAs for subcontractors to determine compliance with inter-local agreement and related laws and regulations. • Development of policy and procedures related to ADSA quality assurance/improvement activities, oversight of assessment, service planning and delivery models and monitoring

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System Improvement: (cont) <i>(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)</i>			
Methods for Analyzing Data and Prioritizing Need for System Improvement	Frequency	Roles and Responsibilities	Method for Evaluating Effectiveness of System Changes
		<p>Quality Monitoring Units review remediation plans to ensure that all required issues are addressed in the plans.</p> <p>ADSA executive staff review and approve remediation plans for implementation.</p>	<p>compliance to HCBS requirements. ADSA staff monitors for irregularities in payment authorizations through on-going review of Social Service Payment System (SSPS) reports. CARE generated reports are reviewed for program compliance and eligibility criteria.</p> <ul style="list-style-type: none"> Analyzing various Quality Monitoring Unit and CARE regional and statewide reports related to their programs to identify needed policy changes/clarifications, areas of improvement, and training. Executive management analyze the results of regional and statewide reports related to programs in order to identify and prioritize policy changes/clarifications, performance improvement activities, and training. <p>The Quality Improvement Strategy is evaluated and adjusted prior to the beginning of a review cycle. In addition, it is also evaluated to determine if changes are needed. Workgroups consisting of ADSA HQ program managers, Home and Community Services and Area Agency on Aging Supervisors, case managers, and nurses evaluate the quality strategy/program. Modifications/expectations are made based on changes in federal or state rules and regulations, ADSA policy and procedures, CMS assurances, input from participants, providers, and analysis of data from various reports including recommendations from the previous review cycle.</p> <p>ADSA also seeks the assistance of CMS and other entities through grants, conferences, or "Best Practices" information, to continue to refine benchmarks for improvement and evaluate the system against those benchmarks</p>

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

The following ambulatory services are provided. *

Outpatient hospital services

Clinic services

Other laboratory services

Home health services

Physicians' services

Prescribed drugs, dentures, prosthetic devices and eyeglasses

Family planning services

*Description provided on attachment.

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State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

- 1. Inpatient hospital services other than those provided in an institution for mental diseases.
 Provided: No limitations With limitations*

- 2.a. Outpatient hospital services.
 Provided: No limitations With limitations*

- d. Rural health clinic services and other ambulatory services furnished.
 Provided: No limitations With limitations*

- e. 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).
 Provided: No limitations With limitations*

- 3. Other laboratory and x-ray services.
 Provided: No limitations With limitations*

- 4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
 Provided: No limitations With limitations*

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

- c. Family planning services and supplies for individuals of childbearing age.
 Provided: No limitations With limitations*

*Description provided on attachment.

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

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

Provided: No limitations With limitations*

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

Provided: No limitations 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.

Provided: No limitations With limitations*

Not Provided:

b. Optometrists' services.

Provided: No limitations With limitations*

Not Provided:

c. Chiropractor's services.

Provided: No limitations With limitations*

Not Provided:

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

Provided: No limitations With limitations*

Not Provided:

*Description provided on attachment.

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

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.

Provided: No limitations With limitations*

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

Provided: No limitations With limitations*

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

Provided: No limitations With limitations*

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

Provided: No limitations With limitations*

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

Provided: No Limitations With limitations*

8. Private duty nursing services.

Provided: No limitations With limitations*

Not Provided:

9. Clinic services.

Provided: No limitations With limitations*

Not Provided:

*Description provided on attachment.

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State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

10. Dental services.

Provided: No limitations With limitations*

Not Provided:

11. Physical therapy and related services.

a. Physical therapy.

Provided: No limitations With limitations*

Not Provided:

b. Occupational therapy.

Provided: No limitations 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).

Provided: No Limitations 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.

Provided: No limitations With limitations*

Not Provided:

*Description provided on attachment.

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State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

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:

*Description provided on attachment.

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State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

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

d. Rehabilitative services.

Provided: No limitations With limitations*

Not Provided:

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

a. Inpatient hospital services.

Provided: No limitations With limitations*

Not Provided:

b. Nursing facility services.

Provided: No limitations With limitations*

Not Provided:

c. Intermediate care facility services.

Provided: 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.

Provided: No limitations With limitations*

Not Provided:

*Description provided on attachment.

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

15.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:

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

Provided: No limitations With limitations*

Not Provided:

17. Nurse -midwife services.

Provided: No limitations With limitations*

Not Provided:

18. Hospice care (in accordance with section 1903(o) of the Act.

Provided: No limitations 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).

Provided: With limitations*

Not Provided:

*Description provided on attachment.

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

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:

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.

Provided: Additional coverage ++

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

Provided Additional coverage ++

21. Certified pediatric or family nurse practitioners' services.

Provided 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

*Description provided on attachment.

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

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

Provided: No limitations 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.

Provided: No limitations With limitations*

Not Provided:

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

Provided: No limitations With limitations*

Not Provided:

c. Reserved.

Provided: No limitations With limitations*

Not Provided:

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

Provided: No limitations With limitations*

Not Provided:

e. Emergency hospital services.

Provided: No limitations With limitations*

Not Provided:

*Description provided on attachment.

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

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: 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

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.

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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State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

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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State WASHINGTONAMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

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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State WASHINGTONAMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

4. a. Nursing facility services

Prior approval of admission

b. Early and periodic screening, diagnosis, and treatment

Early Periodic Screening, Diagnosis and Treatment (EPSDT) is a program providing EPSDT to persons under 21 years of age who are eligible for Medicaid or the Children's Health Program. 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 do not apply other than based on medical necessity.

