Wellpoint • Washington | Foundational Community Supports Program

Provider Manual

Wellpoint

844-451-2828
provider.wellpoint.com/wa

Wellpoint retains the right to add to, delete from and otherwise modify this provider manual. Contracted providers must acknowledge this provider manual and any other written materials provided by Wellpoint as proprietary and confidential.

This provider manual, as part of your provider agreement and related addendums, may be updated at any time and is subject to change. The most updated version is available online at **https://provider.wellpoint.com/washington-provider/patient-care/foundational-community-supports**. To request a printed copy of this manual at no cost, call the FCS Program at **844-451-2828**.

If there is an inconsistency between information contained in this manual and the agreement between you or your facility and Foundational Community Supports (FCS) TPA, the agreement governs. In the event of a material change to the information contained in this manual, we will make all reasonable efforts to notify you through web-posted bulletins and other communications. In such cases, the most recently published information supersedes all previous information and is considered the current directive.

This manual is not intended to be a complete statement of all policies and procedures. We may publish other policies and procedures not included in this manual or on our website or in specially targeted communications including but not limited to bulletins.

Wellpoint does not engage in, aid or perpetuate discrimination against any person by providing significant assistance to any entity or person that discriminates on the basis of race, color or national origin in providing aid, benefits or services to beneficiaries. No person, on the grounds of handicap and/or disability, age, race, color, religion, gender, gender identity, national origin, or any other classification protected under federal or state laws shall be excluded from participation in, be denied the benefits of or be otherwise subjected to discrimination under any program or service provided in the Foundational Community Supports program. Wellpoint does not use or administer criteria having the effect of discriminatory practices on the basis of gender or gender identity and does not select site or facility locations that have the effect of excluding individuals from, denying the benefits of or subjecting them to discrimination on the basis of gender or gender identity.

In addition, in compliance with the *Age Act*, Wellpoint does not discriminate against any person on the basis of age or aid or perpetuate age discrimination by providing significant assistance to any agency, or organization or person that discriminates on the basis of age.

Please note: Per Section 3.7 of the *Provider Agreement*, the provider shall comply with the terms of the provider manual. Material in this provider manual is subject to change.

1. INTRODUCTION 4
1.1 Program Overview 7
1.2 Supportive Housing Services 7
1.3 Supported Employment Services 11
2. CONTACT INFORMATION 16
3. CLIENT ELIGIBILITY AND ENROLLMENT 18
3.1 General Eligibility Criteria 18
3.2 Referrals 18
3.3 Client Requests for Provider Change 20
3.4 Exception to Rule/Limited Extension Requests 20
3.5 Disenrollment 21
4. PROVIDER ROLES, RESPONSIBILITIES AND CREDENTIALING 22
4.1 General Requirements 22
4.2 Enrollment 23
4.3 Quality Monitoring and Reporting 25
4.4 Fraud, Waste and Abuse 27
4.5 Data Sharing and Transfers 32
4.6 Grievances, Appeals and Discrimination 34
4.7 Equal Program Access on the Basis of Gender 34
4.8 Support and Training for Providers 35
5. BILLING AND CLAIMS SUBMISSION 36
5.1 Provider Reimbursement 36
5.2 Claims Submission 36
5.3 Clearinghouse Submissions 36
5.4 Availity Portal 37
5.5 Electronic Claims Submissions 37
5.6 Paper Claims Submissions 38
5.7 Claims Adjudication 39
5.8 Clean Claim Payments 39
5.9 Claim Status 39
5.10 Overpayment Process 40
5.11 Provider Claim Payment Dispute Procedures 44
5.12 Claim payment reconsideration 44
5.13 Claims Payment Reconsideration 44
5.14 Claim Payment Appeal 45
5.15 Claim Correspondence 46

5.16 Claim Payment Dispute 47
5.17 Required Documentation for Claim Payment Disputes 47
6. PROGRAM APPROACH AND RESOURCES 48
6.1 Supportive Housing Services 49
6.2 Supported Employment Services 49
7. TRANSITION ASSISTANCE PROGRAM (TAP) 50
7.1 TAP Provider Credentialing 50
7.2 TAP Client Eligibility and Enrollment 50
7.3 Expenses Reimbursable with TAP Funding 50
7.3 FCS TAP Exception to Policy (ETP) 51
7.4 Requesting TAP Funding 52
7.5 FCS TAP Quality Assurance 52
7.6 FCS TAP Contact Information 52
APPENDIX A: FCS HMIS DATA CONSENT FORM 53
APPENDIX B: ELIGIBILITY ASSESSMENT FORMS 54
APPENDIX C: GOAL SETTING AND ACTION PLANNING 67
APPENDIX D: APPROVED FCS PROTOCOLS 68
APPENDIX E: CHAPTER 182-559 WAC 80

1. INTRODUCTION

Welcome to our network. We're glad you decided to join us.

