DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

December 30, 2024

Charissa Fotinos, MD
Medicaid Director
Washington Health Care Authority
626 8th Avenue
P.O. Box 45502
Olympia, WA 98504-5050

Dear Dr. Fotinos:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the Health-Related Social Needs (HRSN) services protocol and Matrix for the Medicaid Transformation Project 2.0 section 1115(a) demonstration (Project Numbers 11-W-00304/0 and 21-W-00071/0). We have determined the services protocol is consistent with the requirements outlined in the demonstration Special Terms and Conditions (STCs) and are therefore approving it. A copy of the approved protocol and Matrix is enclosed and will be incorporated into the STCs as Attachment U.

We look forward to our continued partnership on the Medicaid Transformation Project 2.0 section 1115(a) demonstration. If you have any questions, please contact your project officer, Diona Kristian at Diona.Kristian@cms.hhs.gov.

Sincerely,

Angela D. Garner -S

Digitally signed by Angela D. Garner -S
Date: 2024.12.30 12:52:12 -05'00'

Angela D. Garner
Director
Division of System Reform Demonstrations
State Demonstrations Group

Enclosure

cc: Edwin Walaszek, State Monitoring Lead, Medicaid and CHIP Operations Group

Washington State Health Care Authority

Health-Related Social Needs (HRSN) services protocol

The Washington State Health Care Authority is submitting the Health-Related Social Needs (HRSN) services protocol for approval by the Centers for Medicare and Medicaid Services (CMS). The protocol addresses the requirements for provision of HRSN services specified in Section 15.7 of the Special Terms and Conditions (STCs) of the Washington State Section 1115 Medicaid Demonstration waiver renewed on June 30, 2023.

The Washington State HRSN services program will allow qualifying Medicaid enrollees to receive evidence-based, non-medical services to address an individual's unmet, adverse social conditions that contribute to poor health. This protocol specifies the set of covered HRSN services under Washington's 1115 Medicaid Demonstration waiver, beneficiary eligibility, expected implementation settings and providers, screening tool(s), determination of medical appropriateness, care plan development, and closed loop referrals.

The state's ongoing design and implementation of HRSN services is informed, in part, by the Taking Action for Healthier Communities (TAHC) Task Force. The task force includes Washington's nine Accountable Communities of Health (ACHs), five managed care organizations (MCOs), and other state partners. Recommendations from the TAHC Task Force contribute to the implementation of HRSN services.

This document reflects the state's plans to date, and the state expects to amend or expand the information provided, as necessary.

Updates to the Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for HRSN Services.

a. The state may choose to cover a subset of the HRSN services and/or beneficiary qualifying criteria specified in Attachment O. Changes to the state's service offerings and eligibility criteria, within what CMS has approved in Attachment O, do not require additional CMS approval. The state must follow the following process to notify CMS of any such HRSN service or qualifying criteria change:
    i. The state must follow the same beneficiary notification procedures as apply in the case of changes to coverage and/or beneficiary service qualification criteria for state plan services, including with respect to beneficiaries who currently qualify for and/or are receiving services who may receive a lesser amount, duration, or scope of coverage as a result of the changes.
    ii. The state must provide public notice.
    iii. The state must submit a letter to CMS no less than 30 days prior to implementation describing the changes, which will be incorporated in the demonstration's administrative record.

b. In addition to the requirements in a. above, if the state seeks to implement additional clinical and social risk factors than what were included in approved Attachment O, the state must follow the process below to update the protocol:
   i. The state must provide a budget neutrality analysis demonstrating the state's expected cost for the additional population(s). The state may only add additional clinical and social risk factors through the protocol process described in this STC if CMS determines the criteria are allowable and doing so would not increase the state's HRSN expenditure authority at the time of demonstration approval of the expenditure authority for HRSN services.
   ii. The state must receive CMS approval for the updated protocol prior to implementation of changes under this subpart (b).
   iii. The state is limited to submitting to CMS one update to its protocol per demonstration year as part of this process outlined in this subpart (b). This restriction is not applicable to the process and scope of changes outlined in (a).

Waiver-funded HRSN Services

I. Introduction

This protocol covers the following set of HRSN services as specified in Section 15.7 of the STCs:

HRSN intervention: Nutrition Supports

- Nutrition counseling and education
- Medically tailored meals for up to 3 meals a day, for up to 6 months[1]
- Meals or pantry stocking for up to 3 meals a day, for up to 6 months[1]
- Fruit and vegetable prescriptions for up to 6 months[1]
- Short-term (no more than 30 days) grocery provision

HRSN intervention: Housing/Home Environment

- Recuperative care and short-term post-hospitalization housing
- Housing transition navigation services

[1] This intervention may be renewed for additional 6-month periods if the state determines the beneficiary still meets the clinical and needs-based criteria.

- Rent/temporary housing
- Community transition services
    - Transportation for non-emergency, non-medical needs
    - Personal care and homemaker services
- Stabilization centers
- Day habilitation programs
- Caregiver respite services
- Medically necessary environmental accessibility and remediation adaptations

HRSN intervention: Case management, outreach, and education

- Case management, outreach, and education

Washington envisions a blend of funding authorities for HRSN services, with the goal of delivering services across the state's entire Medicaid population. Consistent with Washington's special terms and conditions (STC), the state will claim federal financial participation (FFP) under the demonstration only for those individuals who are assessed and meet the approved clinical and social risk factors.

This implementation structure, in particular the establishment of nine Community Hubs, is made possible, in part, by the state's nine Accountable Communities of Health (ACHs). ACHs are independent non-profit organizations aligned with the state's Medicaid purchasing regions and covering all areas of the state. Under the terms of Washington's 1115 waiver, each ACH will establish a Community Hub to provide case management, outreach, and education. The hubs also will support the delivery of other approved HRSN services.

The state will work with tribes to create a single statewide Native Hub to provide similar navigation services and support. Although the nine Community Hubs may limit their services to their respective regions, any qualifying individual in Washington may access community-based care coordination and services through any one of the 10 hubs. The details of the Community Hubs and the Native Hub in the role of HRSN service delivery will be provided in a policy guide that the state is currently developing.

When appropriate, the state will coordinate with managed care organizations (MCOs) to seek parallel in lieu of service (ILOS) authority pursuant to 42 CFR 438.3(e)(2). ILOS will be the primary authority for HRSN services offered through Washington's managed care plans.

Pursuing both avenues for the provision of selected HRSN services will extend the availability of these services to the state's entire Medicaid population.

Regardless of funding authority, these services will be the choice of the individual. Individuals can opt out anytime, and providing these services does not absolve the state or MCO of responsibility to provide coverage for other medically necessary services.

Table 1 outlines the state's current assumptions about funding authority for the covered population(s) for each waiver approved HRSN service.

Table 1

HRSN service	Waiver authority population(s) served	ILOS authority population served
Nutrition supports	Fee-for-service	Managed care
Recuperative care and short-term post-hospitalization housing	Fee-for-service Managed care	N/A
Housing transition navigation services	Fee-for-service Managed care	N/A
Rent/temporary housing	Fee-for-service Managed care	N/A
Community transition services: Non-emergency, non-medical transportation	Fee-for-service Managed care	N/A
Community transition services	Fee-for-service	Managed care
Stabilization centers	Fee-for-service	Managed care
Day habilitation programs	Fee-for-service	Managed care
Care respite services	Fee-for-service	Managed care

Environmental accessibility and remediation adaptations	Fee-for-service	Managed care
Case management, outreach, and education (delivered through the community and Native hubs)	Fee-for-service Managed care	N/A

See Appendix B for further details about each service, including eligibility, expected implementation settings, and provider types.

II. Implementation timeline

Washington State anticipates initial implementation of selected HRSN services, including the launch of the Community Hubs, in mid-2024, and the launch of the Native Hub by early 2025. Further details on the expected timeline will be provided in the state's forthcoming implementation plan.

III. Member Eligibility Criteria

Individuals will need to meet the following eligibility criteria for HRSN services:

- Be enrolled in Apple Health (Medicaid) Have at least one of the **clinical risk factors** (listed in Appendix A)
- Have one of the **social risk factors** (listed in Appendix A) and
- Have the HRSN service be determined to be **medically appropriate** for the individual.

Additional HRSN service specific eligibility criteria may apply and are detailed in Appendix A.

Clinical Risk Factors

Individuals must meet one of the HRSN clinical risk factors listed in Appendix A based on assessment by service provider and included in the individual's care.

Social Risk Factors

Individuals must meet one of the HRSN Social risk factors listed in Appendix A based on assessment by service provider and included in the individual's care.