(1) School-based healthcare services provided to a child with a disability in accordance with the Individuals with Disabilities Education Act (IDEA):

- Address the physical and/or mental disabilities of the child;
- Are prescribed or may be recommended by a physician or another licensed healthcare practitioner within his or her scope of practice under State law; and
- Are included in the child's IEP in accordance with IDEA

(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 requirements and who operates within the scope of his or her license or certification according to State law and professional practice standards.

- (i) *Physical therapist* – A 'qualified physical therapist' is an individual who meets the requirements set forth in 42 CFR 440.110 (a) and who is licensed according to the Washington State Board of Physical Therapy.
- (ii) *Occupational therapist* – A 'qualified occupational therapist' is an individual who meets the requirements set forth in 42 CFR 440.110 (b) and who is licensed according to the Washington State Occupational Therapy Practice Board. Occupational therapy services may be provided by a Certified Occupational Therapy Assistant under the direction/supervision of a licensed occupational therapist according to professional practice standards.
- (iii) *Speech pathologist* – A 'qualified speech pathologist' is an individual who meets the requirements set forth in 42 CFR 440.110 (c) (2) and who is licensed according to the Washington State Board of Hearing and Speech.
- (iv) *Audiologist* – A 'qualified audiologist' is an individual who meets the requirements set forth in 42 CFR 440.110 (c) (3) and who is licensed according to the Washington state Board of Hearing and Speech.

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State WASHINGTONAMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

4. b. EPSDT (cont)

- (v) *Registered nurse, practical nurse* – A ‘qualified registered nurse or practical nurse’ is an individual who is licensed according to the Washington State Health Nursing Commission in accordance with 42 440.60.
- (vi) *Psychologist* – A ‘qualified school psychologist’ is an individual who is licensed according to the Washington State Board of Psychology in accordance with 42 CFR 440.130(d).
- (vii) *Social worker* – A ‘qualified school social worker’ is an individual who is licensed according to the Washington State Board of Health in accordance with 42 CFR 440.130(d).
- (viii) *Mental health counselor* – A ‘qualified school mental health counselor’ is an individual who is licensed according to the Washington State Board of Health in accordance with 42 CFR 440.130(d).
- (ix) In those circumstances when a healthcare-related service is provided under the direction or supervision of a federally qualified therapist, the following restrictions apply. Documentation must be kept supporting the federally qualified therapist’s supervision of services and ongoing treatment of services. The supervising therapist must:
 - (A) See the child at the beginning of and periodically during treatment;
 - (B) Be familiar with the treatment plan as recommended by the healthcare practitioner under State law;
 - (C) Have a continued involvement in the care provided; and
 - (D) Review the need for continued services throughout treatment.
- (b) Covered services are provided in accordance with 1905 (a) of the Social Security Act including (4) (B), (6), (11), (13) (28) and sub-section (r) (5).4.b. EPSDT
 - (i) *Physical therapy evaluation and treatment services* – Assessing, preventing, or alleviating movement dysfunction and related dysfunctional problems.
 - (ii) *Occupational therapy evaluation and treatment services* – Assessing, improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation, improving ability to perform tasks for independent functioning when functions are lost or impaired, preventing through early intervention, initial or further impairment or loss of function.

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State WASHINGTONAMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

4. b. EPSDT (cont)

- (iii) *Speech-language therapy evaluations and treatment services* – Assessment of children with speech and/or language disorders, diagnosis and appraisal of specific speech and/or language disorders, referral for medical and other professional attention necessary for the rehabilitation of speech and/or language disorders, provision of speech or language services for the prevention or 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 for medical or other professional attention for restoration or 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 and remedial services either recommended by a physician or determined to be necessary by the licensed registered nurse, treatment services including those that prevent disease, disability, and other health conditions or their progression and supervision of delegated health care services.
- (vi) *Psychological assessments and psychotherapy services* – Psychological assessments including testing, and psychotherapy to assist a child to adjust to their disability.
- (vii) *Counseling assessments and therapy services* – Therapeutic intervention services to assist a child to adjust to their disability
- (c) Medicaid beneficiaries have freedom of choice of 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTONAMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

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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State WASHINGTONAMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

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:

- For adults: Outpatient psychotherapy and electroconvulsive therapy, in any combination – one hour per day, per client, up to a total of twelve hours per calendar year. Includes family or group psychotherapy.
- For children: Outpatient psychotherapy and electroconvulsive therapy, in any combination – one hour per day, per client, up to a total of twenty hours per calendar year. Includes family or group psychotherapy.
- Psychiatric diagnostic interview examinations – one in a calendar year unless an additional evaluation is medically necessary.

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

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State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

5. a. Physicians' services (cont.)

(10) Psychiatry 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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State WASHINGTONAMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

-
5. b. Medical and surgical services furnished by a dentist
- Short stay procedures also take place in ambulatory surgery settings.
- (1) Nonemergent oral surgeries performed in an inpatient hospital setting are not covered. The exception to this are DDD clients and children 18 years of age and under, whose surgery cannot be performed in an office setting (e.g., orthognathic cleft palate bone grafting). Prior written authorization is required. Documentation must be maintained in the client's record.
- (2) Orthodontic treatment is limited to medically necessary treatment, as follows, and only for children with severe handicapping malocclusion, craniofacial anomalies or cleft lip or palate:
- (a) Clients in the EPSDT program through age twenty (20);
 - (b) Clients in the children's health program through age eighteen (18); and
 - (c) Clients in the MN program through age twenty (20).

