DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region 10
2201 Sixth Avenue, MS/RX 43
Seattle, Washington 98121

JUN 2 2 2011

Susan Dreyfus, Secretary
Department of Social and Health Services
Post Office Box 45010
Olympia, Washington 98504-5010

RE: Washington State Plan Amendment (SPA) Transmittal Number 11-004

Dear Ms. Dreyfus:

The Centers for Medicare & Medicaid Services (CMS) Seattle Regional office has completed its review of Washington State Plan Amendment (SPA) Transmittal Number 11-004. This amendment provides for a voluntary program entitled *Cowlitz County Chronic Care Management*, which provides interventions to enrollees who reside in Cowlitz County and have been diagnosed with a chronic medical condition in addition to behavioral health issues.

This SPA is approved effective April 1, 2011.

If you have any additional questions or require any further assistance, please contact me, or have your staff contact Jan Mertel at (206) 615-2317 or Jan.Mertel@cms.hhs.gov.

Sincerely,

Carol J.C. Peverly
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc: Douglas Porter, Assistant Secretary

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 11-04

2. STATE: Washington

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

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

4. PROPOSED EFFECTIVE DATE
April 1, 2011

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2011 $75,000
b. FFY 2012 $150,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-C pgs 29-~~42~~ 43 **(P&I)**

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

~~Attachment 3.1-C pgs 29-42~~ **(P&I)**

10. SUBJECT OF AMENDMENT:

Cowlitz County Chronic Care Management

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Susan N. Dreyfus

14. TITLE:
Secretary

15. DATE SUBMITTED:
3-25-11

16. RETURN TO:
Ann Myers
Department of Social and Health Services
Medicaid Purchasing Administration
626 8th Ave SE MS: 45504
POB 5504
Olympia, WA 98504-5504

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: **MAR 25 2011**

18. DATE APPROVED: **June 22, 2011**

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
April 1, 2011

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Carol J.C. Peverly

22. TITLE: **Acting Associate Regional Administrator**
Division of Medicaid & Children's Health Operations

23. REMARKS:

6/22/11 - Pen & Ink changes authorized by the State.

FORM HCFA-179 (07-92)

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ALTERNATIVE BENEFITS

BENCHMARK BENEFIT PACKAGE/BENCHMARK EQUIVALENT BENEFIT PACKAGE

3.1 Amount, Duration, and Scope of Services

Medicaid is provided in accordance with the requirements of sections 1902(a), 1902(e), 1902(z), 1903(i), 1905(a), 1905(p), 1905(r), 1905(s), 1906, 1915, 1916, 1920, 1925, 1929, and 1933 of the Act; section 245(h) of the Immigration and Nationality Act; and 42 CFR Parts 431, 440, 441, 442, and 483

C. Benchmark Benefit Package and Benchmark Equivalent Benefit Package (provided in accordance with 1937 of the Act and 42 CFR Part 440).

The State elects to provide alternative benefits:

X Provided

Not Provided

___ Title of Alternative Benefit Plan A
___ Title of Alternative Benefit Plan B
___ Title of Alternative Benefit Plan C
X Title of Alternative Benefit Plan D - *Cowlitz County Chronic Care Management Project*

1. Populations and geographic area covered

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

a) Populations who are full benefit eligibility individuals in a category established on or before February 8, 2006, that may be required to enroll in an alternative benefit plan to obtain medical assistance.
(Note: Populations listed in section 1b. may not be required to enroll in a benchmark plan, even if they are part of an eligibility group included in 1a.)

For full benefit Medicaid eligibility groups included in the alternative benefit plan, please indicate in the chart below:

- Each eligibility group the state will require to enroll in the alternative benefit plan;
- Each eligibility group the state will allow to voluntarily enroll in the alternative benefit plan;
- Specify any additional targeted criteria for each included group (e.g., income standard);
- Specify the geographic area in which each group will be covered.

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Required Enrollment	Opt-In Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
		Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance		
		Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV)		
		Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI)		
		Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII)		
		Other mandatory categorically needy groups eligible under 1902(a)(10)(A)(i) as listed below and include the citation from the Social Security Act for each eligibility group: • •		
		Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX)		
		Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX)		
		Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)		
		Medicaid expansion/optional targeted low-income children eligible under 1902(a)(10)(A)(ii)(XIV)		
		Other optional categorically needy groups eligible under 1902(a)(10)(A)(ii) as listed below and include the citation from the Social Security Act for each eligibility group: •		

b) X

The following populations will be given the option to voluntarily enroll in an alternative benefit plan.

