DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1301 Young Street, Suite 900
Dallas, Texas 75202

Medicaid and CHIP Operations Group

March 23, 2020

Susan Birch, Director
MaryAnne Lindeblad, Medicaid Director
Health Care Authority
Post Office Box 45502
Olympia, WA 98504-5010

RE: Washington State Plan Amendment (SPA) Transmittal Number 20-0001 (Integrated Managed Care Update)

Dear Ms. Birch and Ms. Lindeblad:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the enclosed State Plan Amendment (SPA), Transmittal Number 20-0001. This SPA amends State Plan Attachment 3.1-F, part 2 to reflect the final implementation of the integration of mental health and substance use disorder services (collectively known as "behavioral health") into an Integrated Managed Care (IMC) program and also makes technical corrections.

This SPA is approved effective January 1, 2020.

If you have any questions regarding the review and validation of these contract amendments, please contact me or your staff may contact Rick Dawson at Rick.Dawson@cms.hhs.gov or (206) 615-2387.

Sincerely,

Bill Brooks, Director
Division of Managed Care Plan Operations

Enclosure

cc: Ann Myers, HCA
Jessica Diaz, HCA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 20-0001

2. STATE: Washington

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2020

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
1932(a) of the Social Security Act
42 CFR Sec. 435 and 438

7. FEDERAL BUDGET IMPACT:
a. FFY 2020 $0
b. FFY 2021 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-F Part 2 pages 1 – 39

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 3.1-F Part 2 pages 1 – 28 (remove pages 29 through 39. Note: Removed text from pages 5 – 12 and renumbered pages 13 – 39 as pages 5 – 28)

10. SUBJECT OF AMENDMENT:

Integrated Managed Care Updates

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Exempt

12. SIGNATURE OF STATE AGENCY OFFICIAL:
MaryAnne Lindeblad

13. TYPED NAME:
MaryAnne Lindeblad

14. TITLE:
Director

15. DATE SUBMITTED: 2/20/2020

16. RETURN TO:
Ann Myers
Rules and Publications
Division of Legal Services
Health Care Authority
626 8th Ave SE MS: 42716
Olympia, WA 98504-2716

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 2/20/2020

18. DATE APPROVED: 3/23/2020

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 1/1/2020

20. SIGNATURE OF REGIONAL OFFICIAL:
Bill Brooks

21. TYPED NAME: Bill Brooks

22. TITLE:
Director, Division of Managed Care Plan Operations

23. REMARKS:

APPLE HEALTH MANAGED CARE

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act

The State of Washington enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization [MCOs], primary care case managers [PCCMs], and/or PCCM entities) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid State Plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230).

This authority may *not* be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries described in 42 CFR 438.50(d).

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date. All applicable assurances should be checked, even when the compliance date is in the future. **Please see Appendix A of this document for compliance dates for various sections of 42 CFR 438.**

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.2
42 CFR 438.6
42 CFR 438.50(b)(1)-(2)

B. Managed Care Delivery System

The state will contract with the entity(ies) below and reimburse them as noted under each entity type.

1. X MCO
   a. X Capitation
   b. __ The state assures that all applicable requirements of 42 CFR 438.6, regarding special contract provisions related to payment, will be met.

2. __ PCCM (individual practitioners)
   a. __ Case management fee
   b. __ Other (please explain below)

3. __ PCCM entity
   a. __ Case management fee
   b. __ Shared savings, incentive payments, and/or financial rewards (see 42 CFR 438.310(c)(2))
   c. __ Other (please explain below)

   If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as in 42 CFR 438.2), in addition to PCCM services:

APPLE HEALTH MANAGED CARE

Citation	Condition or Requirement

__ Provision of intensive telephonic case management
__ Provision of face-to-face case management
__ Operation of a nurse triage advice line
__ Development of enrollee care plans.
__ Execution of contracts with fee-for-service (FFS) providers in the FFS program
__ Oversight responsibilities for the activities of FFS providers in the FFS program
__ Provision of payments to FFS providers on behalf of the state.
__ Provision of enrollee outreach and education activities.
__ Operation of a customer service call center.
__ Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement.
__ Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.
__ Coordination with behavioral health systems/providers.
__ Coordination with long-term services and supports systems/providers.
__ Other (please describe:

42 CFR 438.50(b)(4) **C.** Public Process

Describe the public process including tribal consultation, if applicable, utilized for both the design of the managed care program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan managed care program has been implemented. *(Example: public meeting, advisory groups.)*

The state uses the following processes, meetings and correspondence to invite stakeholder input for managed care activities:

- *Statewide Title XIX committee meetings*
- *Monthly open public meetings focusing on the MCOs that provide Apple Health managed care programs but open to anyone*
- *Public website providing information about Apple Health managed care updates and program changes*
- *Regular consultation with American Indian/Alaska Native tribal organizations and clinics on all program changes*
- *Notification of a comprehensive list of stakeholders about changes in the Apple Health managed care program*
- *Notification of enrollees about all proposed substantive changes to the program regarding benefits, administration of benefits (i.e. grievance and appeals, authorizations and denials), service area, or enrollment*

APPLE HEALTH MANAGED CARE

Citation	Condition or Requirement

If the program will include long term services and supports (LTSS), please indicate how the views of stakeholders have been, and will continue to be, solicited and addressed during the design, implementation, and oversight of the program, including plans for a member advisory committee (42 CFR 438.70 and 438.110)

This program does not cover LTSS, but coordinates with the Washington Department of Social and Health Services (DSHS)/Aging and Long Term Support Administration (ALTSA) to ensure provision and coordination of medically necessary health care services and LTSS.