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State WASHINGTONAMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

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 an M.D., D.O., or podiatrist.
- (2) The treatment of flat feet, or non-medically necessary treatment of fungal disease is not covered.
- b. Optometrists' services
- (1) Frames, lenses, and contact lenses must be ordered from the department's contractor.
- c. 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 (continued)
- (1) MAA covers medically necessary eye examinations, refractions, eyeglasses (frames and glasses), and fitting fees as follows:
- Every 24 months for asymptomatic adults 21 years or older; and
 - Every 12 months for asymptomatic children 20 years or younger, and clients identified by MAA as developmentally disabled.
- (2) The department covers medically necessary contact lenses, as defined in rule. Normal replacement for contact lenses is every 12 months.
- (3) Exceptions to numbers (1) and (2) above will be considered for all individuals based on medical necessity.

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6. d. Other practitioners' services

All other practitioners covered by the department include, but are not limited to, the following licensed practitioners: physician assistants, advanced registered nurse practitioners including certified registered nurse anesthetists, psychologists, dental hygienists, denturists, chiropractors (for EPSDT only), dietitians, nutritionists, radiological technicians, , opticians, and licensed non-nurse midwives. These practitioners are limited to services within their scope of practice and specialty area.

Counselors, social workers, and other practitioners are covered as specified in other sections of the State Plan and as approved by the department.

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

Children's mental health outpatient services may be provided up to twenty hours per calendar year, subject to medical necessity. Prior authorization is required for additional services that are medically necessary.

(1) HRSA does not cover services provided by:

- Acupuncturists
- Christian Science practitioners or theological healers
- Herbalists
- Homeopathists
- Naturopaths
- Masseuses
- Masseurs
- Sanipractors

(2) Licensed non-nurse midwives

- To participate in home births and in birthing centers, midwives must be a Department-approved provider.

(3) Psychologists.

- One psychological evaluation per client's lifetime is covered.
- Neuropsychological testing requires prior authorization.

(4) Intentionally left blank

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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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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
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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

Medical supplies, equipment and appliances must be:

- (1) Medically necessary;
- (2) Ordered by the treating physician; and
- (3) In the plan of care.

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:

- (1) Purchase of equipment and appliances and rental of durable medical equipment require prior approval.
- (2) Must be billed separately under a DME provider number.
- (3) Are subject to the requirements in Washington Administrative Code.
- (4) Specific reusable and disposable medical supplies, prosthetics, orthotics, and non-durable equipment which have set limitations, require prior approval (PA) to exceed those limitations.

d. Other Medical services supplies, equipment and appliances

- (1) The Oxygen and Respiratory Therapy Services Program provides medically necessary oxygen and/or respiratory therapy equipment, services, and supplies to eligible clients who reside at home, when the services are medically necessary.

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MEDICALLY NEEDY GROUP(S): ALL

7. d. Home health services (cont.)

- (2) Home infusion-parenteral nutrition equipment and supplies are provided when medically necessary.
 - One germicide and/or one antiseptic allowed on the same day. Justification for exceeding this limit must be documented in the client's file.
- (3) 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 EPSDT purposes. Exceptions to these limitations are based on medical necessity.

- A licensed and certified dietitian must evaluate all clients 20 years of age and younger within 30 days of initiation of medical nutrition, and periodically (at the discretion of the licensed/certified dietitian) while the client is receiving medical nutrition.
- Initial assessments limited to 2 hours (or 8 units) per year.
- Reassessments limited to no more than 1 hour (or 4 units) per day.
- Group therapy limited to 1 hour (or 4 units) per day.

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

- (1) Provided by a Medicare-certified home health agency. A medical rehabilitation facility must subcontract with a Medicare-certified home health agency in order to provide services in the client's home and bill for those services.
- (2) Limited to clients who cannot receive their medically necessary care in the community, and meet one of the following:
 - (a) The client has an acute care need, has not attained a satisfactory level of rehabilitation, and requires frequent intervention; or
 - (b) The client is not medically stable.

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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
- e. 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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MEDICALLY NEEDY GROUP(S): ALL

10. Dental services and dentures
- a. Limited to selected medically necessary services for the identification and treatment of dental problems or the prevention of dental diseases. Some of these services may require prior authorization.
 - b. Crowns are covered only for children through age twenty (20) and require prior authorization.
 - c. Orthodontic treatment is limited to medically necessary treatment, as follows, and only for children with craniofacial anomalies or cleft lip or palate or severe handicapping malocclusion. Limits may be exceeded based on medical necessity.
 - (1) Clients in the EPSDT program through age twenty (20);
 - (2) Clients in the MN program through age twenty (20).
 - d. Clients of the Developmental Disability Division may receive additional services.
 - e. Dentures
 - (1) For limitations indicated in (1) below, limits may be exceeded based on medical necessity. (1) For clients through age twenty (20), allowed per client:
 - Complete, immediate, and overdenture dentures - one maxillary and one mandibular denture in a ten year period.
 - Partial dentures - once every five years, subject to limitations.
 - Replacement full or partial dentures - requires prior authorization when requested within one year of the seat date of the previous dentures.
 - Rebase - once every five years and the dentures must be at least three years old
 - Relines and adjustments - included in the reimbursement if done within six months of the seat date. After six months, allowed once every five years.
 - (2) For clients age twenty-one (21) and over, allowed per client:
 - Immediate dentures - one maxillary and one mandibular denture in a lifetime, and requires prior authorization.
 - Complete dentures - one maxillary and one mandibular denture in a ten-year period and requires prior authorization.
 - Resin and cast metal framework partial dentures - once in a ten-year period and requires prior authorization.
 - Replacement resin partial dentures – not allowed within the ten-year period.
 - Replacement cast metal framework partial dentures - once in a ten-year period.
 - Complete and partial denture relines - once in a five-year period.