Medical Appropriateness

Title XIX or Title XXI eligibility is a mandatory prerequisite for participation in HRSN services covered under this waiver. The state currently defines medically appropriate care as:

> *"a requested service of setting for which care is intended to address the health needs of the individual, including physical, substance use, mental health, and HRSN. The service or setting, including the level or intensity, must be appropriate to the individual's health care needs, social needs, and condition. The service or setting must be reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent worsening of conditions in the individual that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction."*

This definition was developed as part of the state's recent submission for ILOS approval for intensive behavioral supports supervision (IBSS). Although ILOS is not part of the waiver-approved set of HRSN services, work to date provides background and structure for implementation of future HRSN services. As noted before, the state will seek parallel ILOS authority for waiver-funded HRSN services, when appropriate.

In addition to continuing to refine the definition of medical appropriateness, the state will develop a process for determining and documenting medical appropriateness. That process may apply to the provision of both ILOS and waiver-funded HRSN services and will be developed in partnership with ACHs, IHCPs, MCOs, and community and Native hubs, among others. The state anticipates having a pilot process in place by the beginning of Q3 2024, the earliest date hubs are expected to begin providing case management, outreach, and education under terms of the waiver.

The state will determine the appropriate mechanism for sharing medical appropriateness and other eligibility criteria among clinical providers, MCOs, ACHs, IHCPs, community and Native hubs, and community-based organizations (CBOs). That sharing may be used, in part, to identify appropriate HRSN services and make appropriate referrals. Shared information may include:

- Results of HRSN screening
- Medicaid eligibility and enrollment status
- Member utilization of Medicaid services to prevent duplication of benefits
- Others as identified by the state

Throughout the duration of the 1115 waiver, the state will continue to evaluate and revise criteria, as necessary.

IV. Publicly Maintained Criteria

The state will maintain all HRSN eligibility criteria, HRSN service, and medical appropriateness on public-facing webpages. The state will communicate any changes to CMS, and any changes must be approved by CMS prior to posting or implementation if they are inconsistent with the content of this protocol. The state will update its public facing content and will require MCOs, ACHs, community and Native hubs, and provider partners to make similar updates. In addition, the state will create and maintain publicly available policy guides for each approved service.

V. HRSN Services

The state will cover the menu list of HRSN services as defined in Appendix A.

Use of a Third-Party Administrator or Other Contracted Vendor

The state may contract with a Third-Party Administrator (TPA) or other contracted entity to perform administrative functions of HRSN services for both managed care and FFS members.

The procurement process for a contracted entity will be detailed in the HRSN implementation plan and takes into consideration the following administrative functions, among others:

- Training and technical assistance to HRSN providers
- Billing and claim process support as a centralized clearinghouse for billing some HRSN services

Conflict of interest

- Should the state contract with a TPA or other entity to perform administrative or training functions for the provision of HRSN services, the state will establish protocols to ensure that all activities are performed in a manner that guards against conflicts of interest in accordance with all applicable requirements.
- The state shall ensure appropriate protections against conflicts of interest in the service planning and delivery of HRSN services. The state agrees that appropriate separation of assessment, service planning and service provision functions are incorporated into the state conflict of interest policies.
- If the state contracts with Tribal organizations to perform HRSN service authorization and service planning for American Indian/Alaskan Native (AI/AN) enrolled in the state's FFS program, those Tribal organizations may also furnish HRSN services,

subject to protocols established by the state to ensure that assessment, service planning, and service provision are performed in a manner that guards against conflict of interest in accordance with all applicable requirements.

Providing culturally and linguistically appropriate services.

All HRSN services must be provided in a way that is culturally responsive, trauma-informed, and linguistically appropriate for Medicaid and FFS. HRSN service providers are required to support and follow established guidelines, such as:

- The National Standards for Culturally and Linguistically Appropriate Services (CLAS)
- The Centers for Disease Control's (CDC) Office of Readiness and Response (ORR), in collaboration with SAMHSA's National Center for Trauma-Informed Care (NCTIC)
- Any other national established guidelines

Nonduplication of services

- HRSN service will not be duplicative of a state or federally funded service or other HRSN service the member is already receiving.
- The state will work with federal, state, and local agencies to align and leverage existing federal, state, and local services and resources. Alignment with these partnerships will be provided in the implementation plan.
- The state will coordinate with cross-sector waiver-related initiatives.

VI. Provider Qualifications

Service providers will be required to meet the minimum qualifications described below to demonstrate the capacity and experience to provide HRSN services:

Providers will be required to meet minimum qualifications based on HRSN services, as detailed in Table 2 and Appendix A. Entities that contract with HRSN service providers (HCA, MCOs, Community Hubs, etc.) will be required to ensure that HRSN service providers meet and maintain compliance provider qualification requirements.

Table 2

HRSN intervention	Provider qualifications
Nutrition	• Nutrition services providers must have knowledge of principles, methods, and procedures of the nutrition services covered under the waiver, or comparable services meant to support an individual in obtaining food security and meeting their nutritional needs. Nutrition service providers must follow best practice guidelines and industry standards for food safety.
Housing/Home Environment	• Housing services providers must have knowledge of principles, methods, and procedures of housing services covered under the waiver, or comparable services meant to support individuals in obtaining and maintaining stable housing. • Providers of environmental accessibility and remediation adaptation services must maintain all credentials required by local, state, and federal law, including licensing and insurance, to perform relevant services. Environmental accessibility and remediation adaptation providers must have the ability to deliver services in a timely and appropriate manner.
Case management, outreach, and education	• HRSN case management, outreach, and education providers must have knowledge of principles, methods, and procedures of these services or comparable services meant to reach to and engage the populations covered under the waiver and connect them to benefits and services to meet their needs. • HRSN case management, outreach, and education providers must contract with the Community Hubs and Native Hub.

HRSN Provider Experience and Expertise: All HRSN services providers are expected to meet certain qualifications that ensure they are capable of providing high-quality services to members as well as have culturally specific expertise to connect with members of diverse populations. Qualifications may include, for example:

- Maintain sufficient hours of operation and staffing to serve the needs of HRSN participants.

- The ability to comply with applicable federal and state laws.
- The capacity to provide culturally and linguistically appropriate, responsive, and trauma-informed service delivery, including by ensuring their ability to:
    - Adhere to federal and state laws and requirements related to ensuring communication and delivery of services to members with diverse cultural and ethnic backgrounds
    - Meet cultural needs of the community for whom it provides service
    - Provide documentation of how cultural responsiveness and trauma informed care trainings are impacting organizational policies and staff practices
    - Document efforts to recruit and employ staff who reflect the HRSN Provider's region's Medicaid population, including individuals with similar demographics, lived experience, background and language fluency to the greatest extent possible.
- A history of responsible financial stewardship and integrity via state review or oversight and/or annual financial report(s). Community Hubs and the Native Hub will provide HRSN services to eligible Medicaid beneficiaries, regardless of tribal membership, race, or national/ethnic origin. The Native Hub will provide such services statewide, and the Community Hubs may limit services to their associated regions.

VII. Member Identification and Assessment of HRSN Service Need

Member Identification

The state is currently working with MCOs and other state partners during the monthly TAHC Task Force meetings to develop the process for member identification and assessment of HRSN services. The state will ensure that individuals can be identified for HRSN services through many different approaches and by different entities. Such approaches include, but are not limited to:

- Identify individuals through a review of encounter and/or claims data
- Contract with HRSN Service Providers to conduct HRSN Outreach and Engagement to identify individuals and make HRSN Recommendations (described further below)
- Identify individuals through the screening tool identified in Section VIII
- Identify individuals who engage with Community Hubs and/or the Native Hub
- Accept members' self-referral

The following are examples of eligible entities that may support identification and assessment of individuals in need of HRSN services.

- ACHs

- Native Hub participants
- Providers of HRSN services, including, but not limited to:
    - Community-based organizations (CBOs)
    - Social-services agencies
    - Housing agencies and providers
    - Food and nutrition service providers
    - Case management providers
    - Traditional health workers
    - Child welfare providers
    - State, county, city, and local governmental agencies
    - Tribes and Indian health care providers (IHCPs)
    - Physical and behavioral health care providers
- Other entities supporting the infrastructure and delivery of HRSN services, such as technology and technical assistance providers,
- State-contracted third-party administrator and/or financial executor to support HRSN contracting, implementation, and service delivery
- Correctional institutions
- Child welfare workers and other case managers
- Individuals who self-refer for HRSN services

HRSN service referrals

The state is currently working with MCOs and other state partners during the TAHC Task Force meetings to develop a referral process for HRSN services requests. An eligible entity initiating the HRSN service referral process will take into consideration the following:

- Confirmation of individual's Medicaid enrollment and/or eligibility
- Capturing data information pertaining to the individual's name, contact information, and recommended HRSN service
- Identification of one or more HRSN service needs the individual may need and/or the potential HRSN eligibility
- Identification of appropriate culturally, linguistically, and trauma-informed service for the individual
- Documentation of the attempts to collect the individual's information needed to determine eligibility for HRSN service
- Any other additional information the state may deem appropriate.