Please indicate in the chart below:

- Each eligibility group the state will allow to voluntarily enroll in the alternative benefit plan,
- Specify any additional targeted criteria for each included group (e.g., income standard).
- Specify the geographic area in which each group will be covered.

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Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	Mandatory categorically needy low-income parents eligible under 1931 of the Act		
	Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i):		
X	Individuals qualifying for Medicaid on the basis of blindness	*Categorically Needy - Aged, Blind and Disabled adults aged 21 and over, who reside in Cowlitz County, Washington at the time of enrollment, who have been determined at high risk of future high healthcare costs within the next 12 months* *Eligible clients receive services via the fee-for-service system. These are high risk clients with complex medical needs and are diagnosed with one of the following chronic medical conditions, in addition to a mental health and/or chemical dependency issue:* *Diabetes, Heart failure, coronary artery disease, cerebrovascular disease, renal failure, chronic pain associated with musculoskeletal conditions and other chronic illness including migraine, cancer, chronic respiratory conditions including asthma and/or COPD, hematological conditions such as hemophilia, and including persons with comorbid mental health and/or chemical dependency conditions.*	*Cowlitz County, Washington*

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Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area

		The eligible population will exclude clients:
		• *Under age 21;*
		• *Eligible for enrollment in the Department's Healthy Options managed care program;*
		• *Receiving hospice services;*
		• *Receiving case management services for HIV/AIDS;*
		• *Who have End Stage Renal Disease;*
		• *Who are Pregnant;*
		• *With Third Party Coverage that provides a comparable service;*
		• *Who become eligible for Medicare coverage, or*
		• *Clients enrolled in one of the following:*
		  • *The Washington Medicaid Integration Partnership (WMIP); or*
		  • *The Program of All Inclusive Care for the Elderly (PACE) program.*	

X	Individuals qualifying for Medicaid on the basis of disability	*Categorically Needy - Aged, Blind and Disabled adults aged 21 and over, who reside in Cowlitz County Washington at the time of enrollment, who have been determined at high risk of future high healthcare costs within the next 12 months.* *Eligible clients receive services via the fee-for-service system. These are high risk clients with complex medical needs and are diagnosed with one of the following chronic medical conditions, in addition to a mental health and/or chemical dependency issue.* *Diabetes, Heart failure, coronary artery disease, cerebrovascular disease, renal failure, chronic pain associated with musculoskeletal conditions and other chronic illness including migraine, cancer, chronic respiratory conditions including asthma and/or COPD, hematological conditions such as hemophilia, and including persons with comorbid mental health and/or chemical dependency conditions.*	*Cowlitz County, Washington*

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Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area

		The eligible population will exclude clients:
		• *Under age 21;*
		• *Eligible for enrollment in the Department's Healthy Options managed care program;*
		• *Receiving hospice services;*
		• *Receiving case management services for HIV/AIDS;*
		• *Who have End Stage Renal Disease;*
		• *Who are Pregnant;*
		• *With Third Party Coverage that provides a comparable service;*
		• *Who become eligible for Medicare coverage, or*
		• *Clients enrolled in one of the following:*
		  • *The Washington Medicaid Integration Partnership (WMIP); or*
		  • *The Program of All Inclusive Care for the Elderly (PACE) program.*	

	Individuals who are terminally ill and receiving Medicaid hospice benefits under 1902(a)(10)(A)(ii)(vii)		
	Institutionalized individuals assessed a patient contribution towards the cost of care		
	Individuals dually eligible for Medicare and Medicaid		
	Disabled children eligible under the TEFRA option - section 1902(e)(3)		
X	Medically frail and individuals with special medical needs	*Categorically Needy - Aged, Blind and Disabled adults aged 21 and over, who reside in Cowlitz County Washington at the time of enrollment, who have been determined at high risk of future high healthcare costs within the next 12 months.* *Eligible clients receive services via the fee-for-service system. These are high risk clients with complex medical needs and are diagnosed with one of the following chronic medical conditions, in addition to a mental health and/or chemical dependency issue.*	*Cowlitz County, Washington*

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Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area

		Diabetes, Heart failure, coronary artery disease, cerebrovascular disease, renal failure, chronic pain associated with musculoskeletal conditions and other chronic illness including migraine, cancer, chronic respiratory conditions including asthma and/or COPD, hematological conditions such as hemophilia, and including persons with comorbid mental health and/or chemical dependency conditions.
		