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MEDICALLY NEEDY GROUP(S): ALL

11. Physical therapy and related services
- 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. Prior authorization required to exceed set limits for clients twenty-one (21) years of age and older as follows:
 - (1) Prior Authorization is required for physical therapy (PT) when the client:
 - Is 21 years of age and older and requires services beyond one PT evaluation and 48 units PT per year, per client per diagnosis; or
 - Is 21 years of age and older and has a qualifying diagnosis or has completed an approved inpatient rehab stay, and requires services beyond one PT evaluation and 144 units of PT per year, per client, per diagnosis.
 - (2) Prior Authorization is required for occupational therapy (OT) when the client:
 - Is 21 years of age and older and requires services beyond one OT evaluation and 12 OT visits per year, per client; or
 - Is 21 years of age and older and has a qualifying diagnosis or has completed an approved inpatient rehab stay and requires services beyond one OT evaluation and 36 OT visits per year, per client.
 - (3) Prior Authorization is required for speech therapy (ST) when the client:
 - Is 21 years of age and older and requires services beyond one Speech evaluation and 12 Speech visits per year per client; or
 - Is 21 years of age and older and has a qualifying diagnosis and requires services beyond one Speech evaluation and 36 Speech visits per year per client.
 - d. 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.
 - e. 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.
 - f. 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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MEDICALLY NEEDY GROUP(S): ALL

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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State WASHINGTONAMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

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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 January 16, 2004, entitled "State of Washington Supplemental Rebate Contract" has been authorized by CMS.
- 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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MEDICALLY NEEDY GROUP(S): ALL

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)

<u>Citation</u>	<u>Provision</u>
1935(d)(1)	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)	<p>(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.</p> <p><u> X </u> The following excluded drugs are covered:</p> <p><u>select</u> (i) Agents when used for anorexia, weight loss, weight gain: Progesterin derivative appetite stimulant, androgenic agents</p> <p><u> No </u> (ii) Agents when used to promote fertility</p> <p><u> No </u> (iii) Agents when used for cosmetic purposes or hair growth</p> <p><u>select</u> (iv) Agents when used for the symptomatic relief cough and colds: antitussives, expectorants, decongestants, nasal spray, and only the following generic, single ingredient formulations:</p> <ul style="list-style-type: none"> • Guaifenesin 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. <p><u> X </u> (v) Prescription vitamins and mineral products, except prenatal vitamins and fluoride for documented deficiency</p> <p><u>select</u> (vi) Nonprescription (OTC) drugs when determined by the department to be the least costly therapeutic alternative for a medically accepted indication: analgesics/antipyretics, antacids, antibacterial topical preparations, antidiarrheals, antiemetic/antivertigo agents, antiflatulents, antihistamines, antitussives, decongestants, electrolyte replacements, emetics, expectorants, eye antihistamines, fluoride preparations, hyperglycemics, inhalation agents, insulins,</p>

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12. a. Prescribed Drugs (continued)

laxatives, lipotropics, nasal preparations, topical steroidal anti-inflammatories, topical antiparasitics, nicotine replacement patches and gum after completion of the nicotine replacement therapy supply available from the Dept. of Health under their smoking cessation program.

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

X (viii) Barbiturates

X (ix) Benzodiazepines:

X (x) Agents when used to promote smoking cessation (drugs not eligible under Part D and are not covered for dual eligible clients):

- FDA-approved prescription drugs to promote smoking cessation will be covered, consistent with FDA guidelines, only for clients who are eighteen years of age or older and participating in a department-approved smoking cessation program.

 No excluded drugs are covered.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

- 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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State WASHINGTONAMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

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.
- (B) Chemical dependency professionals (CDP) - chapter 18.205 RCW and chapter 246-924 WAC.
- (C) Mental health counselor, marriage and family therapist, or social worker - chapter 18.225 RCW and chapter 246-809 WAC.
- (D) Physician (MD) - chapter 18.71 RCW and chapter 246-919 WAC.
- (E) Physician assistant (PA) - chapter 18.71A RCW and chapter 246-918 WAC.
- (F) Psychologist - chapter 18.83 RCW and chapter 246-924 WAC.

(iii) Settings

Services may be delivered in the following settings: hospitals, residential facilities, outpatient facilities, health care clinics, FQHCs, and Indian Health Service facilities.

(b) 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).

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

-
13. d. Rehabilitative Services (cont)
- (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 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; and
 - (V) Resident discharge or transfer criteria.
 - (vi) 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:
 - (A) Advanced registered nurse practitioner (ARNP): provides screening, detoxification, and referral. Meets requirements of chapter 18.79 RCW and chapter 246-840 WAC.
 - (B) Chemical dependency professionals (CDP): provides screening and referral. Meets requirements of chapter 18.205 RCW and chapter 246-924 WAC.
 - (C) Licensed practical nurse (LPN): provides screening, detoxification, and referral. Meets requirements of chapter 18.79 RCW and chapter 246-840 WAC.
 - (D) Mental health counselor, marriage and family therapist, or social worker: provides screening and referral. Meets requirements of chapter 18.225 RCW and chapter 246-809 WAC.
 - (E) Physician (MD): provides screening, detoxification, and referral. Meets requirements of chapter 18.71 RCW and chapter 246-919 WAC.
 - (E) Physician assistant (PA): provides screening, detoxification, and referral. Meets requirements of chapter 18.71A RCW and chapter 246-918 WAC.
 - (F) Psychologist: provides screening and referral. Meets requirements of chapter 18.83 RCW and chapter 246-924 WAC.
 - (G) Registered nurse (RN): provides screening, detoxification, and referral. Meets requirements of chapter 18.79 RCW and chapter 246-840 WAC.
 - (v) Counseling services for persons admitted must be performed by a Chemical Dependency Professional certified in chemical dependency counseling by DOH according to DOH RCW and WAC.