The state envisions a role for the Community Information Exchange (CIE) in the data collection and data-sharing necessary for the provision of requesting HRSN services by eligible HRSN service provider entities. Guidance for a HRSN service request process will be provided to HRSN service providers and eligibility entities in a publicly available policy guide.

Eligibility Determination and Services Approval

The state is currently working with ACHs, Tribes, IHCPs, MCOs, behavioral and physical health care providers, and other partners to develop processes that take into consideration the following:

- Upon receipt of the information regarding the individual's HRSN needs, the appropriate administrative entity will use reasonable efforts to obtain all other information necessary to 1)determine individual's eligibility for HRSN and 2)authorize the appropriate HRSN services.
- Documentation process for all the required information needed to make a HRSN service eligibility determination.
- Documentation process for all the required information needed to make a HRSN service approval or denial.

The state will require the appropriate administrative entity to:

- Notify the individual or HRSN service approval or denial and provide information about appeals and hearing rights.
- Any another additional information the state may deem appropriate.

Individuals have the option to decline the HRSN services, in which case the state will require the appropriate administrative entity to document the individual's request to decline the HRSN services.

VIII. Screening tool

Individuals may be identified as eligible for HRSN services through an initial screening process conducted by an eligible entity described in Section VII. Any screening tools used to assess beneficiaries for interventions involving pre/post hospitalization or post-transition housing must map to 24 CFR 91.5 definitions, and those used to screen beneficiaries for nutrition interventions must map to USDA's definition of food insecurity.

In collaboration with ACHs, Indian health care providers (IHCPs), the community and Native hubs, MCOs, community members, and others as appropriate, the state will select an approved screening tool that can be used by community and Native hubs, the community-based workforce, care managers, and clinical care providers, among others, to identify individuals with HRSN. The approved screening

tool(s) will be made publicly available and eligible entities have the option to use the state approved screening tool(s) or use the screening tool(s) of their choice. The state reserves the right to review any screening tool selected to ensure it meets minimum criteria.

The state will build on current efforts under way among ACHs, MCOs, clinical partners, and other participants in the Medicaid Quality Improvement Program (MQIP). Those entities are in the process of selecting, testing, and implementing evidence-based screening tools, including Care Coordination System (CCS), Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE), and USDA Food Security Survey, among others. As the state moves forward with its planned statewide community information exchange (CIE) and hub operations are further defined, the goal will be to create a unified screening approach with approved screening tool(s).

Results of the screening will be used to inform navigation services for the individual, the individual's care plan, and referrals to appropriate HRSN services or clinical care.

At minimum the screening to assess an individual's HRSN must include:

- Housing instability
- Food insecurity
- Financial insecurity
- The need for transportation assistance
- Family and community support
- Behavioral health
- Interpersonal safety and violence
- Other HRSN as identified by the state
- Other identified CMS HRSN screening guidelines

As appropriate, the state will develop guidelines for rescreening individuals or revising the screening tool(s).

IX. Care management, care plan and closed loop referrals

The state will establish a process for creating, sharing, and updating plans for individuals who screen positive for HRSN service needs, are Medicaid/CHIP eligible, and whose care meets the standards for medical appropriateness. The shared care plan will include services to

address HRSN and may include plans for physical or behavioral health care. The plan may be shared among community and Native hubs, community-based providers, MCOs, clinical providers, and other appropriate administrative entities to ensure continuity of care.

A shared care plan could require data- and information-sharing among MCOs, community and Native hubs, CBOs, behavioral and physical health care providers, and other appropriate administrative entities. The state will set guidelines for the sharing and protection of clinical and nonclinical information. The state also will continue to work with MCOs, ACHs, and community and Native hubs during the monthly TAHC Task Force to define the scope of clinical care coordination, community-based care coordination, and closed loop referrals. Those definitions will help ensure that coordination efforts complement, rather than duplicate, each other.

The state will determine care plan requirements. At a minimum, a care plan will:

- Be tailored to an individual's HRSN.
- Document the person-centered planning process, including dialogue and referrals between an individual and the care team, and a shared decision-making process.
- Refer the member to a HRSN provider for the approved services, and supporting member choice of provider, ensuring member needs are met by the Provider, including through regular communication with the individual and HRSN Provider delivering the service, and finding alternative providers if needed.
- Identify other HRSN services the member may need.
- Determine what other services the individual is receiving or may be eligible to receive under Medicaid or other programs.
- Coordinate with other social support services and care management the member is already receiving or becomes eligible for while receiving the HRSN service.
- Ensure closed loop referrals to community-based services and the community-based workforce.
- Provide continuity of care.
- Be reviewed at least once every 12 months, and revised upon reassessment of need, when individual's circumstances or needs change, or at the request of the individual.
- Ensure culturally appropriate and trauma-informed care by following established guidelines, such as those set by the Centers for Disease Control's (CDC) Office of Readiness and Response (ORR), in collaboration with SAMHSA's National Center for Trauma-Informed Care (NCTIC).
- Include documentation of resolution of conflict, grievances, or appeals.
- Be confidential.

As noted, the state is committed to creating a mechanism to ensure closed loop referrals, including an effort to establish a statewide CIE. A CIE would, among other things, support efforts to deliver HRSN services. In the interim, the state will work with ACHs, MCOs, and others to leverage their current information-exchange systems to promote continuity of care.

X. Payment

Washington is currently working with CMS to establish protocols for funding case management, outreach, and education services through a per member per month (PMPM) payment model.

For other HRSN services, service providers will submit invoices after providing HRSN services to individuals who meet HRSN social and clinical eligibility criteria. Depending on the individual's coverage, providers will bill either the state or the individual's managed care plan.

Currently the state is exploring the possibility of procuring a third-party administrator (TPA) or other administrative entity to help organizations meet Medicaid billing requirements. ACH and MCO partners, as well as the TAHC Task Force, are guiding the state in this work.

HRSN service providers will be reimbursed according to a fee schedule for HRSN services to be developed by the state.

As appropriate, the state will develop guidelines for payment schedules and will be provided in a policy guide.

Washington State Health Care Authority

Appendix A

Jump to:

Washington State Health Care Authority

Nutrition counseling and education

Description	Authorized by STC 15.2(a)(i). Any combination of educational strategies designed to motivate and facilitate voluntary adoption of food choices and other food and nutrition-related behaviors conducive to health and wellbeing. This service may consist of the following: 1. Provision of nutrition education or information to an individual or group that offers evidence based or evidence informed strategies on adoption of food choices and other food- and nutrition-related behaviors conducive to health and well-being and guidance on food and nutrition resources. 2. Meal preparation education in an individual or group setting. Nutrition education services may be supplemented with handouts, take-home materials, and other informational resources that support nutritional health and well-being. This service must: • Be provided in accordance with evidence-based nutrition guidelines. • Follow food safety standards. • Be person-centered, consider dietary preferences, and be culturally appropriate.
Eligible population	All individuals enrolled in Apple Health (Medicaid).
Social risk factors	Eligible population meeting the USDA definition of low food security, or very low food security.

Clinical risk factors	Individuals with chronic conditions (including but not limited to diabetes, cardiovascular disorders, chronic infectious diseases such as human immunodeficiency virus (HIV), cancer, chronic gastrointestinal disorders, respiratory conditions such as cystic fibrosis, eating disorders, and chronic behavioral health conditions).
Duration and frequency (if applicable)	N/A
Implementation setting	Beneficiaries may receive services at: • Clinical settings (inpatient and outpatient) • Food banks • Community centers • Farmers markets • Member residence • Others as approved by the state
Provider type	A Registered Dietitian Nutritionist (RDN) (preferred), qualified health care professional, or, if not available, a community health worker to develop a medically appropriate nutrition care plan.

Medically Tailored Meals (MTMs)

Description	Authorized by STC 15.2(a)(ii). Meals tailored to support individuals with health-related condition(s) for which nutrition supports would improve health outcomes. This service includes: 1. Initial assessment and reassessment, if needed, with a provider to develop a medically appropriate nutrition care plan.

2. The preparation and provision of the prescribed meals consistent with the nutrition care plan, up to 3 meals a day, for up to 6 months at a time; and
3. Delivery of the meal.

Each meal must contain sufficient food to support approximately one-third of an individual's daily nutritional need as indicated by the Dietary Reference Intakes and Dietary Guidelines. The meal may also include an accompanying fluid/drink and/or a supplementary food item to support meeting a member's nutrition needs between meals if medically appropriate (for example, to provide access to fluids and/or support taking medication accompanied by food). Meals may consist of fresh or frozen food.

This service may be provided for up to 6 months with an option for renewal for up to 6 months if clinical and social needs factors still apply.