Earning your respect and gaining your loyalty are essential to a successful collaboration in the delivery of quality services. This manual contains everything you need to know about us and how we work with you on the Foundational Community Supports (FCS) program.

This information is subject to change. We encourage use of the manual at **https://provider.wellpoint.com/washington-provider/patient-care/foundational-community-supports.** for the most up-to-date information.

And we want to hear from you! Participate in our advisory council or call our FCS team at **844-451-2828** with any suggestions, comments or questions. Together, we can make a difference in the lives of our clients.

Our Washington office

Address:	Wellpoint Foundational Community Supports TPA 705 5th Avenue South, Suite 300 Seattle, WA 98104
Phone:	**844-451-2828**
Fax:	**844-470-8859**

Important contact information

Department	**Details**
FCS Provider Services	Phone: **844-451-2828** The FCS team is available Monday-Friday from 8 a.m.-5 p.m. Pacific time. The interactive voice response (IVR) system is available 24 hours a day, 7 days a week. Interpreter Services For interpretation help, call the FCS phone line.
FCS Member Services	Phone: **844-451-2828** The FCS team is available Monday-Friday from 8 a.m.- 5 p.m. Pacific time. The interactive voice response (IVR) system is available 24 hours a day, 7 days a week.
Wellpoint Electronic Data Interchange	Availity Client Services at **800-AVAILITY** (**800-282-4548**)

Department	Details
Claims information	Submit claims online at **https://availity.com**.* Check claims status online. Electronic claims payer ID for clearinghouse: Availity: **WLPNT** Mail paper claims to: Washington Claims Wellpoint P.O. Box 61010 Virginia Beach, VA 23466-1010
Critical incident reporting	Critical incidents must be reported to Wellpoint on the same business day of occurrence or provider awareness. Reporting forms and instructions are available online at **https://provider.wellpoint.com/washington-provider/patient-care/foundational-community-supports**.
Client eligibility	Phone: **844-451-2828** Online: **https://www.waproviderone.org**
Operations intake — contract	Nonparticipating supported employment and/or supportive housing providers needing to contract can submit their request via email to FCSTPA@wellpoint.com. Include the following with your request: *W-9* NPI number (type 2 organization NPI) Provider Medicaid ID Primary contact information with address, phone number and email. If you are inquiring about the status of your contract, email FCSTPA@wellpoint.com and include the TIN of the contract you're inquiring about.
Operations intake — credentialing	To request initial credentialing or recredentialing on an existing contract, requesting the status of the credentialing process, requesting the change of a credentialing contact and/or credentialing address, or have general credentialing questions, email FCSTPA@wellpoint.com. Include the following information for all requests: Full facility name NPI number Tax ID number(s) facility is billing under

Department	Details
Operations intake — TIN changes	For TIN changes, email the following required information and documentation to FCSTPA@wellpoint.com: Copy of new *W-9* and former *W-9* Requested changes on letterhead with name, NPI number, TIN and any additional information (such as date of change). Note: The letter must have a physical signature; stamped signatures are not accepted.
Operations intake — address changes	For address changes, provider demographic updates, or terminations, email all relevant information to FCSTPA@wellpoint.com. For address changes: Specify if the request is for a practice address, billing/remit address or both. Phone numbers are required for all address change requests. Add the phone number to your request – even if it's unchanged – so we can ensure it is correct. For terminations: Include the full name of the facility, NPI and the effective date of the termination. For legal name changes: If the change is for the business name only, provide a new *W-9*.
Claim payment disputes	We have several options to file claim payment disputes:
	Verbally (for reconsiderations only): Call Provider Services at 1-833-731-2274.Online (for reconsiderations and claim payment appeals): Use the secure Provider Availity Payment Appeal Tool at **https://availity.com**. Through Availity, you can upload supporting documentation and receive immediate acknowledgement of your submission. Written (for reconsiderations and claim payment appeals): Mail all required documentation to: Payment Dispute Unit Wellpoint P.O. Box 61599 Virginia Beach, VA 23466-1599 Wellpoint requires the following information when submitting a claim payment dispute (reconsideration or claim payment appeal): Your name, address, phone number, email, and either your NPI number or TIN The member's name and Medicaid ID number A listing of disputed claims including the Wellpoint claim number and the date(s) of service(s) All supporting statements and documentation.
Wellpoint Customer Service	For physical and behavioral health member services may be reached Monday-Friday 8 a.m. to 5 p.m. at **833-731-2167** (TDD/TTY **800-855-2880**).