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MEDICALLY NEEDY GROUP(S): ALL

13. d. Rehabilitative Services (cont)

- (vi) Alcohol and drug detoxification is provided 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.
- (vii) 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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State WASHINGTONAMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

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) The persons providing the evaluation and treatment services in outpatient and residential treatment centers must be Chemical Dependency Professionals (CDPs) certified in chemical dependency counseling by DOH according to DOH WAC and RCW.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

13. d. Rehabilitative Services (cont)

(4) Adult Day Health (ADH) is a supervised daytime program providing nursing and rehabilitative therapy services. Adult Day Health services are only appropriate for adults with medical or disabling conditions that require the intervention or services of a registered nurse or licensed rehabilitative therapist acting under the supervision of the client's physician. The coverage of Adult Day Health services will end on December 31, 2009.

(a) Provider Qualifications

The Adult Day Health Center must be certified per state law and have a core provider agreement with State Medicaid Agency. Minimum staffing requirements for Adult Day Health Centers include an administrator, program director, registered nurse, activity coordinator, a PT/OT or speech therapist, and a social worker. The administrator and program director may be the same person. Adult Day Health Center staff must meet employee qualifications outlined in state law.

(b) Settings

Adult Day Health is a site-based service located in community settings. Adult Day Health Centers must meet facility and physical environment requirements outlined in state law.

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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) 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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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 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:

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 consumers 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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MEDICALLY NEEDY GROUP(S): ALL

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 for 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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MEDICALLY NEEDY GROUP(S): ALL

13. d. Rehabilitative services (cont.)

9. Behavior Rehabilitation Services.

Behavior rehabilitative are services provided to children to remediate debilitating disorders, upon the certification of a physician or other licensed practitioner of the healing arts within the scope of their practice within state law. Prior approval is required.

Service Description

Specific services include milieu therapy, crisis counseling and regularly scheduled counseling and therapy, as well as medical treatment.

Milieu therapy refers to those activities performed with children to normalize their Psychosocial development and promote the safety of the child and stabilize their environment. The child is monitored in structured activities which may be recreational, rehabilitative, academic, or a variety of productive work activities.

As the child is monitored, intervention is provided to remediate the dysfunctional behaviors and encourage appropriate responses in a broad range of settings.

Crisis counseling is 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.

Regularly scheduled counseling and therapy, as well as psychological testing, is provided. The purpose of which is to remediate specific dysfunctions which have been explicitly identified in a continually updated formal treatment plan. Therapy may be in an individual or group setting.

It may be directed toward the child alone, the child within his/her biological or the adopted family, or the child within his/her peer group. Medical treatment may also be provided. Twenty-four hour nursing is provided for children who are medically compromised to such an extent that they are temporarily unable to administer self care and are impaired medically/developmentally immediate the caretaker's ability to provide medical/remedial care.

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MEDICALLY NEEDY GROUP(S): ALL

13. d. 9. Rehabilitative services/Behavior rehabilitation (cont.)

Population to be Served

Children who receive these services suffer from developmental disabilities and behavioral/emotional disorders that prevent them from functioning normally in their homes, schools, and communities. They exhibit such symptoms as drug and alcohol abuse; anti-social behaviors that require an inordinate amount of intervention and structure; sexual behavior problems; victims of severe family conflict; behavioral disturbances often resulting from psychiatric disorders of the parents; medically compromised and developmentally disabled children who are not otherwise served by the state agency's Division of Developmental psychological Disabilities; and impairments.

Provider Qualifications

Service include Social Staff: Responsibilities development of service plans; individual, group, and family counseling; and assistance to child care staff in providing appropriate treatment for clients. The minimum qualification is a Masters Degree in social work or a closely allied field.

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

Program Coordinator: Responsibilities include supervising staff, providing overall direction to the program and assuring that contractual requirements and intents are met. Minimum qualifications are to be at least 21 years of age with a Bachelors Degree, preferably with major in study psychology, sociology, social work, social sciences, or a closely allied field, and two years experience in the supervision and management of the group care program for adolescents.

Counselor: 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. Minimum qualifications are to be at least 21 years of age possessing a Master's Degree with major study in social one year work or a closely allied field and of experience in the care of troubled adolescents or, a Bachelor's Degree with major study in social work, psychology, experience in the care of troubled adolescents.

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State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

17. Nurse midwife services

Limited to facilities approved by the department to provide this service, or in the case of home births, to clients and residences approved for this service. To participate in home births, midwives must be an MAA-approved provider.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTONAMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

18. Hospice care (in accordance with section 1903(o) of the Act)
- Includes pediatric palliative care services that are provided for approved clients 20 year old and younger who have a life limiting diagnosis.
20. Extended services for pregnant women, through the sixty days postpartum period
- The extended services include:
- a. Maternity support services, by a provider approved by the Department of Health and the department, consisting of 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 licenced, 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 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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State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

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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State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

23. a. Transportation
- (1) Ambulance transportation is provided as an optional service for emergencies or as required by state law.
 - (2) All non-emergency transportation services, to assure clients have access to and from covered services, are provided using administrative matched dollars in accordance with Section 42 CFR 431.53, and are not considered a medical service described in the coverage section of the State Plan.
 - (3) Transportation for clients who also have Medicare Part D is provided at the same level of service as, and under the same restrictions for, prescription drug pickups.