Members cannot receive medically tailored meals, meals or pantry stocking, or short-term grocery provisions concurrently.

If the member is a pregnant/postpartum person, then the member may receive these services either throughout their pregnancy and up to 12 months postpartum. The timing of eligibility determination during pregnancy or postpartum period does not affect the allowable duration of benefit. The intervention may apply to subsequent pregnancies/postpartum periods during the demonstration period if the member meets the needs-based clinical criteria at the time of the subsequent pregnancies/postpartum periods.

If the member is a child/adolescent (0-21 years of age) or a pregnant person meeting needs-based criteria, additional meal support may be provided for the household.

The service must:

- Be provided in accordance with nutrition-related national guidelines, such as the Dietary Guidelines for Americans, or

	evidence-based practice guidelines for specific chronic diseases and conditions. • Follow food safety standards. • Consider an individual's personal and cultural dietary preferences.
Eligible population	All individuals enrolled in Apple Health (Medicaid).
Social risk factors	Eligible population meeting the USDA definition of low food security , or very low food security.
Clinical risk factors	Eligible population: • with chronic conditions (including but not limited to diabetes, cardiovascular disorders, chronic infectious diseases such as human immunodeficiency virus (HIV), cancer, chronic gastrointestinal disorders, respiratory conditions such as cystic fibrosis, eating disorders, and chronic behavioral health conditions), and • has been or is being discharged from institutional care, a hospital, or congregate settings ,within 6 months, such as skilled nursing facilities, large group homes, residential settings, Institutions of Mental Diseases, correctional facilities, and acute care hospitals; or at high risk of hospitalization or nursing facility placement.
Duration and frequency (if applicable)	Up to 3 meals a day for up to 6 months.
Implementation setting	N/A
Provider type	A Registered Dietitian Nutritionist (RDN) (preferred), or, if not available, a primary care provider to develop a medically appropriate nutrition care plan.

Meals or Pantry stocking

Description	Authorized by STC 15.2(a)(iii).

	This service allows an individual to purchase an assortment of foods aimed at promoting improved nutrition for the individual. Individuals may pick up food from food retailers or have food delivered to the individual's home or private residence if delivery service is available. This service must be consistent with the nutrition care plan. Examples of allowable foods include: • Fruits and vegetables • Meat, poultry, and fish • Dairy products • Breads and cereals • Snack foods and non-alcoholic beverages • Seeds and plants, which produce food for the household to eat This service may: • Take into account an individual's household size • Be administered through, for example, a voucher or prepaid card to be used only at a food retailer for allowable purchases • Be provided in conjunction with resources on the Dietary Guidelines for Americans to encourage healthy food selection This service must: • Be provided in accordance with evidence-based nutrition guidelines. • Follow food safety standards. • Be person-centered, consider dietary preferences, and be culturally appropriate. • Not supplant or duplicate the work of other federal or state non-Medicaid agencies.
Eligible population	All individuals enrolled in Apple Health (Medicaid).

Social risk factors	Eligible population meeting the USDA definition of low food security, or very low food security.
Clinical risk factors	Eligible population with chronic conditions (including but not limited to diabetes, cardiovascular disorders, chronic infectious diseases such as human immunodeficiency virus (HIV), cancer, chronic gastrointestinal disorders, respiratory conditions such as cystic fibrosis, eating disorders, and chronic behavioral health conditions).
Duration and frequency (if applicable)	This service is available for up to 3 meals per day for up to 6 months. It may be renewed for additional 6-month periods if the state determines the beneficiary still meets all eligibility criteria. Members cannot receive medically tailored meals, meals or pantry stocking, or short-term grocery provisions concurrently.
Implementation setting	N/A
Provider type	N/A

Fruit and vegetable prescriptions

Description	Authorized by STC 15.2(a)(iv). This service allows an individual to purchase fruits and vegetables from participating food retailers and farms. Fruits and vegetables available for purchase through this service may be fresh, frozen, or canned. Individuals may pick up food from food retailers or have food delivered to where the individual resides if delivery service is available. This service may: • When the individual receiving the service is a child or pregnant individual, take into account an individual's household, using the SNAP definition of a household to determine the benefit level for these beneficiaries.

	• Be administered through, for example, a voucher or prepaid card to be used only at a food retailer for allowable purchases • Be provided in conjunction with resources on the Dietary Guidelines for Americans to encourage healthy food selection This service must: • Be provided in accordance with evidence-based nutrition guidelines. • Follow food safety standards. • Be person-centered, consider dietary preferences, and be culturally appropriate. • Not supplant or duplicate the work of other federal or state non-Medicaid agencies.
Eligible population	All individuals enrolled in Apple Health (Medicaid).
Social risk factors	Eligible population meeting the USDA definition of low food security, or very low food security.
Clinical risk factors	Eligible population with chronic conditions (including but not limited to diabetes, cardiovascular disorders, chronic infectious diseases such as human immunodeficiency virus (HIV), cancer, chronic gastrointestinal disorders, respiratory conditions such as cystic fibrosis, eating disorders, and chronic behavioral health conditions).
Duration and frequency (if applicable)	This service is available for up to 6 months. It may be renewed for additional 6-month periods if the state determines the beneficiary still meets all eligibility criteria.
Implementation setting	N/A
Provider type	N/A

Short-term grocery provisions

Description	Authorized by STC 15.2(a)(v). This service allows an individual to purchase an assortment of foods aimed at promoting improved nutrition for the individual. Individuals may pick up food from food retailers or have food delivered to the individual's home or private residence if delivery service is available. This service must be consistent with the nutrition care plan. Examples of allowable foods include: • Fruits and vegetables • Meat, poultry, and fish • Dairy products • Breads and cereals • Snack foods and • Non-alcoholic beverages • Seeds and plants, which produce food for the household to eat This service may: • Take into account an individual's household size If the member is a child/adolescent (0-21 years of age) or a pregnant person • Be administered through, for example, a voucher or prepaid card to be used only at a food retailer for allowable purchases • Be provided in conjunction with resources on the Dietary Guidelines for Americans to encourage healthy food selection This service must: • Be provided in accordance with evidence-based nutrition guidelines. • Follow food safety standards. • Be person-centered, consider dietary preferences, and be culturally appropriate.

	• Not supplant or duplicate the work of other federal or state non-Medicaid agencies.
Eligible population	All individuals enrolled in Apple Health (Medicaid).
Social risk factors	• Eligible population meeting the USDA definition of low food security, or very low food security.
Clinical risk factors	Eligible population who: • Is enrolled in LTSS and • has been or is being discharged within 6 months from the hospital or skilled nursing facility, or at high risk of hospitalization or nursing facility placement.
Duration and frequency (if applicable)	Individuals may stock up on groceries for 30 days, no more than once per calendar year. The cost of groceries for each instance of the service may not exceed 200% of the U.S. Department of Agriculture (USDA) SNAP Allowance for one month. Members cannot receive medically tailored meals, meals or pantry stocking, or short-term grocery provisions concurrently.
Implementation setting	N/A
Provider type	N/A

Recuperative care and short-term post-hospitalization housing

Description	Authorized by STC 15.2(b)(i). Recuperative care and short-term post-hospitalization housing settings provide a safe and stable place for eligible individuals to receive treatment on a short-term basis. This service is for individuals who are transitioning out of institutions and at risk of incurring other Medicaid state plan services, such as inpatient hospitalizations or emergency department visits (as determined by a provider at the plan or network level).

	Eligible cost: • Room and board, food as well as food delivery costs, transportation, medical supplies Service may include: • Shelter • Clinical assessments • Behavior health screenings (for psychosocial needs) • Case management support in accessing benefits and housing • 24-hour bed rest and 24-hour wellness checks • Medical oversight that includes medication monitoring and ongoing assessments to determine whether or not treatments/care plans are effective • Minor clinical interventions (e.g. wound care, infection control, non-pharmacological pain management) • Medical case management for care coordination, transportation to medical appts, 3 meals per day • Safe storage for belongings, laundry • Cell phone for tele-health appointments
Eligible population	All individuals enrolled in Apple Health (Medicaid)
Social risk factors	• Eligible population who are homeless or at risk of homelessness, as defined by 24 CFR 91.5 with the exception of the annual income requirement in 24 CFR 91.5 (1)(i).
Clinical risk factors	Eligible population who is:

- At risk[2] of incurring other Medicaid state plan services, such as inpatient hospitalizations or emergency department visits (as determined by clinicians at the plan or network level); and

- Meets at least one of the following three (3) health needs-based criteria:

  1) Individual assessed to have a behavioral health need, which is defined as one or both of the following criteria:

     a) Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a mental illness; and/or

     b) Substance use need, where an assessment using the American Society of Addiction Medicine (ASAM) Criteria indicates that the individual meets at least ASAM level 1.0, indicating the need for outpatient Substance Use Disorder treatment.