D. State Assurances and Compliance with the Statute and Regulations

If applicable to the State Plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. X The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)

42 CFR 438.50(c)(2)
1902(a)(23)(A)

2. __ The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts (including for PCCM entities) will be met.

1932(a)(1)(A)
42 CFR 438.50(c)(3)

3. X The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring beneficiaries to receive their benefits through managed care entities will be met.

1932(a)(1)(A)
42 CFR 431.51
as 1905(a)(4)(C)
42 CFR 438.10(g)(2)(vii)

4. X The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies defined in section 1905(a)(4)(C) will be met.

1932(a)(1)(A)

5. X The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i).

1932(a)(1)(A)
42 CFR 438
1903(m)

6. X The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs, PCCMs, and PCCM entities will be met.

1932(a)(1)(A)

7. X The state assures that all applicable requirements of 42 CFR 438.4, 438.5, 438.7, 438.8, and 438.74 for payments under any risk contracts will be met.

APPLE HEALTH MANAGED CARE

Citation	Condition or Requirement

42 CFR 438.4
42 CFR 438.5
42 CFR 438.7
42 CFR 438.8
42 CFR 438.74
42 CFR 438.50(c)(6)

1932(a)(1)(A)
42 CFR 447.362
42 CFR 438.50(c)(6)

8. __ The state assures that all applicable requirements of 42 CFR 447.362 for payments under any non-risk contracts will be met.

45 CFR 75.326

9. X The state assures that all applicable requirements of 45 CFR 75.326 for procurement of contracts will be met.

42 CFR 438.66

10. Assurances regarding state monitoring requirements:

X The state assures that all applicable requirements of 42 CFR 438.66(a), (b), and (c), regarding a monitoring system and using data to improve the performance of its managed care program, will be me

X The state assures that all applicable requirements of 42 CFR 438.66(d), regarding readiness assessment, will be met.

X The state assures that all applicable requirements of 42 CFR 438.66(e), regarding reporting to CMS about the managed care program, will be met.

1932(a)(1)(A)
1932(a)(2)

E. Populations and Geographic Area

1. *Included Populations*. Please check which eligibility groups are included, if they are enrolled on a **Mandatory (M)** or **Voluntary (V)** basis (as defined in 42 CFR 438.54(b)) or **Excluded (E),** and the geographic scope of enrollment. Under the **Geographic Area** column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions. Also, if type of enrollment varies by geographic area (for example, mandatory in some areas and voluntary in other areas), please note specifics in the **Geographic Area** column. Under the **Notes** column, please note any additional relevant details about the population or enrollment.

   NOTE: Effective January 1, 2020, the state's Integrated Managed Care program expanded statewide.

APPLE HEALTH MANAGED CARE

A. Mandatory Eligibility Groups (Eligibility Groups to which a state must provide Medicaid coverage).

Effective January 1, 2020: *In Washington's Integrated Managed Care program, the following Eligibility Groups apply statewide:*

1. Family/Adult

Eligibility Group	Citation – (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if MVE varies by area)	Notes
1. Parents and Other Caretaker Relatives	§435.110	X			Statewide	
2. Pregnant Women	§435.116	X			Statewide	
3. Children Under Age 19 (inclusive of deemed newborns under §435.117)	§435.118	X			Statewide	
4. Former Foster Care Youth (up to age 26)	§435.150			X		
5. Adult Group (Non-pregnant individuals age 19 – 64 not eligible for Medicare with income no more than 133% FPL)	§435.119	X			Statewide	
6. Transitional Medical Assistance (Includes adults & children, if not eligible under §435.116, §435.118 or §435.119)	1902(a)(52), 1902(e)(1), 1925, and 1931(c)(2) of SSA	X			Statewide	
7. Extended Medicaid due to Spousal Support Collections	§435.115	X			Statewide	

2. Aged/Blind/Disabled Individuals

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
8. Individuals Receiving SSI age 19 and over only (See E.2. below regarding age <19)	§435.120	X			Statewide	
9. Aged and Disabled Individuals in 209(b) States	§435.121				N/A	
10. Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA Increase since April, 1977	§435.135	X			Statewide	
11. Disabled Widows and Widowers Ineligible for SSI due to an increase of OASDI	§435.137	X			Statewide	
12. Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	§435.138	X			Statewide	
13. Working Disabled under 1619(b)	1619(b), 1902(a)(10)(A)(i)(II), and 1905(q) of SSA	X			Statewide	
14. Disabled Adult Children	1634(c) of SSA	X			Statewide	