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State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

23. d. Nursing facility services provided for patients under 21 years of age
Admission requires prior approval.

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State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

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:

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.

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 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).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTONAMOUNT, 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 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;
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:

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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 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 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:

Entire State

C. Comparability of Services:

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 WASHINGTON

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.

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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ALTERNATIVE BENEFITS

BENCHMARK BENEFIT PACKAGE/BENCHMARK EQUIVALENT BENEFIT PACKAGE

1937(a), The State elects to provide alternative benefits under Section 1937 of the
1937(b) Social Security Act.

A. Populations

The State will provide the benefit package to the following populations:

- a. Required Populations who are full benefit eligible individuals in a category established on or before February 8, 2006, will be required to enroll in an alternative benefit package to obtain medical assistance except if within a statutory category of individuals exempted from such a requirement.

List the population(s) subject to mandatory alternative coverage:

- b. Opt-In Populations who will be offered opt-in alternative coverage and who will be informed of the available benefit options prior to having the option to voluntarily enroll in an alternative benefit package.

List the populations/individuals who will be offered opt-in alternative coverage:

Categorically Needy - Aged, Blind and Disabled adults aged 21 and over, currently receiving services via the fee-for-service system. These are high risk clients with complex medical needs and are diagnosed with one of the following chronic medical conditions:

Diabetes, heart failure, coronary artery disease, cerebrovascular disease, renal failure, chronic pain associated with musculoskeletal conditions, and other chronic illness including migraine, cancer, chronic respiratory conditions including asthma and/or COPD, hematological conditions such as hemophilia, and comorbid depression and/or anxiety.

Contractors will accept eligible clients in the order in which they request enrollment in the program. No eligible client will be refused enrollment in the disease management program.

The program is being phased in by large groups of clients (1000 per quarter in King County, 4000 per quarter statewide), which will allow careful implementation and evaluation of the program. (See attached approval from the Institutional Review Board).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON**ALTERNATIVE BENEFITS****BENCHMARK BENEFIT PACKAGE/BENCHMARK EQUIVALENT BENEFIT PACKAGE****A. Populations (contd)**

For the opt-in populations/individuals, describe the manner in which the State will inform each individual that such enrollment is voluntary, that such individual may opt out of such alternative benefit package at any time and regain immediate eligibility for the regular Medicaid program under the State plan.

Eligible individuals are encouraged to participate in the program through mailings from the state and the Disease Management (DM) contractors, and telephonic outreach by the DM contractors. Individuals who choose to participate in the opt-in program maintain eligibility for the regular Medicaid benefits at all times. The opt-in program adds additional disease management services for individuals determined to be in the high-risk group described above.

For the opt-in populations/individuals, provide a description of the benefits available under the alternative benefit package and a comparison of how they differ from the benefits available under the regular Medicaid program, as well as an assurance that the State will inform each individual of this information.

In addition to all regular Medicaid program benefits, the alternative benefit package includes disease management interventions, provided either face-to-face, or telephonically, by a Registered Nurse Care Manager, or Licensed Master's Level Social Worker (hereinafter referred to as "the Care Manager"). Individuals who provide these services must meet all Washington state licensing and/or certification requirements for their position. Whether services are provided face-to-face or telephonically is determined in the initial assessment. If the newly enrolled client is unable to interact with the Care Manager telephonically, arrangements are made for the Care Manager to visit with the enrollee on a face-to-face basis. The standard call frequency is once per month; however, schedules for calls and for face-to-face visits are based on enrollee need and may occur more frequently. Interventions provided by the Care Manager include:

- 1. Assessment of new enrollees for risk factors, health status, self-management skills, adherence to the enrollee's treatment plan, knowledge of and adherence to prescribed medications;*
- 2. Development of a six month care plan in coordination with the client's caregivers and Primary Care Provider. The plan is based on the client's specific needs, including language barriers, mental health needs, multiple medications and others.*

The plan includes education about self-management, appropriate use of resources, how to navigate the health care system and how to work with the client's provider to develop a plan of care and adhere to that plan, and is developed in coordination with the client and the client's family/caregivers and provider.

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State WASHINGTON**ALTERNATIVE BENEFITS****BENCHMARK BENEFIT PACKAGE/BENCHMARK EQUIVALENT BENEFIT PACKAGE****A. Populations (cont)**

3. *After the care plan has been developed and agreed to by the enrollee, the Care Manager monitors the client via telephone and/or face-to-face visits (If necessary) to ensure the enrollee understands the plan and is adhering to it and to provider instructions for care.*
4. *The Care Manager will ensure that the enrollee's PCP and other provider are aware of the care plan and will update providers about the enrollee's progress in adhering to the plan.*
5. *If the enrollee needs help in accessing services through another service system, such as mental health or chemical dependency, the Care Manager will provide assistance to the enrollee in accessing such services by coordinating with providers in the other system.*
6. *Care Managers (as defined above) will provide all disease management interventions. However, lay health workers provide some non-clinical services to enrollees, including: locating the enrollee if contact information provided by the state is incorrect; conducting the initial enrollment screening; mailing health information (brochures, etc) to enrollees; and arranging for transportation to medical and other appointments arranged for by the Care Manager.*

All disease management interventions, including the health risk assessment, care plan development, education and monitoring, and assistance in coordinating services with other systems, will be provided by the Care Manager. All Care Managers (Registered Nurses and licensed Social Workers) are employed by either the Statewide or the Local Disease Management Contractors. Additionally, the Local Disease Management Project subcontracts with the local Information and Assistance Agency to provide services such as client location, initial screenings and program information.

