



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

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

November 17, 2005

Robin Arnold-Williams, Secretary
Department of Social and Health Services
PO Box 45010
Olympia, Washington 98504-5010

Washington State Plan Amendment 05-013

Dear Ms. Arnold-Williams:

We have completed our review of State Plan Transmittal Number 05-013 which amends the Program of All-Inclusive Care for the Elderly (PACE) program. The amendment updates the PACE program information as described in Supplement 3 to Attachment 3.1-A, pages 6 through 14 to:

- Change references from "HCFA" to "CMS";
- Increase the needs allowance fee for PACE participants to:
 - \$ 51.62 for single participants
 - \$103.24 for couples
- Correct a typographical error on page 8;
- Update enrollment and disenrollment information to remove deemed eligibility;
- Update the name of the administering agency to the Aging and Disability Services Administration (ADSA) Home and Community Services (HCS) office; and
- Change the reference from "Comprehensive Assessment" to the name of the assessment tool which is "CARE".

This plan amendment is approved effective July 1, 2005 as requested by the State.

If you need additional assistance please contact Wendy Hill-Petras at (206) 615-3814 or wendy.hillpetras@cms.hhs.gov.

Sincerely,

Karen S. O'Connor
Associate Regional Administrator
Division of Medicaid and Children's Health

cc: Douglas Porter, Assistant Secretary, Medical Assistance Administration
Ann Myers, State Plan Coordinator, HRSA

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 05-013	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 July 1, 2005	

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 2005 \$0 b. FFY 2006 \$0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 3 to Attachment 3.1-A Pages 6 through 14	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Supplement 3 to Attachment 3.1-A Pages 6 through 14

DESCRIPTION OF AMENDMENT:

PACE Program Updates

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED: Exempt

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: <i>Robin Arnold-Williams</i>	16. RETURN TO: Ann Myers Department of Social and Health Services Health and Recovery Services Administration 925 Plum St SE MS: 45533 Olympia, WA 98504-5533
13. TYPED NAME: ROBIN ARNOLD-WILLIAMS	
14. TITLE: Secretary	
15. DATE SUBMITTED: Sept. 21, 2005	
17. DATE RECEIVED: SEP 22 2005	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: SEP 22 2005	18. DATE APPROVED: NOV. 17, 2005
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DATE OF APPROVED MATERIAL: July 01, 2005	SIGNATURE OF REGIONAL OFFICIAL: <i>[Signature]</i>
TYPED NAME: Karen S. O'Connell	TITLE: Associate Regional Administrator Division of Medicaid and Children's Health
REMARKS:	

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Spousal Post Eligibility

3. X State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a) Allowances for the needs of the:

1. Individual (check one)

(A) The following standard included under the State plan (check one):

- 1. SSI
- 2. Medically Needy
- 3. The special income level for the institutionalized
- 4. Percent of the Federal Poverty Level: %
- 5. X Other (specify):
 - *Institutions*: \$51.62 for single or \$103.24 for a couple.
 - *Community residential facility*: MNIL
 - *Home*: MNIL for single (with community spouse) 100% of Federal Poverty Level for married couple, both on PACE.

(B) The following dollar amount:

(C) The following formula is used to determine the needs allowance:

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

II. Compliance and State Monitoring of the PACE Program

For State Medicaid Agencies also serving as PACE State Administering Agencies, the State further assures all requirements of section 1934 of the Social Security Act will be met. All relevant provisions are included in the contract with the PACE entities, either as contractor or State responsibility. Both scheduled and unscheduled on-site reviews will be conducted by State staff.

- A. **Readiness Review:** The State will perform a Readiness Review of the applicant entity that assures the entity has fully developed its policies and procedures, obtained commitments from key staff, developed its solvency plan and has a facility that meets State and Federal requirements at the time of the application, in accordance with Section 460.12(b)(1).
- B. **Monitoring During Trial Period:** During the trial period, the State, in cooperation with CMS, will conduct comprehensive reviews of a PACE organization to ensure compliance with State and federal requirements.

At the conclusion of the trial period, the State, in cooperation with CMS, will continue to conduct reviews of a PACE organization, as appropriate, taking into account the quality of care furnished and the organization's compliance with State and federal requirements.

- C. **Annual Monitoring:** The State assures that at least annually it will reevaluate whether a participant meets the level of care required under the State Medicaid plan for coverage of nursing facility services. The State understands that this determination may be waived if there is no reasonable expectation of improvement or significant change in the participant's conditions because of the severity of a chronic condition or the degree of impairment of functional capacity.

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D. Monitoring of Corrective Action Plans: The State assures it will monitor the effectiveness of corrective actions required to be taken by the PACE organization.