		The eligible population will exclude Clients:
		• *Under age 21;*
		• *Eligible for enrollment in the Department's Healthy Options managed care program;*
		• *Receiving hospice services;*
		• *Receiving case management services for HIV/AIDS;*
		• *Who have End Stage Renal Disease;*
		• *Who are Pregnant;*
		• *With Third Party Coverage that provides a comparable service;*
		• *Who become eligible for Medicare coverage, or*
		• *Clients enrolled in one of the following:*
		  • *The Washington Medicaid Integration Partnership (WMIP); or*
		  • *The Program of All Inclusive Care for the Elderly (PACE) program.*	

	Children receiving foster care or adoption assistance under title IV-E of the Act		
	Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII)		
	Individuals eligible as medically needy under section 1902(a)(10)(C)(i)(III)		
	Individuals who qualify based on medical condition for long term care services under 1917(c)(1)(C)		

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Limited Services Individuals

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	TB-infected individuals who are eligible under 1902(a)(10)(A)(ii)(XII)		
	Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v)		

c) For optional populations/individuals (checked above in 1a. & 1b.), describe in the text box below the manner in which the State will inform each individual that:

- Enrollment is voluntary;
- Each individual may choose at any time not to participate in an alternative benefit package and;
- Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State plan.

Eligible clients are encouraged to participate in the program through mailings from the state, coordinated outreach by the CCM contractor and their community partners (including mental health agencies, agencies providing services to the homeless, chemical dependency programs and the Community Health Centers who participate in the project), and telephonic outreach by the CCM contractor. Clients who choose to participate in the program maintain eligibility for the regular Medicaid benefits at all times. The opt-in program provides chronic care management services to clients determined to be in the high-risk group described above.

Clients are told at the time they are contacted (and via correspondence if that is the method of contact) that they are not required to participate in the program to maintain Medicaid benefits, and that they may end their enrollment at any time. Clients are also told they may re-enroll at a later time, if they determine they would like to participate in the program.

The state monitors this requirement via review of letters and documents, as well as client records kept by the RN care managers.

An Enrollee or his/her representative may request disenrollment from the program at any time for any reason by calling the Department or the Contractor. Enrollees or their representatives may also request re-enrollment into the program at any time if he or she still meets eligibility requirements. Enrollment in the program or disenrollment from the program shall be made prospectively for the month following the month in which the request was made.

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2. Description of the Benefits

X The State will provide the following alternative benefit package (check the one that applies).

a) X Benchmark Benefits

FEHBP-equivalent Health Insurance Coverage – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(I) of Title 5, United States Code.

State Employee Coverage – A health benefits coverage plan that is offered and generally available to State employees within the State involved.

In the text box below please provide either a World Wide Web URL (Uniform Resource Locator) link to the State's Employee Benefit Package or insert a copy of the entire State's Employee Benefit Package.

Coverage Offered Through a Commercial Health Maintenance Organization (HMO) – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State involved.

In the text box below please provide either a World Wide Web URL link to the HMO's benefit package or insert a copy of the entire HMO's benefit package.

X **Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide a full description of the benefits in the plan, including any applicable limitations. Also include a benefit by benefit comparison to services in the State plan or to services in any of the three Benchmark plans above.

In addition to all regular Medicaid program benefits, the alternative benefit package provides a locally based Chronic Care Management (CCM) Program to eligible Medicaid clients through a coordinated system of services provided by the Community Mental Health Agency (CMHA) in partnership with medical and chemical dependency agencies. This program will offer a comprehensive, voluntary program that incorporates outreach, chronic care management, health education and assistance to clients in managing their chronic healthcare conditions. Additionally, the Contractor will provide coordination of medical, mental health and chemical dependency services, and other community services based on the needs of program Enrollees.