APPLE HEALTH MANAGED CARE

B. Optional Eligibility Groups

Effective January 1, 2020: *In Washington's Integrated Managed Care program, the following Eligibility Groups apply statewide:*

1. Family/Adult

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Optional Parents and Other Caretaker Relatives	§435.220				N/A	
2. Optional Targeted Low-Income Children	§435.229	X			Statewide	
3. Independent Foster Care Adolescents Under Age 21	§435.226				NA	
4. Individuals Under Age 65 with Income Over 133%	§435.218				N/A	
5. Optional Reasonable Classifications of Children Under Age 21	§435.222	X			Statewide	
6. Individuals Electing COBRA Continuation Coverage	1902(a)(10)(F) of SSA				N/A	

2. Aged/Blind/Disabled Individuals

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
7. Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash	§435.210 and §435.230				N/A	
8. Individuals eligible for Cash except for Institutionalized Status	§435.211	X			Statewide	
9. Individuals Receiving Home and Community-Based Waiver Services Under Institutional Rules	§435.217	X			Statewide	
10. Optional State Supplement Recipients 1634 and SSI Criteria States – with 1616 Agreements	§435.232	X			Statewide	
11. Optional State Supplemental Recipients209(b) states and SSI criteria states without 1616 Agreements	§435.234				N/A	
12. Institutionalized Individuals Eligible under a Special Income Level	§435.236	X			Statewide	
13. Individuals Participating in a PACE Program under Institutional Rules	1934 of the SSA			X		Clients in PACE, a voluntary program, are excluded from IMC
14. Individuals Receiving Hospice Care	1902(a)(10)(A)(ii)(VII) and 1905(o) of the SSA	X			Statewide	
15. Poverty Level Aged or Disabled	1902(a)(10)(A)(ii)(X) and 1902(m)(1) of the SSA				N/A	
16. Work Incentive Group	1902(a)(10)(A)(ii)(XIII) of the SSA				N/A	
17. Ticket to Work Basic Group	1902(a)(10)(A)(ii)(XV) of the SSA	X			Statewide	
18. Ticket to Work Medically Improved Group	1902(a)(10)(A)(ii)(XVI) of the SSA	X			Statewide	
19. Family Opportunity Act Children with Disabilities	1902(a)(10)(A)(ii)(XIX) of the SSA				N/A	
20. Individuals Eligible for State Plan Home and Community-Based Services	§435.219	X			Statewide	

3. Partial Benefits

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
21. Family Planning Services	§435.214			X		
22. Individuals with Tuberculosis	§435.215				N/A	
23. Individuals Needing Treatment for Breast or Cervical Cancer (under age 65)	§435.213			X		

C. Medically Needy

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Medically Needy Pregnant Women	§435.301(b)(1)(i) and (iv)			X		
2. Medically Needy Children under Age 18	§435.301(b)(1)(ii)			X		
3. Medically Needy Children Age 18 through 20	§435.308			X		
4. Medically Needy Parents and Other Caretaker Relatives	§435.310				N/A	
5. Medically Needy Aged	§435.320			X		
6. Medically Needy Blind	§435.322			X		
7. Medically Needy Disabled	§435.324			X		
8. Medically Needy Aged, Blind and Disabled in 209(b) States	§435.330				N/A	

APPLE HEALTH MANAGED CARE

2. Voluntary Only or Excluded Populations. Under this managed care authority, some populations cannot be subject to mandatory enrollment in an MCO, PCCM, or PCCM entity (per 42 CFR 438.50(d)). Some such populations are Eligibility Groups separate from those listed above in E.1., while others (such as American Indians/Alaskan Natives) can be part of multiple Eligibility Groups identified in E.1 above.

Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
Medicare Savings Program – Qualified Medicare Beneficiaries, Qualified Disabled Working Individuals, Specified Low Income Medicare Beneficiaries, and/or Qualifying Individuals	1902(a)(10)(E), 1905(p), 1905(s) of the SSA		X		
"Dual Eligibles" not described under Medicare Savings Program - Medicaid beneficiaries enrolled in an eligibility group other than one of the Medicare Savings Program groups who are also eligible for Medicare			X		
American Indian/Alaskan Native— Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes	§438.14	X		Statewide	
Children Receiving SSI who are Under Age 19 - Children under 19 years of age who are eligible for SSI under title XVI	§435.120	X		Statewide	
Qualified Disabled Children Under Age 19 - Certain children under 19 living at home, who are disabled and would be eligible if they were living in a medical institution.	§435.225 1902(e)(3) of the SSA			N/A	

APPLE HEALTH MANAGED CARE

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
Title IV-E Children - Children receiving foster care, adoption assistance, or kinship guardianship assistance under title IV-E *	§435.145		X		
Non-Title IV-E Adoption Assistance Under Age 21*	§435.227		**X**		
Children with Special Health Care Needs - Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the state in terms of either program participation or special health care needs.		X		Statewide	

* = Note – Individuals in these two Eligibility Groups who are age 19 and 20 can have mandatory enrollment in managed care, while those under age 19 cannot have mandatory enrollment. Use the Notes column to indicate if you plan to mandatorily enroll 19 and 20 year olds in these Eligibility Groups.