III. Rates and Payments

A. The State assures CMS that the capitated rates will be equal to or less than the cost to the agency of providing those with fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

Rate Methodology

Actual fee-for-service data for calendar year 2001, after comparison with calendar year 2000 data and adjusted, was trended forward by adding the various vendor rate increases authorized by the legislature. Data was initially arrayed based on gender, age in 10-year increments, Medicare eligibility (Medicaid only and dual eligibility) service program (nursing home or HCBS) and service type (acute and long-term care). Only services received by persons eligible for nursing facility services or HCBS, residing in King County, age 55 and over were included in the base data.

The following four groups, as approved by CMS, will be used to determine payment for PACE:

- Medicaid Eligible Only, age 64 and under;
- Medicaid Eligible Only, age 65 and above;
- Medicaid & Medicare Eligible, age 64 and under;
- Medicaid & Medicare Eligible, age 64 and above.

1. X Rates are set at a percent of fee-for-service costs
2. Experience-based (contractors/State's cost experience or encounter date) (please describe) – See rate methodology above
3. Adjusted Community Rate (please describe)
4. Other (please describe)

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- B. X The rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.
Actuary Tim Barclay, from Milliman USA, Incorporated, 1301 Fifth Avenue, Suite #3600, Seattle, WA 98101-2605 is responsible for determining the rates to be reasonable and predictable.
- C. X The State will submit all capitated rates to the CMS Regional Office for prior approval.
 - A. IV. Enrollment and Disenrollment: For both State Medicaid Agencies and State Administering Agencies, the State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month. In cases where the State Medicaid Agency is separate from the State Administering Agency, the State Medicaid Agency assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the two agencies.

Enrollment Process (please describe):

The State Administering Agency assesses any potential participant including those who are not eligible for Medicaid to ensure that the individual meets the nursing facility level of care. Eligible individuals may enroll the first of the month following the date the PACE organization received the signed enrollment agreement. The agency will conduct a face-to-face reassessment of PACE clients every twelve (12) months and/or whenever the client's circumstances or physical condition substantially changes.

Medicaid Eligible Only, age 64 and under;
Medicaid Eligible Only, age 65 and above;
Medicaid & Medicare Eligible, age 64 and under;
Medicaid & Medicare Eligible, age 65 and above.

- 1. X Rates are set at a percent of fee-for-service costs
- 2. Experience-based (contractors/State's cost experience or encounter date) (please describe) – See rate methodology above
- 3. Adjusted Community Rate (please describe)
- 4. Other (please describe)

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- R. Enrollee Information (Please describe the information to be provided to enrollees): Enrollees shall receive a copy of their CARE: Service Summary, financial award notices, and notice of fair hearing rights for any adverse actions. Enrollees are entitled to a fair hearing after it has gone through the PACE organization's internal appeal process. Medicaid fair hearing rights shall be translated for individuals with limited English proficiency.

The State assures that the following information is provided to all enrollees prior to and at the time of enrollment and annually thereafter, by the PACE organization in accordance with its approved policies and procedures.

Detailed information about 460.112, Participant Rights, 460.120, 460.122, Grievance and Appeals processes; 460.154, Enrollment Agreement; and 460.156, Other enrollment procedures are contained in the Participant Handbook of which the Enrollment Agreement is a part.

The process for explaining the information contained in the Participant Handbook, in a manner understandable to the enrollee, is conducted in the following manner:

In accordance with Policy Number 301.03, issued 7/13/01, the process begins with a contact by telephone or in-person between the potential participant and the PACE Intake Coordinator. The Intake Coordinator, after making an initial determination of eligibility, arranges a home visit. During the home visit, the Intake Coordinator explains the PACE organization using the Participant Handbook and answers any questions from the individual and/or caregiver. If the individual is interested in joining, a site visit is arranged at which time the individual meets with members of the multidisciplinary team and again is provided with opportunities to ask questions.

At this time, the Intake Coordinator contacts the Aging and Disability Services Administration (ADSA) Home and Community Services (HCS) office to start the process of determining functional and financial eligibility for individuals requesting Medicaid coverage, or to determine functional eligibility only for individuals who pay privately.

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If the individual is determined to be eligible and if the individual agrees to accept the program conditions, he/she signs an enrollment agreement in accordance with Policy 301.04, issued 7/13/01 which requires that all individuals who enroll in PACE must sign an enrollment agreement. Prior to signing, the Intake Coordinator again reviews the Participant Handbook with the individual and he/she receives a copy of the Handbook for reference.

All enrollees also receive a PACE enrollment card in accordance with the requirements in 460.156.