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To provide some perspective on the population being served by this program, the State has gathered the following information:

- *Virtually all high-cost Medicaid beneficiaries have multiple physical and behavioral health conditions and disabilities.*
- *For people with disabilities, each additional chronic condition is associated, on average, with an increase in costs of approximately $8,400/year. (CHCS Briefing Paper, March 08)*
- *Nearly two-thirds (61%) of adults on Medicaid have a chronic condition; almost 83% have 3 or more; Over 60% have 5 or more. Because most of these clients receive SSI benefits, they are in unmanaged fee-for-service medical systems, with little access to medical and behavioral health services or assistance in coordinating their care. (CHCS, October 2007)*
- *In Washington State, 5% of Medicaid beneficiaries account for 50% of the costs. (Governor Memo 09/06)*

To provide SSI clients with some form of care coordination and assistance in managing their multiple healthcare conditions, the State contracts with entities to provide chronic care management.

The Contracted provider will work to develop strong provider partnerships, utilizing the CMHA setting as the foundation for service provision, including local medical providers, other mental health centers, chemical dependency treatment centers, community housing/homelessness resources, and community corrections and social services agencies. The Contracted provider will provide Technical Assistance to providers who act as PCPs for program Enrollees to assist them in managing the Enrollee's condition and coordinate services with other community providers. ***Note****: There is a single provider contracted to provide services for this program.*

When an eligible client is referred to the chronic care management program, the contractor's outreach staff shall work to locate the client to describe the program, obtain the client's consent to participate in the program and conduct the nonmedical portion of the initial assessment. These activities are conducted by licensed Social Workers and a Licensed Practical Nurse, under the direction of the Registered Nurse Care Manager. The care management nurse will then contact the Enrollee to conduct the nursing assessment portion of the assessment.

Upon receipt of client data supplied by the State, the contractor shall determine the following:

1. *Determine where Enrollees have received mental health services; either through the Regional Support Network, or the fee-for-service system;*
2. *Determine which eligible clients have access to primary care and other needed resources, including whether the client has had a non-emergent primary care visit within the last year:*
    a. *If the client does not have regular access to primary care, work with local clinics and primary care providers to obtain a primary care provider (PCP) for the client;*
    b. *For clients who have not accessed services through the mental health system but have an indication of a mental health diagnosis, the Contractor will work to locate and contact the client to determine why he or she has not accessed mental health services;*
    c. *For clients determined to have a mental health need, the Contractor shall conduct an initial assessment to determined whether he or she meets the Access to Care Standards (ACS) for receiving services through the RSN system;*

d. For clients who have not accessed services through the chemical dependency system but have an indication of a chemical dependency diagnosis, the Contractor will 1) work to locate and contact the client to determine why he or she has not accessed chemical dependency services; 2) provide assistance in gaining access to chemical dependency services and 3) work with the client and provider to develop a treatment plan as part of the care management treatment plan.

e. If he or she is eligible, provide assistance in gaining access to mental health services and work with the client and provider to develop a treatment plan;

f. If the client does not meet ACS, use the information obtained in the mental health intake evaluation and transmitted to the Care Manager from the mental health provider to assist the Enrollee and PCP to coordinate a treatment plan through the PCPs office and the chronic care management program.

3. After the Client has consented to participate, the RN nurse care manager works with the care team to develop a care plan with active participation by the Enrollee, representatives of the Enrollee's identified natural support network when chosen by the Enrollee, and his or her care providers (physical health, mental health and/or chemical dependency treatment as appropriate) in goal setting and prioritization.

4. A care manager or other care team member accompanies the Enrollee to mental health, chemical dependency or medical and other healthcare appointments as desired by the Enrollee, and will facilitate access to available community resources as indicated by the Enrollee's care plan.

5. The Care Management staff provides technical assistance to providers who act as PCPs for program Enrollees to manage the Enrollee's condition and coordinate services with other community providers. The Contractor's staff shall conduct case conferences with medical and other providers involved in Enrollee treatment as necessary in order to share information as permitted by Enrollee consent or medical information regulations. Enrollee-specific and common issues shall be discussed in order to maximize the problem-solving of the multidisciplinary team.