3. **(Optional) Other Exceptions.** The following populations (which can be part of various Eligibility Groups) can be subject to mandatory enrollment in managed care, but states may elect to make exceptions for these or other individuals. Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

Population	V	E	Notes
Other Insurance--Medicaid beneficiaries who have other health insurance		X	*The exclusion applies only to enrollees receiving premium assistance*
Reside in Nursing Facility or ICF/IID- Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).		X	*Short-term residents of NFs are mandatorily enrolled; long-germ NF residents are exempt. Residents of ICF/IID are exempt.*
Enrolled in Another Managed Care Program-Medicaid beneficiaries who are enrolled in another Medicaid managed care program		X	
Eligibility Less Than 3 Months-- Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program		X	
Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).			
Retroactive Eligibility–Medicaid beneficiaries for the period of retroactive eligibility.			
Other (Please define):			

1932(a)(4)
42 CFR 438.54

F. Enrollment Process

Based on whether mandatory and/or voluntary enrollment are applicable to your program (see E. Populations and Geographic Area and definitions in 42 CFR 438.54(b)), please complete the below:

1. For **voluntary** enrollment: (see 42 CFR 438.54(c))
   a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 54(c)(3).

Newly eligible beneficiaries receive information about how to access the state's "Welcome to Apple Health" handbook on the Health Care Authority website. The handbook provides general information about Medicaid programs and services and gives information about how to enroll in Apple Health Managed Care if the beneficiary so desires.

AI/AN individuals are provided with specific information about their ability to remain in fee-for-service for all health care services, as well as their managed care options for MCO managed care or Primary Care Case Management (PCCM – Described in a separate State Plan Amendment).

If an AI/AN individual chooses to enroll in managed care, they must proactively enroll through the Health Benefit Exchange, ProviderOne portal or by calling the Medical Assistance Customer Service Center (MACSC).

States with voluntary enrollment must have an enrollment choice period or passive enrollment. Please indicate which will apply to the managed care program:

Voluntary individuals, other than AI/AN individuals, are passively enrolled into a managed care plan using the same process and plan assignment algorithms as described in Section 2, Mandatory Enrollment. The state notifies all clients of enrollment through an automatically generated letter. This letter provides a link to the Apple Health Client booklet. The Client booklet informs the client of plan options and how to change plans. If the enrollee wishes to disenroll from managed care, the enrollee may contact the Health Care Authority by phone, email, or in writing to request their managed care enrollment end. The enrollee is also provided this information through the Apple Health Model Handbook, provided by the MCO to enrollees.

b. X If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(c)(1)(i) and 42 CFR 438.54(c)(2)(i), during which individuals who are subject to voluntary enrollment may make an active choice to enroll in the managed care program, or will otherwise continue to receive covered services through the fee-for-service delivery system.

i. Please indicate the length of the enrollment choice period:

Enrollment is continuously open for all managed care programs prospectively for the following month. AI/AN beneficiaries eligible for voluntary enrollment may contact the state's Medical Assistance Customer Service Center (MACSC) to enroll or to end managed care enrollment OR switch to a different MCO at any time. If voluntary enrollees end enrollment, they may re-enroll in managed care at any time prospectively for the following month.
Note: managed care enrollees may change MCOs monthly without cause.

c. X If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 38.54(c)(1)(ii) and 54(c)(2)(ii), for individuals who are subject to voluntary enrollment.

i. If so, please describe the algorithm used for passive enrollment and how the algorithm and the state's provision of information meets all of the requirements of 42 CFR 438.54(c)(4),(5),(6),(7), and (8).

Voluntary individuals, other than AI/AN individuals, are passively enrolled into a managed care plan using the same process and plan assignment algorithms as described in Section 2, Mandatory Enrollment. The state notifies all clients of enrollment through an automatically generated letter. This letter provides a link to the Apple Health Client booklet. The Client booklet informs the client of plan options and how to change plans. If the enrollee wishes to disenroll from Managed Care, the enrollee may contact the Health Care Authority by phone, email, or in writing to request their managed care enrollment end. The enrollee is also provided this information through the Apple Health Model Handbook, provided by the MCO to enrollees.

ii. Please indicate how long the enrollee will have to disenroll from the plan and return to the fee-for-service delivery system:

Voluntary enrollees may contact the Health Care Authority and request disenrollment at any time. Disenrollment will be effective the first of the following month.

2. For **mandatory** enrollment: (see 42 CFR 438.54(d))
   a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(d)(3).

Newly eligible beneficiaries are able to select a plan in the state's Health Benefit Exchange at the time they become eligible for Medicaid, and are enrolled the first of the month in which eligibility is determined. If the newly eligible beneficiary does NOT select a plan at the time eligibility is determined, the state assigns them to a plan based on the algorithm described in item c. below.

If a beneficiary wishes to disenroll from the plan to which they are assigned, they may do so calling MACSC, using the ProviderOne portal, or through the state's Health Benefit Exchange (HBE).