  2) Individual assessed to have a need for assistance, demonstrated by the need for:

[2]. There is a predictive model, or a framework, being used by the National Institute for Medical Respite Care (NIMRC) which includes guiding principles, standards and models of care for medical respite. **https://nimrc.org/wp-content/uploads/2023/05/Framework-for-MRC-Delivery_-2023.pdf**

	a) Assistance with three or more Activities of Daily Living (ADLs) defined in WAC 388- 106-0010, one of which may be body care, and/or b) Hands-on assistance with one or more ADLs, one of which may be body care. 3) Individual assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support).
Duration	Recuperative care: up to 90 days at a time and no more than 6 months per rolling 12-month period. Short-term post-hospitalization housing: up to six months once during the demonstration period. All section 1115 demonstration HRSN housing interventions with room and board are limited to global HRSN housing cap of a combined 6 months per rolling 12-month period.
Implementation setting	Implementation settings for recuperative care and short-term post-hospitalization housing must have appropriate clinicians who can provide medical and/or behavioral health care. The facility cannot be primarily used for room and board without the necessary additional recuperative support services. Medical respites without clinicians on site must work closely with Federally Qualified Health Centers (FQHCs) and provide care coordination through case management services. Implementation settings may include: • Hospitals, health centers, and other clinics • Wellness/respite centers • Social service centers • Skilled nursing facilities • Assisted living facilities

	• Residential group homes or small apartment buildings • Community centers • Adult family homes • Transitional housing facilities • Other as approved by the state Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g. gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space are excluded from the demonstration.
Provider type	Providers may include: • Licensed physical health providers • Licensed behavioral health providers • Providers of transitional housing support • Case managers • Others as approved by the state
Specific provider qualifications	Both clinical and non-clinical staff with preferred experience consisting of registered nurses – patient care and admission coordinators, certified Community Health Workers and/or Peer specialists, Certified Medical Assistants (CMA), Mental Health Practitioner (Masters level SW or Licensed Mental Health Counselors), Behavioral Health Specialists (bachelor's level in psychology/sociology). Medical Respite providers should be following the guidelines of the National Institute of Medical Respite Care, meet the Standards for Medical Respite Care Programs, and complete HCA's Attestation for Respite Providers. Facility requirements: A facility that provides MRC services must meet local codes and ordinances for licensing, safety, and occupancy.

Washington State Health Care Authority

Housing transition navigation services

Description	Authorized by STC 15.2(b)(ii). Housing transition navigation services are services that aim to remove barriers to affordable housing including transition costs and housing deposits to assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to help a person establish a basic household. Short-term transition and moving costs necessary to establish a basic household such as: 1. Expenses needed to secure housing (i.e. security deposits, application fees, background checks); and first month's rent as required by landlord for occupancy. All section 1115 demonstration HRSN housing interventions with room and board are limited to global HRSN housing cap of a combined 6 months per rolling 12-month period. Room and board-only interventions are limited to a combined 6 months per household per demonstration period. 2. Utility set-up fees/deposits and up to six months of unresolved utility arrearages if necessary to set up services in new residence; and first month coverage of utilities, including water, garbage, sewage, recycling, gas, electric, internet and phone (inclusive of land line phone service and cell phone service), with a ceiling of up to six months in total retrospective/prospective payments of utilities per demonstration period. 3. Relocation expenses (i.e., moving, transportation to new residence, and storage costs) 4. Pantry stocking at move in (differs from meals and pantry stocking HRSN service)

	a. This service must be provided in conjunction with resources on the Dietary Guidelines for Americans to encourage healthy food selection b. Individuals may stock up on groceries for 30 days, no more than once per calendar year. The cost of groceries for each instance of the service may not exceed 200% of the U.S. Department of Agriculture (USDA) SNAP Allowance for one month. 5. Basic household goods and furniture, which may include appliances and utensils necessary for food consumption, bedding, furnishings, cribs, bathroom supplies, and cleaning supplies 6. Medically necessary environmental modifications including landlord approved and medically necessary home accessibility modifications, assistive technology, and devices to maintain healthy temperatures and clean air.
Eligible population	• All individuals enrolled in Apple Health (Medicaid).
Social risk factors	• Eligible population who are homeless or at risk of homelessness, as defined by 24 CFR 91.5 with the exception of the annual income requirement in 24 CFR 91.5 (1)(i); • For the service of pantry stocking, eligible population meeting the USDA definition of low food security, or very low food security.
Clinical risk factors	Eligible population who meets at least one of the following three (3) health needs-based criteria: 1) Individual assessed to have a behavioral health need, which is defined as one or both of the following criteria: a) Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a mental illness; and/or

b) Substance use need, where an assessment using the American Society of Addiction Medicine (ASAM) Criteria indicates that the individual meets at least ASAM level 1.0, indicating the need for outpatient Substance Use Disorder treatment.

2) Individual assessed to have a need for assistance, demonstrated by the need for:

a) Assistance with three or more Activities of Daily Living (ADLs) defined in WAC 388- 106-0010, one of which may be body care, and/or

b) Hands-on assistance with one or more ADLs, one of which may be body care.

3) Individual assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support).

Duration and frequency (if applicable)	Allowable expenditures may be covered up to a financial limit established by the state over the course of one 12-month period per instance, starting at the initial provision of services to support housing search, selection, and tenancy sustainability of individuals experiencing HRSN.
Implementation setting	N/A
Provider type	Any provider who is eligible to hold a contract with Washington State's Department of Social and Health Services (DSHS), HCA, and/or the Department of Commerce (Commerce) and any housing related contracts held through these contractors' awardees.

	Provider organizations must have demonstrated experience with providing housing-related services and supports and may include entities such as: • Vocational services agencies • Providers of services for individuals experiencing homelessness • Life skills training and education providers • County agencies • Public hospital systems • Mental health or substance use disorder treatment providers, including county behavioral health agencies • Social services agencies • Affordable housing providers • Supportive housing services providers • Permanent Supportive Housing operators • Peer Support service providers • Federally qualified health centers and rural health clinics • Others as approved by the state
Specific Provider qualifications	Any provider who is eligible to hold a contract with Health Care Authority, Department of Social and Health Services, and/or Department of Commerce and any housing-related contracts held through these contractors' awardees.

Rent/temporary housing

Description	Authorized by STC 15.2(b)(iii). Rent/temporary housing provides stable independent living situations for individuals transitioning out of institutional care or congregate settings who are homeless or at risk of homelessness. Payment may cover rent and/or short-term, temporary stays for up to six months including: • Rent payments for apartments, single room occupancy (SRO) units, single-family homes, multifamily homes, mobile home

	communities, accessory dwelling units (ADUs), co-housing communities, trailers, manufactured homes; or • Manufactured home lots, motel or hotel when it is serving as the individual's primary residence; or • Transitional and recovery housing including bridge, site-based, population-specific, and community living programs that may or may not offer supportive services and programming. Rent/temporary housing 1. Rent payment (past due or forward rent but capped at six months of total rent payments per demonstration period). All section 1115 demonstration HRSN housing interventions with room and board are limited to global HRSN housing cap of a combined 6 months per rolling 12-month period. 2. Storage fees and movers' fees 3. Renter's insurance, if required by the lease 4. Landlord paid utilities that are part of the rent payment and not duplicative of other HRSN utility payments 5. Recurring utilities, including expenses for garbage, water, sewage, recycling, gas, electric, Internet, Phone (inclusive of land line phone service and cell phone service) , with a ceiling of up to six months in total retrospective/prospective payments of utilities per demonstration period. 6. Non-refundable, non-recurring utility set-up costs for utilities or restart costs if the service has been discontinued, and up to six months of arrears related to unpaid utility bills, but capped at six months of total arrears/prospective utility payments per demonstration.
Eligible population **Social risk factors**	All individuals enrolled in Apple Health (Medicaid). • Eligible population who are homeless or at risk of homelessness, as defined by 24 CFR 91.5 with the exception of the annual income requirement in 24 CFR 91.5 (1)(i);

Clinical risk factors	Eligible population who meets at least one of the following three (3) health needs-based criteria: 1) Individual assessed to have a behavioral health need, which is defined as one or both of the following criteria: a) Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a mental illness; and/or b) Substance use need, where an assessment using the American Society of Addiction Medicine (ASAM) Criteria indicates that the individual meets at least ASAM level 1.0, indicating the need for outpatient Substance Use Disorder treatment. 2) Individual assessed to have a need for assistance, demonstrated by the need for: a) Assistance with three or more Activities of Daily Living (ADLs) defined in WAC 388- 106-0010, one of which may be body care, and/or b) Hands-on assistance with one or more ADLs, one of which may be body care. 3) Individual assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support).
Duration and frequency (if applicable)	Up to six months once during the demonstration period.