The State undertakes the following steps:

At the time of enrollment, the HCS case manager sends the PACE organization proof of nursing home certification contained in the CARE Assessment document. HCS will send proof of recertification on an annual basis. In addition, the HCS case manager provides the authorization for enrollment for Medicaid recipients and calculates the monthly participant fee for the enrollee, if any.

- C. Disenrollment Process (Please describe - voluntary and involuntary): The PACE organization will notify the state of involuntary disenrollments after the organization has followed its approved internal process. The state will respond within five business days of receiving the request for a review. The state will notify the enrollee of the adverse action and, the right to a fair hearing. Enrollees may choose to voluntarily disenroll from PACE at any time of the month. The state will assist with returning any disenrolled participant (voluntary or involuntary) to the previous Medicaid coverage program, effective the beginning of the next month possible.

The PACE organization follows Policy Number 302.1 for Voluntary Disenrollments:

All participants have the right to voluntarily disenroll from the PACE organization without cause at any time. Once the participant has notified the PACE organization staff that he/she wishes to disenroll, either in person or in writing, members of the multidisciplinary team work with the participants to see if the reasons(s) for disenrolling can be resolved. If there is no resolution, the PACE

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Social Worker has the individual or his/her caregiver sign the disenrollment form. The disenrollment form advises participants of the following:

- They may be contacted by HCS or CMS to verify their desire to disenroll
- Attests to the fact that they understand that they are disenrolling and
- That they have been informed that they will return to the traditional Medicare and Medicaid systems as of the disenrollment date and no longer are required to receive services through the PACE organization.

The social worker notifies the multidisciplinary team and the HCS case manager and financial worker regarding the anticipated date for disenrollment. The effective date of disenrollment will be the last day of the month administratively possible using the most expedient process available. The multidisciplinary team ensures that the participant is reinstated in other Medicare and Medicaid programs after disenrollment by making appropriate referrals, transferring medical records and coordinating with CMS and HCS to ensure participant's reinstatement. All services to the participant are continued during the disenrollment process.

The social worker sends the official disenrollment letter to the participant and his/her representative and the nursing home, if the participant is currently residing there. The social worker also notifies the PACE organization business office. The Accounting Assistant in the business office will remove the participant's name from the billing cycle and will report the disenrollment to CMS.

HCS undertakes the following steps:

An HCS representative may contact the former enrollee to verify his/her desire to disenroll.

- D. The State assures that before an involuntary disenrollment is effective, it will review and determine in a timely manner that the PACE organization has adequately documented grounds for disenrollment.

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- E. In the event a PACE participant disenrolls or is disenrolled from a PACE program, the State will work with the PACE organization to assure the participant has access to care during the transitional period.
 - F. The State assures it will facilitate reinstatement in other Medicaid/Medicare programs after a participant disenrolls.
 - G. The State assures that the State PACE requirements and State procedures will specify the process for how the PACE organization must submit participant information to the State.
- VI. Marketing: For State Medicaid Agencies also acting as PACE State Administering Agencies, the State assures that a process is in place to review PACE marketing materials in compliance with Section 460.82(b)(ii).
- VII. Services: The following items are the medical and remedial services provided to the categorically needy and medically needy. (Please specify): All services as allowed under the Washington State Medicaid State Plan, in Section 3.1A.
- The State assures that the State agency that administers the PACE program will regularly consult with the State Agency on Aging in overseeing the operation of the PACE program in order to avoid service duplication in the PACE service area and to assure the delivery and quality of services to PACE participants.
- VIII. Decisions that require joint CMS/State Authority
- A. For State Medicaid Agencies also acting as PACE State Administering Agencies, waivers will not be granted without joint CMS/State agreement:
 - 1. The State will consult with CMS to determine the feasibility of granting any waivers related to conflicts of interest of PACE organization governing board members.

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2. The State will consult with CMS to determine the feasibility of granting any waivers related to the requirements that: members of the multidisciplinary team are employees of the PACE organization; and that members of the multi-disciplinary team must serve primarily PACE participants.
 - B. Service Area Designations: The State will consult with CMS on changes proposed by the PACE organization related to service area designation.
 - C. Organizational Structure: The State will consult with CMS on changes proposed by the PACE organization related to organizational structure.
 - D. Sanctions and Terminations: The State will consult with CMS on termination and sanctions of the PACE organization.
- IX. State Licensure Requirements

For State Medicaid Agencies also acting as PACE State Administering Agencies, the State assures that Life Safety Code requirements are met for facilities in which the PACE organization furnishes services to PACE participants in accordance with Section 460.72(b), unless CMS determines that a fire and safety code imposed by State law adequately protects participants and staff.

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