SSI blind and disabled adults and children become eligible and renew their eligibility through the Department of Social and Health Services (DSHS) Community Services Offices (CSOs). They receive notification of assignment to a managed care plan from the Health Care Authority (HCA) upon receipt of eligibility information from DSHS by HCA, or may enroll in managed care by contacting MACSC or through the ProviderOne Portal.

Additionally, newly eligible SSI beneficiaries who have been assigned to a managed care plan in which they do not wish to be enrolled may change plans through ProviderOne or by calling MACSC.

All other beneficiaries have the ability to search the HBE for a specific clinic or provider and then determine with which plans that clinic or provider contracts. The HBE also provides information about each of the MCOs available in the potential enrollee's service area by way of providing HEDIS information for each plan, as well as client survey information for each plan. Because most beneficiaries select a plan based on whether their primary care provider (PCP) is contracted, this additional information can help support that decision, or can provide direction for those beneficiaries who do not already have a PCP.

If the beneficiary does not select a plan during the eligibility determination process, the state assigns the beneficiary to a plan and sends the beneficiary notice of the assignment and information about how to access the state's "Welcome to Apple Health" beneficiary handbook for Apple Health Integrated Managed Care on the state's website. Also included are directions on how to change plans if the beneficiary wishes to choose a different plan.

SSI beneficiaries are assigned using the same methodology as all other beneficiaries, and receive the same enrollee materials.

Newly eligible beneficiaries receive a notice from HCA that contains a link to the online "Welcome to Apple Health" booklet, which contains basic information about Medicaid, how to enroll in Apple Health Managed Care and other information. This booklet can be requested in paper form from HCA if the beneficiary prefers it in hard copy.

Beneficiaries also receive a handbook from the MCO, produced from an HCA-developed template for Apple Health Integrated Managed Care as part of the welcome packet.

b. __ If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(d)(2)(i), during which individuals who are subject to mandatory enrollment may make an active choice to select a managed care plan, or will otherwise be enrolled in a plan selected by the state's default enrollment process.

i. Please indicate the length of the enrollment choice period:

_____

c. X If applicable, please check here to indicate that the state uses a **default** enrollment process, as described in 42 CFR 438.54(d)(5), for individuals who are subject to mandatory enrollment.

i. If so, please describe the algorithm used for default enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (5), (7), and (8).

The state default assignment algorithm is based on network adequacy, performance under two HEDIS Clinical Performance measures (Childhood Immunization Combo 2 Status, and Comprehensive diabetes care: retinal eye exam) and one Administrative Measure (Initial Health Screen).

As regions transition to the Fully Integrated Managed Care program, default assignment is based on network adequacy and performance under one Administrative Measure (Initial Health Screen) until enough information is collected to base assignment using the algorithm above.

Note: managed care enrollment is continuously open; enrollees may change MCOs monthly without cause

d. __ If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(d)(2), for individuals who are subject to mandatory enrollment.

   i. If so, please describe the algorithm used for passive enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (6), (7), and (8).

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1932(a)(4)
42 CFR 438.54

3. State assurances on the enrollment process.

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

42 CFR 438.52

a. X The state assures that, per the choice requirements in 42 CFR 438.52:
   i. Medicaid beneficiaries with mandatory enrollment in an MCO will have a choice of at least two MCOs unless the area is considered rural as defined in 42 CFR 438.52(b)(3);
   ii. Medicaid beneficiaries with mandatory enrollment in a primary care case management system will have a choice of at least two primary care case managers employed by or contracted with the state;
   iii. Medicaid beneficiaries with mandatory enrollment in a PCCM entity may be limited to a single PCCM entity and will have a choice of at least two PCCMs employed by or contracted with the PCCM entity.

42 CFR 438.52

b. __ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs in accordance with 42 CFR 438.52(b). Please list the impacted rural counties:

X This provision is not applicable to this 1932 State Plan Amendment.

42 CFR 438.56(g)

c. X The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.
__ This provision is not applicable to this 1932 State Plan Amendment.

42 CFR 438.71

d. _X_ The state assures that all applicable requirements of 42 CFR 438.71 regarding developing and implementing a beneficiary support system that provides support to beneficiaries both prior to and after MCO, PCCM, or PCCM entity enrollment will be met.

1932(a)(4)
42 CFR 438.56

G. Disenrollment

1. The state will __/ will not _X_ limit disenrollment for managed care.

2. The disenrollment limitation will apply for _____ (up to 12 months).

3. _X_ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56.

2. Describe the state's process for notifying the Medicaid beneficiaries of their right to disenroll without cause during the 90 days following the date of their initial enrollment into the MCO, PCCM, or PCCM entity. *(Examples: state-generated correspondence, enrollment packets, etc.)*

   Beneficiaries are notified of the ability to disenroll from a managed care plan and change enrollment to another plan in online "Welcome to Apple Health" information they receive from the state upon eligibility determination. While enrollment in managed care is mandatory for most populations, the ability to change plans on a monthly basis is also available. Note: the state's "churn rate" for plan changes is less than 3% of total enrollment.