Implementation setting	Services to be provided in independent living situations, such as in-home, and interim housing settings. Payments must be provided only in connection with dwellings that meet maintenance regulation code within the local jurisdiction for safety, sanitation, and habitability. Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g. gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space are excluded from the demonstration.
Provider type	Provider organizations must have demonstrated experience with providing housing-related services and supports and may include entities such as: • Vocational services agencies • Providers of services for individuals experiencing homelessness • Life skills training and education providers • County agencies • Public hospital systems • Mental health or substance use disorder treatment providers, including county behavioral health agencies • Social services agencies • Affordable housing providers • Supportive housing services providers • Permanent supportive housing operators • Peer support service providers • Federally qualified health centers and rural health clinics • Others as approved by the state
Specific Provider qualifications	Any provider who is eligible to hold a contract with Health Care Authority, Department of Social and Health Services, and/or Department of Commerce and any housing-related contracts held through these contractors' awardees.

Community transition services

Description	Authorized by STC 15.2(b)(iv).

	Community transition services help individuals live in the community and avoid further institutionalization by providing: 1. Transportation for nonmedical, non-emergency needs. 2. Personal care and homemaker services. Personal Care and homemaker services are short-term care for individuals who do not qualify or no longer qualify for standard Home and Community Based services, have behavioral health conditions, and whose condition would be exacerbated by an unstable living environment. Access to this service would allow individuals to continue their community stabilization. At a minimum, the service will include meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on individual needs, the service may also include: • Limited or short-term assistance with Instrumental Activities of Daily Living (IADLs) and/or Activities of Daily Living (ADLs), including: ○ Personal care services (such as bowel and bladder care, bathing, grooming, transfer, and paramedical services); ○ Medication management; ○ House cleaning; ○ Meal preparation; ○ Laundry; ○ Grocery shopping; ○ Accompaniment to medical appointments.
Eligible population	All individuals enrolled in Apple Health (Medicaid) who are enrolled *in the Foundational Community Supports program*.
Social risk factors	• Eligible population who are homeless, at risk of homelessness, or transitioning out of an emergency shelter as defined by 24 CFR 91.5 with the exception of the annual income requirement in 24 CFR 91.5 (1)(i).

Clinical risk factors

Eligible population has been or is being discharged from institutional care, a hospital, or congregate settings such as skilled nursing facilities, large group homes, residential settings, Institutions of Mental Diseases, correctional facilities, and acute care hospitals; or at high risk of hospitalization or nursing facility placement; and

Eligible population who meets at least one of the following three (3) health needs-based criteria:

1) Individual assessed to have a behavioral health need, which is defined as one or both of the following criteria:

a) Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a mental illness; and/or

b) Substance use need, where an assessment using the American Society of Addiction Medicine (ASAM) Criteria indicates that the individual meets at least ASAM level 1.0, indicating the need for outpatient Substance Use Disorder treatment.

2) Individual assessed to have a need for assistance, demonstrated by the need for:

a) Assistance with three or more Activities of Daily Living (ADLs) defined in WAC 388- 106-0010, one of which may be body care, and/or

b) Hands-on assistance with one or more ADLs, one of which may be body care.

	3) Individual assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support).
Duration	N/A
Implementation setting	• The services are available in a home that is owned, rented, leased, or occupied by the individual or their caregiver. • For a home that is not owned by the individual, the individual must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.).
Provider type	Providers may include: • Home health agencies • Area Agencies on Aging (AAA) • Foundational Community Supports providers • Other providers as approved by the state
Specific provider qualifications	Any provider who is eligible to hold a contract with Health Care Authority or Department of Social and Health Services.

Stabilization centers

Description	Authorized by STC 15.2(b)(v). Community Stabilization Centers are alternative destinations for individuals who are found to be publicly under the influence of substances, and/or recently experienced an overdose, and would otherwise be transported to the emergency department or jail. Stabilization centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to stabilize and access case management and other

	supportive services. Stays are limited to less than 24 hours. Service does not include room and board. Specific services may include, but are not limited to: • Behavioral and physical health screening • Case management to include referral to community supportive services • Basic medical services, to include staff who can screen individuals for medical and behavioral health needs. • Telehealth to include prescribing of medications for opioid use disorder • Peer Services • On-site shower and laundry services • Nutritional support
Eligible Population	All individuals enrolled in Apple Health (Medicaid).
Social risk factors	• Eligible population who are homeless or at risk of homelessness, as defined by 24 CFR 91.5 with the exception of the annual income requirement in 24 CFR 91.5 (1)(i)
Clinical risk factors	• Eligible population who are under the influence of substances or recently overdosed and report an active substance use disorder and ○ are seeking services and support and are reluctant to seek care in a traditional clinical or emergency department setting; and ○ are reluctant to seek care in a traditional clinical or emergency department setting; or ○ who in the absence of a diversion alternative, would be taken to an emergency room or jail; or ○ who are at risk of withdrawal or recurrent overdose symptoms.
Duration	Less than 24 hours.
Implementation setting	Provider facilities may include designated stabilization centers or other appropriate and allowable substance use disorder (SUD) facilities. This

	may include existing "diversion centers" which offer short-term placement and shelter to homeless individuals, diverting them away from the criminal court system. If shelter is provided, it is through the setting and not through this service. Clinical, behavioral health and navigation, coordination services are provided in this setting supported by nurses, mental health professionals, community health workers, and certified peer counselors. Induction on medications for opioid use disorder via on site or remote site prescribing provider.
Provider type	Providers may include: • Behavioral health agencies • Homelessness services agencies • Federally qualified health centers • Community Based Organizations • Others as approved by the state
Specific provider qualifications	Nurses, mental health professionals, and for care coordination/navigation services, community health workers and peer support specialists. Providers must have: • Experience and expertise with providing these services, assessment and management of acute intoxication and post overdose care; • Experience in working with unhoused or other marginalized populations; and • Experience working from a harm reduction, trauma informed philosophy. Services are provided under the supervision of a DEA registered provider.

Day habilitation programs

Description	Authorized by STC 15.2(b)(vi). Day habilitation programs help an individual acquire, retain, and improve self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. Day habilitation program services promote independence within the community and do not include room and board. Examples of program services may include: • Developing and maintaining interpersonal relationships • Education about the use of public transit and other transportation options • Behavioral health and physical health management skill development • Prevocational Services and Supports – services and supports to build skills necessary to perform compensated work in community integrated employment • Personal skills development in conflict resolution • Development of daily living skills (e.g., cooking cleaning, shopping, or money management) • Community resource awareness such as police, fire, or local services to support independence in the community. • Community participation Programs may include assistance with, but not limited to, the following • Seeking, selecting, securing housing • Settling disputes with landlord • Managing personal financial affairs and personal crisis planning • Seeking and securing employment • Accessing and navigating additional social services • Asserting civil and statutory rights through self-advocacy

	• Building and maintaining interpersonal relationships, including a circle of support • Coordination with Apple Health managed care plan to link member to any community supports and/or enhanced care management services for which the member may be eligible • Referral to housing resources if member does not meet current eligibility criteria • Assistance with income and benefits advocacy including Housing and Essential Needs (HEN), Supplemental Nutrition Assistance Program (SNAP), and SSI if member is not receiving these services and is eligible • Coordination with Apple Health managed care plan to link member to health care, mental health services, and substance use disorder services based on the individual needs of the member for members who are not receiving this linkage through other supports • Services may be provided in conjunction with but will not duplicate other related housing and employment supports and services.
Eligible population	All individuals enrolled in Apple Health (Medicaid).
Social risk factors	• Eligible population who are homeless or at risk of homelessness, as defined by 24 CFR 91.5 with the exception of the annual income requirement in 24 CFR 91.5 (1)(i);
Clinical risk factors	

Eligible population who meets at least one of the following three (3) health needs-based criteria:

1) Individual assessed to have a behavioral health need, which is defined as one or both of the following criteria:

a) Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning

(including ability to live independently without support) resulting from the presence of a mental illness; and/or

b) Substance use need, where an assessment using the American Society of Addiction Medicine (ASAM) Criteria indicates that the individual meets at least ASAM level 1.0, indicating the need for outpatient Substance Use Disorder treatment.

2) Individual assessed to have a need for assistance, demonstrated by the need for:

a) Assistance with three or more Activities of Daily Living (ADLs) defined in WAC 388- 106-0010, one of which may be body care, and/or

b) Hands-on assistance with one or more ADLs, one of which may be body care.

3) Individual assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support).