6. The care manager ensures that the care team takes the Enrollee's health needs into account by overseeing that the following activities are conducted:

a. Screen and assess risk factors, health status, self-management skills, level of readiness for self management (using PAM-13 or other metric as mutually determined by the Contractor and the State), depression status (using PHQ-9 or other metric as mutually determined by the Contractor and the State) adherence to provider's treatment plan, knowledge of and adherence to prescribed medication, housing status, as well as the Enrollee's specific needs, including limited English proficiency and health literacy;

b. Encourage the Enrollee to sign a Release of Information form to facilitate exchange of information between the care management program and other health care and social services providers;

c. Attempt to link the Enrollee to a primary care provider if the Enrollee does not have one;

d. Develop a care plan specific to the areas of risk identified in the Health Risk Assessment, including goals set together with the Enrollee, so the Enrollee may develop the skills to:

i. *Self-manage his/her condition(s);*
ii. *Understand the appropriate use of resources needed to care for his/her condition(s);*
iii. *Identify "triggers" that negatively affect his/her health condition with the goal of seeking appropriate attention before he or she reaches crisis level;*
iv. *Utilize the health care system appropriately, including the importance of making and keeping scheduled appointment with primary care or other providers; and*
v. *Reach agreement with his or her medical provider on a treatment plan and adhere to that plan.*

e. *Develop interventions to educate Enrollees on the skills described above, including how to navigate through the complex healthcare systems;*

f. *Determine the frequency of follow-up during the participation period based on the Enrollee's risk level;*

g. *Coordinate referrals and mental health intake evaluations for Enrollees who request mental health services or who are assessed in the initial screening as needing mental health services;*

h. *Coordinate referrals and intake evaluations for Enrollees who request chemical dependency services or who are assessed in the initial screening as needing chemical dependency services. The Contractor's staff shall ensure that the Enrollee has a signed Release of Information form to facilitate exchange of information between the care manager and the chemical dependency program. Additionally, the care manager shall support the Enrollee to get to treatment appointments and shall provide support in transitioning the Enrollee to care in the community when treatment has been completed.*

7. *Based on the results of the assessment, determine the frequency of visits between the care manager and the Enrollee. The nurse shall meet with the Enrollee in the location of his or her choice, unless the Contractor determines that this location is unsafe for the nurse; in this case, the nurse shall attempt to find a location that is mutually acceptable.*

8. *The Contractor's progress is measured, at minimum, for success at achieving the following process and outcome measures:*

a. *An engagement rate of at least 40% of potential Enrollees who have been identified by the Department as eligible for the CCM program. For the purposes of this project, engagement means that eligible Clients as have been contacted by the contractor's outreach staff, have agreed to participate in the CCM program and have completed an initial assessment;*

b. *An increase in formal linkages and communication mechanisms among community providers who serve Enrollees;*

c. *An increase in the number of Enrollees with an identified primary care provider;*

d. *An increase in the number of Enrollees receiving appropriate mental health and chemical dependency treatment;*

e. *A decrease in avoidable Enrollee emergency room visits;*

f. *A decrease in Enrollee hospitalizations.*

9. *The Contractor maintains documentation of services provided by the CCM program for each Enrollee. The Contractor shall share information with the Enrollee's medical providers and/or case managers as needed to ensure the Enrollee receives necessary services and periodically to maintain reasonable and relevant communication with the Enrollee's healthcare and social service providers. Documentation includes:*

   a. *An ongoing record of the Enrollee's health status.*
   b. *A description of efforts to contact Enrollees by: telephone, mail and/or in person;*
   c. *Coordination activities with other entities;*
   d. *Name of Primary Care Provider;*
   e. *Results of initial screening and Health Risk Assessment (HRA) including the PAM™-13 and PHQ9 for each new Enrollee;*
   f. *Referrals for mental health or chemical dependency services;*
   g. *Description of CCM interventions;*
   h. *Results of CCM interventions;*
   i. *Notes on Enrollee participation towards development of self-management skills and meeting his or her treatment goals;*
   j. *Information and education provided to the Enrollee to help improve the Enrollee's self-management skills;*
   k. *Copies of the Release of Information (ROI) signed by the Enrollee to allow exchange of information on the Enrollee's health status among the Contractor's staff and other providers. A copy of the ROI is also sent to the State's Research and Data Analysis Division for inclusion into the PRISM risk modeling program.*

Clients eligible for this voluntary chronic care management program must be residing in Cowlitz County, Washington, at the time of enrollment. If the enrollee moves to one of the following contiguous zip codes during enrollment, maintains a health home in Cowlitz County, and is actively engaged in the chronic care management program, he or she may continue to receive program services via the Contractor. If the enrollee disenrolls or loses eligibility while living in a contiguous zip code, he or she may not re-enroll in the program unless he or she moves back to Cowlitz County.