3. Describe any additional circumstances of "cause" for disenrollment (if any).

   Medicaid beneficiaries may disenroll (change plans) prospectively each month, without cause.

H. Information Requirements for Beneficiaries

1932(a)(5)(c)
42 CFR 438.50
42 CFR 438.10

_X_ The state assures that its State Plan program is in compliance with 42 CFR 438.10 for information requirements specific to MCOs, PCCMs, and PCCM entity programs operated under section 1932(a)(1)(A)(i) State Plan Amendments.

1932(a)(5)(D)(b)
1903(m)
1905(t)(3)

I. List all benefits for which the MCO is responsible

Complete the chart below to indicate every State Plan-approved service that will be delivered by the MCO, and where each of those services is described in the state's Medicaid State Plan. For "other practitioner services", list each provider type separately. For rehabilitative services, habilitative services, EPSDT services and 1915(i), (j) and (k) services list each program separately by its own list of services. Add additional rows as necessary.

NOTE: The state's Managed Care Programs are not responsible for provision of 1915(i), (j) and (k) services, which are provided through separate programs with the Department of Social and Health Services and coordinated for MCO enrollees by the MCO with which the beneficiary is enrolled.

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In the first column of the chart below, enter the name of each State Plan-approved service delivered by the MCO. In the second – fourth column of the chart, enter a State Plan citation providing the Attachment number, Page number, and Item number, respectively.

Note: The Services below are provided in all counties of the state.

State Plan-Approved Service Delivered by the MCO	**Medicaid State Plan Citation**		
	Attachment #	**Page #**	**Item #**
Physician services including but not limited to: critical care, newborn care, neonatal intensive care, osteopathy, manipulative therapy, physical exams, physical care plan oversight, standby services, physician visits, inpatient services, outpatient services, bio-feedback training psychiatric services, optometry services, oral health exams and services, neurodevelopmental, performing and/or reading diagnostic tests, surgical services including bariatric surgery.	*3.1-A*	*17,18,19, 27, 28, 28a*	*5.a, 10*
Anesthesia	*3.1-A*	*12, 28.b*	*3.b, 10.7*
Ambulatory surgery center	*3.1-A*	*26*	*9.b*
Applied behavior analysis	*3.1-A*	*21*	*6.d.(7)*
Blood, blood components, human blood products	*3.1-F part 2*	*20*	
Hearing aids	*3.1-A*	*33*	*12.c*
Contraceptives	*3.1-A*	*32a*	*12.a.*
Collaborative Care Model	*3.1-A*	*21b*	*6.d.(8)*
Drugs - prescribed	*3.1-A*	*4,30,31,32,32a,*	*12.a*
Drugs - over the counter	*3.1-A*	*32a, 32b*	*12.a*
Durable medical equipment	*3.1-A*	*23*	*7.c*
Early, elective induction (before 39 weeks)	*4.19-A Part 1*	*12*	*C*

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Enrollee health education	*3.1-F Part 2*	*2*	*Bullet*
Enteral and parenteral nutritional supplements and supplies, including prescribed infant formula	*3.1-A*	*24*	*7.c.*
Family planning	*3.1-A*	*1*	*4.c*
Fitting prosthetic & orthotic devices	*3.1-A*	*23*	*7.c*
Genetic services other than prenatal diagnosis and genetic counseling including: testing, counseling and laboratory services.	*3.1-A*	*60*	*20.d*
Hemophiliac blood products	*3.1-F Part 2*	*21*	
Home health	*3.1-A*	*3, 22, 23, 24*	*7*
Hospice	*3.1-A*	*7, 59, 59a, 59b*	*18*
Immunizations, including the varicella zoster (shingles) vaccine for enrollees age sixty (60) and over. For enrollees under age sixty (60), the Contractor may require prior authorization.	*3.1-F Part 2*		
Inpatient services	*3.1-A*	*11*	*1*
Laboratory, radiology, imaging	*3.1-A*	*1, 12*	*3*
Medical examinations, including wellness exams for adults & EPSDT for children; adult exams not in Plan	*3.1-A (EPSDT)*	*14*	*4.b*
Medication for Opioid Use Disorder (formerly Medication Assisted Treatment (MAT)	*3.1-A*	*18.b*	*5.a.(12)*
Nutritional counseling	*3.1-A*	*13.b, 23*	
Outpatient hospital services	*3.1-A*	*11a*	*2*
Pediatric concurrent care - see EPSDT hospice			
Pediatric palliative care - see EPSDT hospice			
Private duty nursing for children age 17 and younger	*3.1-A*	*3, 25*	
Renal failure treatment	*3.1-A*	*26, 27*	*9.a*
Respiratory care	*3.1-A*	*8, 60*	*22*
Screening, brief intervention, & referral to treatment (SBIRT)	*3.1-A*	*35, 36*	*13.c*
Tobacco cessation counseling services for pregnant women	*3.1-A*	*1, 16.d*	*4.d*