Duration and frequency (if applicable)	Less than 24 hours.
Implementation setting	Day habilitation program services are provided in an out-of-home, non-facility setting
Provider type	Providers of day habilitation services may include: • Behavioral health or substance use disorder treatment providers • Licensed psychologists • Registered nurses

	• Home health agency staff • Homeless services providers • Vocational skills agency staff • Peer support service providers • Clubhouse staff • Recovery Café staff • Others as approved by the state
Specific Provider qualifications	These services are often considered as peer mentoring or psycho-social rehabilitation services when provided by an unlicensed caregiver with the necessary training and supervision. Providers who offer the services include, but are not limited to: • Behavioral health or substance use disorder treatment providers • Licensed Psychologists • Licensed Certified Social Workers • Registered Nurses • Home health agencies • Homeless services providers, including housing and employment navigation services providers • Vocational skills agencies • Peer support service providers • Clubhouses • Recovery Cafes • Community Peer Run Organizations • Occupational Therapists • Other providers as approved by the state

Caregiver respite services

Description	Authorized by STC 15.2(b)(vii).

	Caregiver respite services provide intermittent temporary supervision on a short-term basis. Services provided to the individual are primarily non-medical and may include attending to the individual's basic self-help needs and other activities of daily living (ADL), including interaction, socialization, and continuation of usual daily routines that would ordinarily be performed by a caregiver. Respite should be made available when it is useful and necessary to maintain a person in their own home and to preempt caregiver burnout to avoid institutional placement. Services may include help with activities of daily living (bathing, dressing, etc.), daily housework (e.g., dishes, laundry, vacuuming), preparing meals, transportation to appointments, grocery shopping and assistance with yard and household maintenance, and general companionship. Respite services must be consistent with provider requirements and service requirements include: • Providing observation, direct support, and monitoring to meet the physical, emotional, social, and mental health needs of an individual consumer by someone other than the primary caregivers. • Service provided in a variety of settings such as the person's or caregiver's home, an organization's facilities, or in a respite worker's home, etc. • Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals. • Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals. • Services that attend to the member's basic self-help needs and other activities of daily living, including interaction, socialization and continuation of usual daily routines that would ordinarily be

	performed by those persons who normally care for and/or supervise them. • Service provided in a manner necessary to provide relief for the person or caregivers. • Concurrent or auxiliary services may be provided by staff who are not assigned to provide respite care, such as recreational therapy, peer support, etc.
Eligible population	All individuals enrolled in Apple Health (Medicaid).
Social risk factors	• Eligible population whose unpaid caregivers require relief to avoid the enrollee being placed in an institution; and • Eligible population who self-identified current caregiver stress or fatigue or competing time commitment or scheduled vacation; and • Eligible population who self-identified challenge finding or affording alternative care.
Clinical risk factors	Individuals who live in the community and are compromised in their activities of daily living and/or have been assessed to have a behavioral health need that requires constant or near-constant supervision (e.g., a child with serious emotional disturbance (SED)) and whose unpaid caregivers require relief. The population eligible for caregiver respite services includes, but is not limited to, individuals who meet eligibility and criteria for or are enrolled in the following complex care services: • Health Home program • Intensive Outpatient and Partial Hospitalization Pilot Program (IOP/PH) • Mobile Crisis Response Services: • New Journey's First Episode Psychosis: • Program of Assertive Treatment (PACT): • Wraparound with Intensive Services (WISe): • Approved for Private Duty Nursing based on Apple Health criteria

	The client and caregiver meet at least one of the following: Client: • Clinical and/or physical decline that increases the client's medical or physical needs. • Complex clinical and/or behavioral needs (as described above) or placement on hospice. • Pregnant or recently postpartum. • Repeated emergency department use or multiple crisis encounters. Caregiver: • Medical needs (including but not limited to appointments, recovery after medical treatments or procedures, and having a contagious condition that would put the client at risk) • Needing additional rest to recover from a medical condition or event (including but not limited to injuries, pregnancy, and postpartum). • Requires services provided on an hour by hour basis due to the absence of or need for relief of those persons normally providing care to the individuals. • Requires services provided by the day/overnight on a short-term basis because of the absence of or relief need for those normally providing care to the individuals.
Duration and frequency (if applicable)	Eligible individuals may receive up to 336 hours of services per calendar year. The limit is inclusive of all in-home and in-facility services. Additional hours can be approved if the caregiver experiences an event, including medical treatment and hospitalization, that leaves an individual without their caregiver.
Implementation setting	Caregiver respite services are provided to the individual in their own home, health care facility, adult day care, or another location being used as the home. The service is inclusive of all in-home and in-facility services. Caregiver respite services cannot be provided virtually or via telehealth.

Provider type	Providers may include, but are not limited to: • Residential facility approved by the State • Providers contracted by county behavioral health • Behavioral health agencies • Home health agencies • Short-term Residential Therapeutic Program Providers or other care providers who are serving youth with complex needs • Respite facilities • Adult day cares • Adult Family Home • County Agencies • Residential Care Facility for the Elderly • Child Day Care Facility; Child Day Care Center; Family Child Care Home • Private Duty Nursing agencies • Licensed respite care agencies • Agencies providing meal services • Agencies providing housing for low-income clients • Crisis support agencies • Others as approved by the state

Specific Provider qualifications	Providers must have:
	• Experience and expertise with providing these unique services
	• Developmentally appropriate training for the population served
	Provided in under the supervision of the individuals service provider
	• Washington State registration as a licensed (RN, LPN, CNA, CMA, RMA, etc.), certified or registered caregiver or caregiver agency. Housing services provider, nutrition services provider, DME providers. Must be able to demonstrate:
	  ○ Sufficient staff to provide services as needed.
	  ○ Cultural competency.
	  ○ Credentialed by the appropriate Washington state agency with no restrictions.

- Signed Core Provider Agreement with the Washington Health Care Authority.

Environmental Accessibility, Remediation, and Adaptation

Description	Authorized by STC 15.2(b)(viii). Environmental accessibility, remediation and adaptation services provide physical changes to a home that are necessary to ensure the health, welfare, and safety of the individual or enable the individual to function with greater independence in the home. All services are subject to HCA approval. Services included are: • Accessibility Modifications • Remediation • Adaptation Home Devices ***Accessibility Modifications*** The provision of home/environmental accessibility modification services to eliminate known home-based health and safety risks and ensure the occupants' health and safety in the living environment. Examples of Accessibility Modifications include: • Ramps and grab-bars • Wheelchair access improvements like doorway widening, stair lifts, and roll-in showers • Installation of specialized electric and plumbing systems to accommodate medical equipment • Door and cabinet handles • Non-skid surfaces • Sound proofing • Overhead track systems • Stair lifts

- Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower)
- Installation and testing of a Personal Emergency Response System (PERS) for individuals who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed)

Remediation

The provision of home/environmental remediation services to eliminate known home-based health and safety risks and ensure the occupants' health and safety in the living environment. Examples of Remediation include:

- Allergen-impermeable mattress and pillow dustcovers
- Ventilation improvements and air filters
- Integrated Pest Management (IPM) services
- De-humidifiers
- Minor mold removal and remediation services
- Carpet replacement
- Housing safety inspections
- Installation of washable curtains or synthetic blinds to prevent allergens

Adaptation Home Devices

1. The provision, service delivery, and installation as needed of a home device to individuals for whom such equipment is clinically appropriate as a component of treatment or prevention for a home-device specific medical indication (e.g., air conditioner for individuals at health risk due to significant heat or
   heaters for individuals at increased health risk due to significant cold)
2. Air filtration devices for individuals at health risk due to compromised air quality, and replacement air filters as needed
3. Refrigeration units for individuals who lack a working refrigeration unit or a unit that meets their medical needs

	4. Portable power supplies (PPS's) for individuals who need access to electricity-dependent equipment (e.g., ventilators, dialysis machines, intravenous equipment, chair lifts, mobility devices, communication devices, etc.) or are at risk of public safety power shutoffs that may compromise their ability to use medically necessary devices Modifications must be conducted in accordance with applicable State and local building codes. Modifications are payable up to a total lifetime maximum of $7,500. An enrollee may receive an exception to this maximum if their physical condition or living situation has changed so significantly that additional modifications are necessary to ensure their health, welfare, or independence.
Eligible population	All individuals enrolled in Apple Health (Medicaid).