Both the Statewide and Local Disease Management projects provide Care Management services described above; however, in the local disease management program, the Care Manager is required to accompany each enrollee to at least one doctor visit to ensure the enrollee knows how to ask appropriate questions and how to use the information provided by the doctor.

Additionally, the local disease management program includes a medical home program component that consists of a network of primary care providers who are trained in the chronic care model of disease management. This includes using a health care team to most efficiently and effectively manage a client's chronic condition. This includes the client's self management of their disease condition.

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State WASHINGTON

ALTERNATIVE BENEFITS

BENCHMARK BENEFIT PACKAGE/BENCHMARK EQUIVALENT BENEFIT PACKAGE

A. Populations (contd)

c. Geographical Classification

States can provide for enrollment of populations on a statewide basis, regional basis, or county basis.

Services under this alternative benefit package are available statewide.

List any geographic variations:

The State intends to contract with one Statewide Care Management (SCM) contractor, who will identify eligible clients using predictive modeling and will provide nurse care management and medical home assistance to high-risk clients. Additionally, the State will contract with Local Care Management (LCM) program(s) that will provide nurse care management services on a local level, and will provide medical home support services to providers who serve eligible individuals, as well as assisting all eligible individuals who do not have a medical home to find one.

Please provide a chart, listing eligible populations (groups) by mandatory enrollment, opt-in enrollment, geography limitations, or any other requirements or limitations.

All clients in the Aged, Blind and Disabled Categorically Needy eligibility group are eligible for the alternative benefit package of services. All enrollment is voluntary (opt-in). There are no geographical limitations other than the differences described above. Dual eligible Medicare clients will be phased in to the program as the new information system "(ProviderOne)" allows for enrollment.

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ALTERNATIVE BENEFITS

BENCHMARK BENEFIT PACKAGE/BENCHMARK EQUIVALENT BENEFIT PACKAGE

B. Description of the Benefits

The State will provide the following alternative benefit packages (check all that apply).

1937(b) 1. Benchmark Benefits

- a. FEHBP-equivalent Health Insurance Coverage – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(l) of Title 5, United States Code.
- b. State Employee Coverage – A health benefits coverage plan that is offered and generally available to State employees within the State involved. Attach a copy of the State’s employee benefits plan package.
- c. Coverage Offered Through a Health Maintenance Organization (HMO) – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State involved. Attach a copy of the HMO’s benefit package.
- d. Secretary-approved Coverage – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide a description of the State’s plan. Provide a full description of the benefits package including the benefits provided and any applicable limits.

The alternative benefits package includes all Medicaid State Plan services, plus disease management services and assistance in locating a primary care provider for clients in the high-risk group. Disease management services include a nurse advice line and education and disease management services. Washington’s disease management program is designed to help patients better understand and manage their chronic health condition(s)(including diabetes, heart failure and respiratory conditions) through education, lifestyle changes, and adherence to a prescribed plan of care, and to provide assistance to patients in accessing needed services.

The covered State plan services supported by this program are those specified and limited in Attachment 3.1-A, Amount, Duration and Scope of Services, Categorically Needy.

2. Benchmark-Equivalent Benefits.

Specify which benchmark plan or plans this benefit package is equivalent to, and provide the information listed above for that plan: _____.

- a. The State assures that the benefit package(s) have been determined to have an actuarial value equivalent to the specified benchmark plan or plans in an actuarial report that: 1) has been prepared by an individual who is a member of the American Academy of Actuaries; 2) uses generally accepted actuarial principles and

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State WASHINGTON**ALTERNATIVE BENEFITS****BENCHMARK BENEFIT PACKAGE/BENCHMARK EQUIVALENT BENEFIT PACKAGE****B. Description of the Benefits (cont)**

methodologies; 3) uses a standardized set of utilization and price factors; 4) uses a standardized population that is representative of the population being served; 5) applies the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and 6) takes into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage. Attach a copy of the report.

b. ___ The State assures that if the State provides additional services under the benchmark benefit package(s) from any one of all the following categories: 1) prescription drugs; 2) mental health services; 3) vision services, and/or 4) hearings services, the coverage of the related benchmark-equivalent benefit package(s) will have an actuarial value that is at least 75 percent of the actuarial value of the coverage of that category of services included in the benchmark benefit package. Attach a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c. ___ The State assures that the actuarial report will select and specify the standardized set and populations used in preparing the report.

(1) ___ Inclusion of Basic Services – This coverage includes benefits for items and services within the following categories of basic services: (Check all that apply).