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Telemedicine	*3.1-A*	*10a*	
Transplants	*3.1-E*	*1 - 6*	
Therapies - occupational, speech, physical	*3.1-A*	*4, 29*	*11.a,b,c*
Pharmacy – prescriptions	*3.1-A*	*30*	*12.a*
Vision care	*3.1-A*	*20*	*6.b*
EPSDT services			
Oral health exams and services	*3.1-A*	*14*	*4.b.1*
Eye exams, refractions, eyeglasses	*3.1-A*	*14*	*4.b.2*
Hearing aids and other hearing devices	*3.1-A*	*15*	*4.b.3*
Outpatient physical therapy	*3.1-A*	*15*	*4.b.4*
Home health	*3.1-A*	*15*	*4.b.5*
Hospice	*3.1-A*	*16*	*4.b.6*
School-based health care	*3.1-A*	*16*	*4.b.7*
Intensive behavior services/applied behavior analysis (ABA)	*3.1-A*	*21*	*7*
Habilitative services – available to children and expansion-eligible adults only			
Assistive technology	*3.1-L Alternative Benefit Plan*	*ABP5*	*EHB 7*
Behavior support & consultation	*See above*	*See above*	*See above*
Community access	*See above*	*See above*	*See above*
Community guide	*See above*	*See above*	*See above*
Therapy	*See above*	*See above*	*See above*
Supported employment	*See above*	*See above*	*See above*
Transportation	*See above*	*See above*	*See above*
Other habilitative	*See above*	*See above*	*See above*

Rehabilitative services			
Rehabilitation – physical medicine and rehabilitation	*3.1-A*	*37*	*d (1)*
Rehabilitative - mental health services			
Brief intervention	*3.1-A*	*46*	*13 d.7.B.*
Crisis services	*3.1-A*	*47*	*13.d.7.B*
Day support	*3.1-A*	*47*	*13.d.7.B*
Family treatment	*3.1-A*	*47*	*13.d.7.B*
Freestanding evaluation & treatment	*3.1-A*	*48*	*13.d.7.B*
Group treatment	*3.1-A*	*49*	*13.d.7.B*
High intensity treatment	*3.1-A*	*49*	*13.d.7.B*
Individual treatment	*3.1-A*	*50*	*13.d.7.B*
Intake evaluation	*3.1-A*	*50*	*13.d.7.B*
Medication for Opioid Use Disorder (formerly Medication Assisted Treatment (MAT)- the medication component of the treatment plan for treating an SUD, including prescribing or administering medication, except for methadone, in the SUD clinic setting	*3.1-A*	*18.b*	*5.a.(12)*
Medication management	*3.1-A*	*50*	*13.d.7.B*
Medication monitoring	*3.1-A*	*50*	*13.d.7.B*
Mental health services in residential settings	*3.1-A*	*51*	*13.d.7.B*
Peer support	*3.1-A*	*51*	*13.d.7.B*
Psychological assessment	*3.1-A*	*52*	*13.d.7.B*
Rehabilitation case management	*3.1-A*	*52*	*13.d.7.B*
Special population evaluation	*3.1-A*	*52*	*13.d.7.B*
Stabilization services	*3.1-A*	*53*	*13.d.7.B*
Substance Use Disorder services, including but not limited to alcohol, drug, and chemical dependency treatment, and inpatient alcohol and drug detoxification (also known as withdrawal management).	*3.1-A*	*37 – 40d*	*13.d.2*
Substance Use Disorder Peer Counselors	*3.1-A*	*40*	*13.d*
Therapeutic psychoeducation	*3.1-A*	*53*	*13.d.7.B*

Other practitioners			
Advanced registered nurse practitioners, includes certified registered nurse anesthetists	*3.1-A*	*20*	*6.d*
Chiropractors (for EPSDT only)	*3.1-A*	*20*	*6.d*
Counselors, social workers, others as described	*3.1-A*	*20*	*6.d*
Emergency medical services (EMS) providers	*3.1-A*	*21c*	*6.d*
Licensed mental health practitioners: advanced social workers, independent clinical social workers, marriage & family therapists, mental health counselors, psychiatric advanced nurse practitioners, psychologists	*3.1-A*	*20*	*6.d*
Licensed non-nurse midwives	*3.1-A*	*20*	*6.d*
Naturopathic physicians (limited to physician-related primary care services)	*3.1-A*	*20*	*6.d*
Opticians	*3.1-A*	*20*	*6.d*
Physician assistants	*3.1-A*	*20*	*6.d*
Psychologists	*3.1-A*	*20*	*6.d*