Social risk factors	For each corresponding service, eligible population who is:
	
	• Accessibility modifications/Remediation
	  ○ An individual or family who requires a clinically appropriate home modification/ remediation service and the housing can either be modified or remediated cost-effectively, or the housing cannot be modified or remediated cost-effectively and the member needs a home inspection and/or to transition to another housing option.
	  ○ An individual or family who lives in housing that is physically inaccessible or unsafe due to a member's disability or medical condition and the housing can either be modified cost effectively, or the housing cannot be modified cost-effectively and the member needs a home inspection and/or to transition to another housing option.
	  ○ An individual or family who is living in housing that is negatively impacting their health, due to factors including but not limited to pests, mold, elements of the home are in

	disrepair, the member has exposure to pathogens/hazards, and/or the property is inadequately maintained, and the member either needs a home inspection or healthy home good, or the member needs to transition to another housing option. • Adaptation Home Devices: ○ Individuals at risk for institutionalization due to inaccessible living environments

Clinical risk factors	For each corresponding service, eligible population who has:
	
	• Accessibility modifications:
	  ○ Chronic health conditions causing physical limitations with inaccessible living environments
	
	• Remediation:
	  ○ Chronic health conditions for which remediation may be reasonably expected to improve health outcomes, such as (but not limited to) poorly controlled asthma, COPD, or other chronic respiratory conditions such as cystic fibrosis or interstitial lung disease
	
	• Adaptation Home Devices:
	  ○ Chronic health conditions for which devices may be reasonably expected to improve health outcomes and device specific medical indications for adaptation home devices, including:
	  ▪ Air conditioners for individuals at health risk due to significant heat;
	  ▪ Heaters for individuals at increased health risk due to significant cold;

	▪ Air filtration devices for individuals at health risk due to compromised air quality, and replacement air filters as needed; ▪ Refrigeration units for individuals who lack a working refrigeration unit or a unit that meets their medical needs (e.g., because it has inadequate temperature controls to meet their medication storage needs, etc.); or, ▪ Portable power supplies (PPS's) for individuals who need access to electricity-dependent equipment (e.g., ventilators, dialysis machines, intravenous equipment, chair lifts, mobility devices, communication devices, etc.) or are at risk of public safety power shutoffs that may compromise their ability to use medically necessary devices.
Duration	N/A
Implementation setting	The services are available in a home that is owned, rented, leased, or occupied by the individual or their caregiver. For a home that is not owned by the individual, the individual must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.). When authorizing services, the managed care plan must receive and document a current licensed health care provider's order specifying the requested services for the enrollee, a brief written evaluation specific to the enrollee describing how and why the service meets the needs of the individual; and that a home visit has been conducted to determine the suitability of any requested services. In most cases, enrollees and medical providers will need to work with a community-based organization that can conduct the home visit and

	support the enrollee through the choice and construction of services. These organizations may include Area Agencies on Aging and other community-based service organizations. In order to refer an enrollee for services, the medical provider may not have a financial relationship with the entities that conduct home visits or provide or install the determined service.
Provider type	Providers may include: • Home Health agencies • Medical equipment and supplies providers • Area Agencies on Aging (AAA) • Others as approved by the state
Specific provider qualifications	Providers must have experience and expertise in providing these unique services in a culturally and linguistically appropriate manner. • Qualified provider enrollment: For all Apple Health programs, providers are required to successfully complete the provider enrollment process and core provider agreements with HCA for health care services. For managed care, providers must also complete the credentialing process with each MCO. MCOs must ensure quality care is available through the provider, which may include onsite quality review as appropriate. • Qualified providers, acting within the scope of their license to practice and who are appropriately licensed and contracted, include: o Licensed and allowable providers. o Providers operating in Washington State must be licensed as above. • Providers of adaptation home devices during significant weather events (e.g., ACs during heat waves) must have knowledge and experience in providing such devices during significant weather events including the ability to store devices and distribute them prior to or

	during the event so that members have access to the devices when they need them most (i.e., while the event is taking place)

Case management, outreach, and education

Description	Authorized by STC 15.2(c). Community-Based Connector Services are case management, outreach, and education services which provide linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees. This service includes the following HRSN service navigation assistance activities: • Contacting and engaging individuals who belong to one or more HRSN Covered Populations and who may be eligible for HRSN services • Using multiple strategies for engagement, including in person meetings where the member lives, seeks care, or is accessible; community and street-level outreach; and mail, text, phone, and email; Working with the individual to provide the information necessary for assessment of HRSN service need, including through multiple engagements with the individual as needed • Helping the individual to enroll, re-enroll, or maintain enrollment in Apple Health • Providing help with securing and maintaining entitlements and benefits, such as TANF, WIC, SNAP, Social Security, Social Security Disability, and Veterans Affairs benefits, federal and state housing programs, and other federal and state benefits • Assisting in obtaining identification and other required documentation (e.g., Social Security card, birth certificate, prior rental history) needed to receive benefits and other supports

	• Connecting individuals to settings where basic needs can be met, such as access to shower, laundry, shelter, and food • Providing members who may have a need for medical, peer, social, educational, legal, and other related services with information and logistical support necessary to connect them with the needed resources and services • Providing application assistance and coverage of state and federal benefit programs' application fees as required for the services and activities listed above.
Eligible population	All individuals enrolled in Apple Health (Medicaid).
Social risk factors	Eligible populations who: • Are homeless or at risk of homelessness, as defined by 24 CFR 91.5 with the exception of the annual income requirement in 24 CFR 91.5 (1)(i); • Meet the USDA definition of low food security, or very low food security; • Experience poverty or near poverty, as defined by income below 200% of FPL; or • Screen positive for an HRSN.
Clinical risk factors	Eligible population with: • Complex behavioral health need: Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a mental illness; and/or Substance use need, where an assessment using the American Society of Addiction Medicine (ASAM) Criteria indicates that the individual meets at least ASAM level 1.0, indicating the need for outpatient Substance Use Disorder treatment. • Developmental disability need: An individual with an Intellectual Disability or Developmental Disability that requires services or supports to achieve and maintain care goals. • Individual assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring

improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support). Examples may include chronic conditions such as: congenital anomalies that adversely impact health or function, blindness, disabling dental disorders, chronic neurological diseases, chronic cardiovascular diseases, chronic pulmonary diseases, chronic gastrointestinal diseases, chronic liver diseases, chronic renal diseases, chronic endocrine diseases, chronic hematologic disorders, chronic musculoskeletal conditions, chronic infectious diseases, cancers, autoimmune disorders, immunodeficiency disorders or chronic immunosuppression.

- Needs for Assistance with ADLs/IADLs or Eligible for LTSS: An individual who needs assistance with one or more Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (iADLs)
- Interpersonal Violence Experience: An individual who is experiencing or has experienced interpersonal violence (IPV), including domestic violence (DV), sexual violence (SV), or psychological violence
- Repeated Emergency Department Use and Crisis Encounters: An individual with repeated use of emergency department care (defined as two or more visits in the past six months or five or more visits within the past 12 months); with two or more crisis encounters in the past six months or five or more crisis encounters in the past 12 months, which represent an exacerbation of mental health distress, defined to include: receipt of crisis/outreach team services; use of behavioral health mobile crisis, crisis respite services, or school behavioral health crisis services; any length of stay in an adult jail or youth detention facility; or any length of stay in emergency foster care; and who was exited from a housing or behavioral healthcare program (e.g., shelter setting, day habilitation program, etc.) or from a school or an early childhood program in the past 12 months due to behaviors that are likely manifestations of health conditions, including behavioral health and developmental syndromes, stemming from trauma, child abuse, and neglect

	Pregnant/Postpartum: An individual who is currently pregnant or up to 12 months postpartum. • Children less than 6 years of age: A child who is less than six years of age and currently has, at least one of the following: - Malnutrition or at risk of developmental or growth delay or impairment as a result of insufficient nutrition as a clinical risk factor for case management related to nutrition services only. - Child maltreatment as defined by the CDC (https://www.cdc.gov/violenceprevention/pdf/CM_Surveillance-a.pdf) - Is a child with a special healthcare need (CYSHCN) as defined by HRSA (https://mchb.hrsa.gov/programs-impact/focusareas/children-youth-special-health-care-needs-cyshcn#i) - Low birth weight of <2500 grams - Mental health condition - Health conditions, including behavioral health and developmental syndromes, stemming from trauma, child abuse, and neglect. • Adults 65 years of age or older: An adult who is 65 years of age or over and currently has at least one of the following: - Two or more chronic health conditions - Social isolation placing at risk for early death, neurocognitive disorders, sleep disruption, cardiovascular disease, and elder abuse - Malnutrition as a clinical risk factor for case management related to nutrition services only. - Health conditions, including behavioral health and developmental syndromes, stemming from trauma, child abuse, and neglect
Duration and frequency (if applicable)	N/A

Implementation setting	Services may be initiated and provided in the home and community, community-based, or clinical settings and may include but are not limited to: • Physical and behavioral health care settings • Tribal clinics • Community-based organizations • Social service organizations • Food banks and farmers markets • Day habilitation settings • Stabilization centers • Carceral settings, including prisons and jails • Housing agencies • Home and community • Others as approved by the state
Provider type	The state will contract directly with community and Native hubs to provide HRSN services. Community and Native hubs will be the sole contractors for case management, outreach, and education service under this demonstration: • Nine Community Hubs, each operated by a regional ACH, will provide case management services to Apple Health managed care and fee-for-service individuals in their associated region. • The Native Hub will provide case management services to Apple Health individuals statewide in close coordination and partnership with Washington Tribes.