- ___ Inpatient and outpatient hospital services;
- ___ Physicians' surgical and medical services;
- ___ Laboratory and x-ray services;
- ___ Well-baby and well-child care services as defined by the State, including age-appropriate immunizations in accordance with the Advisory Committee on Immunization Practices
- ___ Other appropriate preventive services, as designated by the Secretary.
- ___ Clinic services (including health center services) and other ambulatory health care services.
- ___ Federally qualified health care services
- ___ Rural health clinic services
- ___ Prescription drugs
- ___ Over-the-counter medications
- ___ Prenatal care and pre-pregnancy family services and supplies

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State WASHINGTON**ALTERNATIVE BENEFITS****BENCHMARK BENEFIT PACKAGE/BENCHMARK EQUIVALENT BENEFIT PACKAGE****B. Description of the Benefits (cont)**

- Inpatient Mental Health Services not to exceed 30 days in a calendar year
 - Outpatient mental health services furnished in a State-operated facility and including community-based services
 - Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices)
 - Disposable medical supplies including diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formulas and dietary supplements.
 - Nursing care services, including home visits for private duty nursing, not to exceed 30 days per calendar year
 - Dental services
 - Inpatient substance abuse treatment services and residential substance abuse treatment services not to exceed 30 days per calendar year
 - Outpatient substance abuse treatment services
 - Case management services
 - Care coordination services
 - Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
 - Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services.
 - Premiums for private health care insurance coverage
 - Medical transportation
 - Enabling services (such as transportation, translation, and outreach services)
 - Any other health care services or items specified by the Secretary and not included under this section
- (2) Additional benefits for voluntary opt-in populations:
- Home and community-based health care services
 - Nursing care services, including home visits for private duty nursing

Attach a copy of the benchmark-equivalent plan(s) including benefits and any applicable limitations.

3. Wrap-around/Additional Services

- a. The State assures that wrap-around or additional benefits will be provided for individuals under 19 who are covered under the State plan under section 1902(a)(10)(A) to ensure early and periodic screening, diagnostic and treatment (EPSDT) services are provided when medically necessary. Wrap-around benefits must be sufficient so that, in combination with the benchmark or benchmark-equivalent benefits package, these individuals receive the full EPSDT benefit, as medically necessary. Attach a description of the manner in which wrap-around or additional services will be provided to ensure EPSDT services are provided when medically necessary (as determined by the State).

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ALTERNATIVE BENEFITS

BENCHMARK BENEFIT PACKAGE/BENCHMARK EQUIVALENT BENEFIT PACKAGE

B. Description of the Benefits (cont)

b. The State has elected to also provide wrap-around or additional benefits.

Attach a list of all wrap-around or additional benefits and a list of the populations for which such wrap-around or additional benefits will be provided.

The following services will be provided for all eligible Aged, Blind and Disabled, Categorically Needy clients, age 21 and over:

- 1) *Identification of clients with complex medical needs, including chronic conditions such as heart failure, diabetes, and respiratory conditions using predictive modeling;*
- 2) *Referral of identified clients to either local or statewide program, depending on the client's location*
- 3) *Health risk assessment and development of care plan, based on the client's desire to participate in the program and the client's identified needs;*
- 4) *Assistance to clients in:*
 - a. *Locating a medical home (Primary Care Provider) and learning to use the medical home appropriately;*
 - b. *Improving health outcomes using evidence-based medicine; and*
 - c. *Preventing avoidable medical costs through improved self-management skills.*
- 5) *Offering support to potential providers to enable them to accept new clients. The support of medical home development includes sharing information with providers about their Disease Management population, supporting the use of client registries to allow improved tracking of preventive measures provided to clients with chronic illness, receiving referrals directly from providers for clients with high-risk disease states, exchanging care plan information to improve symptom management and avoidance of emergency department services, and providing direct feedback on quality of care provided for Disease Management clients.*

C. Service Delivery System

Check all that apply.

- 1. The alternative benefit package will be furnished on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider.
- 2. The alternative benefit package will be furnished on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1915(b)(1).
- 3. The alternative benefit package will be furnished through a managed care entity consistent with applicable managed care requirements.
- 4. Alternative benefits provided through premium assistance for benchmark-equivalent in employer-sponsored coverage.

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ALTERNATIVE BENEFITS**BENCHMARK BENEFIT PACKAGE/BENCHMARK EQUIVALENT BENEFIT PACKAGE****C. Service Delivery Systems (cont)**

5. ___ Alternative benefits will be provided through a combination of the methods described in items 1-4. Please specify how this will be accomplished.

D. Additional Assurances

- a. X The State assures that individuals will have access, through benchmark coverage, benchmark-equivalent coverage, or otherwise, to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).
- b. X The State assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb).

E. Cost Effectiveness of Plans

Benchmark or benchmark-equivalent coverage and any additional benefits must be provided in accordance with economy and efficiency principles.

F. Compliance with the Law

X The State will continue to comply with all other provisions of the Social Security Act in the administration of the State plan under this title.

G. Implementation Date

X The State will implement this State Plan amendment on January 1, 2007.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Methods Used to Assure Necessary Transportation of Clients

- I. Transportation is provided to eligible individuals for necessary medical and remedial care.
 - A. Ambulance Transportation
 1. Ambulance (emergency) transportation shall be provided when the medical necessity is such that the use of any other method of transportation is inadvisable or as required by state law.
 - B. Non-emergency Medical Transportation by Means Other Than Ambulance
 1. Transportation is provided as an administrative service for eligible clients to receive covered services at eligible provider or facility locations, when a client has no other transportation resources available to them. Eligible individuals may request non-emergency medical transportation service from public or private agencies ("brokers") that the state has contracted with to provide or arrange transportation services.
 2. Non-emergency medical transportation will be provided through direct vendor payments as an administrative service during contract negotiations or planning with brokers, or for services not provided for through broker contracts.

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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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.

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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 catheterizations 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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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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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:

- A. Buy-in agreements with the Secretary of HHS. This agreement covers:
1. Individuals receiving SSI under title XVI 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. 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:
- 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.