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Citation	Condition or Requirement
1932(a)(5)(D)(b)(4) 42 CFR 438.228	**J.** X The state assures that each MCO has established an internal grievance and appeal system for enrollees
1932(a)(5)(D)(b)(5) 42 CFR 438.62 42 CFR 438.68 42 CFR 438.206 42 CFR 438.207 42 CFR 438.208	**K.** Services, including capacity, network adequacy, coordination, and continuity X The state assures that all applicable requirements of 42 CFR 438.62, regarding continued service to enrollees, will be met. X The state assures that all applicable requirements of 42 CFR 438.68, regarding network adequacy standards, will be met. X The state assures that all applicable requirements of 42 CFR 438.206, regarding availability of services, will be met. X The state assures that all applicable requirements of 42 CFR 438.207, regarding assurances of adequate capacity and services, will be met. X The state assures that all applicable requirements of 42 CFR 438.208, regarding coordination and continuity of care, will be met.
1932(c)(1)(A) 42 CFR 438.330 42 CFR 438.340	**L**. X The state assures that all applicable requirements of 42 CFR 438.330 and 438.340, regarding a quality assessment and performance improvement program and state quality strategy, will be met.
1932(c)(2)(A) 42 CFR 438.350 42 CFR 438.354 42 CFR 438.364	**M**. X The state assures that all applicable requirements of 42 CFR 438.350, 438.354, and 438.364 regarding an annual external independent review conducted by a qualified independent entity, will be met.
1932 (a)(1)(A)(ii)	**N**. Selective Contracting Under a 1932 State Plan Option To respond to items #1 and #2, place a check mark. The third item requires a brief narrative. 1. The state will X/will not __ intentionally limit the number of entities it contracts under a 1932 State Plan option.

APPLE HEALTH MANAGED CARE

Citation	Condition or Requirement

2. X The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 State Plan option. *(Example: a limited number of providers and/or enrollees.)*

   The state's process for adding new Managed Care Organizations (MCOs) for the Apple Health Managed Care program is as follows:

   - *The MCO that wishes to participate in Apple Health Managed Care may submit a letter of interest to the state along with all of the following documentation:*
     - *Certificate of registration from the Washington Office of the Insurance Commissioner (OIC) that allows the MCO to provide health care services under a risk-based contract*
     - *Acceptance of the terms and conditions of the Apple Health Managed Care contract*
     - *Proof of network adequacy in the service areas in which the MCO wishes to participate*
     - *Attestation that the MCO meets the quality standards for Apple Health Managed Care that have been established by the state for the currently participating Apple Health Managed Care MCOs*

   If the state determines that there is a need for an additional MCO in the proposed service areas, the state conducts an onsite readiness review of the applicant's operations, including:

   - *Customer service*
   - *Grievance and appeal processes*
   - *Subcontracting*
   - *Quality and Performance Improvement (QAPI)*
   - *Care coordination*

   Network adequacy is validated in a separate process, as is financial viability to provide these services.

   If the applicant meets the contract standards reviewed at the readiness review, the state issues an Apple Health Managed Care contract.

4. X The selective contracting provision in not applicable to this State Plan.

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Appendix A: Compliance Dates (from Supplementary Information in 81 FR 27497, published 5/6/2016)

States must comply with all provisions in effect as of the issuance of this preprint. Additionally, the following compliance dates apply:

Compliance Dates	Sections
For rating periods for Medicaid managed care contracts beginning before July 1, 2017, states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in 42 CFR parts 430 to 481, edition revised as of October 1, 2015. **States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2017.**	§§ 438.3(h), 438.3(m), 438.3(q) through (u), 438.4(b)(7), 438.4(b)(8), 438.5(b) through (f), 438.6(b)(3), 438.6(c) and (d), 438.7(b), 438.7(c)(1) and (2), 438.8, 438.9, 438.10, 438.14, 438.56(d)(2)(iv), 438.66(a) through (d), 438.70, 438.74, 438.110, 438.208, 438.210, 438.230, 438.242, 438.330, 438.332, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424, 438.602(a), 438.602(c) through (h), 438.604, 438.606, 438.608(a), and 438.608(c) and (d)
For rating periods for Medicaid managed care contracts beginning before July 1, 2018, states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015. **States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2018.**	§§ 438.4(b)(3), 438.4(b)(4), 438.7(c)(3), 438.62, 438.68, 438.71, 438.206, 438.207, 438.602(b), 438.608(b), and 438.818
States must be in compliance with the requirements at § 438.4(b)(9) no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2019.	§ 438.4(b)(9)

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States must be in compliance with the requirements at § 438.66(e) no later than the rating period for Medicaid managed care contracts starting on or after the date of the publication of CMS guidance.	§ 438.66(e)
States must be in compliance with § 438.334 no later than 3 years from the date of a final notice published in the Federal Register.	§ 438.334
Until July 1, 2018, states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42	§§ 438.340, 438.350, 438.354, 438.356, 438.358, 438.360, 438.362, and 438.364
Compliance Dates	**Sections**
CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.	
States must begin conducting the EQR-related activity described in § 438.358(b)(1)(iv) (relating to the mandatory EQR-related activity of validation of network adequacy) **no later than one year from the issuance of the associated EQR protocol.**	§ 438.358(b)(1)(iv)
States may begin conducting the EQR-related activity described in § 438.358(c)(6) (relating to the optional EQR-related activity of plan rating) **no earlier than the issuance of the associated EQR protocol.**	§ 438.358(c)(6)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0933. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

CMS-10120 (exp. TBD – currently 4/30/17)