Zip codes contiguous to Cowlitz County are as follows:

1. *Lewis County:*
   - *98538 – Curtis*
   - *98564 – Mossyrock*
   - *98572 – Pe Ell*
   - *98591 – Toledo*
   - *98593 – Vader*

2. *Clark County:*
   - *98601 – Amboy*
   - *98629 – La Center*
   - *98642 - Ridgefield*
   - *98675 - Yacolt*

3. *Wahkiakum County:*
   - *98612 - Cathlamet*

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b) Benchmark-Equivalent Benefits.

Specify which benchmark plan or plans this benefit package is equivalent to:

(i) Inclusion of Required Services -- The State assures the alternative benefit plan includes coverage of the following categories of services: (Check all that apply).

Inpatient and outpatient hospital services;

Physicians' surgical and medical services;

Laboratory and x-ray services;

Well-baby and well-child care services as defined by the State, including age-appropriate immunizations in accordance with the Advisory Committee on Immunization Practices;

Other appropriate preventive services including emergency services and family planning services included under this section.

(ii) Additional services

Insert a full description of the benefits in the plan including any limitations.

(iii) The State assures that the benefit package has been determined to have an aggregate actuarial value equivalent to the specified benchmark plan in an actuarial report that:

- Has been prepared by an individual who is a member of the American Academy of Actuaries;
- Using generally accepted actuarial principles and methodologies;
- Using a standardized set of utilization and price factors;
- Using a standardized population that is representative of the population being served;
- Applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
- Takes into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

Insert a copy of the report.

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iv ¦ The State assures that if the benchmark plan used by the State for purposes of comparison in establishing the aggregate value of the benchmark-equivalent package includes any of the following four categories of services, the actuarial value of the coverage for each of these categories of services in the benchmark-equivalent coverage package is at least 75 % of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State:

- Prescription drugs;
- Mental health services;
- Vision services, and/or
- Hearings services,

In the text box below provide a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c) ___ Additional Benefits

___ Insert a full description of the additional benefits including any limitations.

Other Additional Benefits (If checked, please describe)

3. Service Delivery System

Check all that apply.

¦ The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider.

¦ The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1905(a)(25) and 1905(t).

¦ The alternative benefit plan will be provided through a managed care organization consistent with applicable managed care requirements (42 CFR 438, 1903(m), and 1932).

The alternative benefit plan will be provided through PIHPs (Pre-paid Inpatient Health Plan) consistent with 42 CFR 438.

X The alternative benefit plan will be provided through PAHPs (Pre-paid Ambulatory Health Plan).

Alternative benefit services for will be offered through Prepaid Ambulatory Health Plan Contracts (PAHPs) between chronic care management providers and the state. All other Medicaid State Plan services will be provided via the state's fee-for-service system and Regional Support Network for Mental Health services.

1937 STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

____ The alternative benefit plan will be provided through a combination of the methods described above. Please describe how this will be accomplished.

4. Employer Sponsored Insurance

The alternative benefit plan is provided in full or in part through premiums paid for an employer sponsored health plan.

5. Assurances

The State assures EPSDT services will be provided to individuals under 21 years old who are covered under the State Plan under section 1902(a)(10)(A).

Through Benchmark only

As an Additional benefit under section 1937 of the Act

X The State assures that individuals will have access to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

X The State assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Act.

X The State assures transportation (emergency and non-emergency) for individuals enrolled in an alternative benefit plan. Please describe how and under which authority(s) transportation is assured for these beneficiaries

Transportation is provided by the State through the transportation services program derived from and authorized under the State Plan Attachment 3.1-A page 62 Sec. 24 Transportation. Transportation is provided through statewide brokered services contracts.

6. Economy and Efficiency of Plans

X The State assures that alternative benefit coverage is provided in accordance with Federal upper payment limits, procurement requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Rates information, including certification of actuarial soundness, will be submitted with the rates and contract package.

7. Compliance with the Law

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

8. Implementation Date

X The State will implement this State Plan amendment on *April 1, 2011*