1.1 Program Overview

Wellpoint is the single third-party administrator (TPA) contracting with the Washington Health Care Authority for the Foundational Community Supports (FCS) program. As the third-party administrator, Wellpoint facilitates program implementation, enhances quality, supports providers and pays claims.

The FCS program provides targeted Apple Health (Medicaid) benefits to assist eligible individuals with complex health needs obtain and maintain stable housing and employment. These may include any of the following:

- Coaching
- Advocacy
- Information and referral
- Linking and coordinating
- Ongoing supports

The project aims to identify the interrelation of health problems and housing stability. Homelessness is cyclical and puts individuals/families at a greater risk for physical and mental health conditions and substance use disorders. There is also substantial evidence linking unemployment to poor physical and mental health outcomes, even in the absence of pre-existing conditions.

Employment is an important aspect of an individual's well-being and quality of life. Supported Employment assists people with disabilities to participate as much as possible in the competitive labor market, working in a preferred job with the level of support and services needed to obtain and maintain competitive employment in an integrated work setting.

The FCS program creates statewide, targeted home- and community-based services (HCBS) intended to help Apple Health (Medicaid) beneficiaries with complex health needs transition to and maintain community placements.

Supportive Housing services and Supported Employment services are the core benefits of the FCS program. They follow *WAC 182-559* and *STCs 59-67* protocol around providing a set of home- and community-based services (HCBS), including Community Support Services (CSS) and Supported Employment — Individual Placement and Support (IPS), to populations that meet the needs-based criteria. HCBS could be provided to members under a 1915(i) state plan amendment.

1.2 Supportive Housing Services

Supportive Housing services are a specific intervention for people who, but for the availability of services, do not succeed in housing and who, but for housing, do not succeed in services. Supportive Housing services help individuals who are homeless or unstably housed live with maximum independence in community-integrated housing.

Activities are intended to ensure successful community living through the utilization of skills training, cueing, modeling and supervision as identified by the person-centered assessment. Services can be provided flexibly, including in-person or on behalf of an individual.

Eligible Target Populations
Eligible populations for Supportive Housing services include individuals who are 18 or older and meet needs-based criteria and at least one risk factor:

- Have at least one assessed health needs-based criteria and is expected to benefit from community support services:
  - Mental health need where there is a need for improvement, stabilization or prevention of deterioration of functioning resulting from the presence of mental illness
  - Need for outpatient substance use disorder treatment
  - Need for assistance with three or more activities of daily living (ADL)
  - Need for hands-on assistance with one or more activity of daily living (ADL)
  - Complex physical health need — a long continuing or indefinite physical condition requiring improvement, stabilization or prevention of deterioration of functioning, including the ability to live independently without support
- Have at least one risk factor:
  - Are chronically homeless as defined by the U.S. Housing and Urban Development. (see note below).
  - History of frequent and/or lengthy stays in the settings defined in *24 CFR 578.3*, or from a skilled nursing facility as defined in *WAC 388-97-0001*:
    - Frequent is defined as two or more contacts in the past 12 months.
    - Lengthy is defined as 90 or more consecutive days within an institutional care facility.
  - History of frequent adult residential care stays:
    - Frequent is defined as two or more contacts in the past 12 months.
    - Adult residential care, enhanced adult residential care, or assisted living facilities as defined in *WAC 388-110-020*
    - Adult family homes as defined in *WAC 388-76-10000* ○ History of frequent turnover of in-home caregivers, where within the last 12 months the individual utilized three or more different in-home caregiver providers, and the current placement is not appropriate for the individual.
  - Have a PRISM score of 1.5 or above.

Note: This also includes individuals who previously met the U.S. Department of Housing and Urban Development (HUD) definition of chronic homelessness but have been housed in the last 60 days (Time housed may not exceed 60 days).

When billing, use this category of service: Supportive Housing services, per diem (code H0043).

The recommendation is that each per diem code is for at least 60 minutes of services, including at least one instance of face-to-face interaction with the client. Supportive Housing services will reflect a commitment to principles and philosophy of service including:

- **Tenant choice.** Supportive Housing tenants will be able to choose where they want to live.
  - Tenants cannot be evicted from their housing for rejecting services.

- **Access.** Supportive Housing units will be available to people who are experiencing homelessness, are precariously housed and/or who have multiple barriers to housing stability, including disabilities and substance abuse.
- **Quality.** Supportive Housing units will be similar to other units in the community.
- **Integration.** Supportive Housing tenants with disabilities will have a right to receive housing and supportive services in the most integrated settings available.
- **Independent, permanent housing.** Supportive Housing tenant leases or subleases will confer full rights of tenancy, including limitations on landlords' entry into the property and the right to challenge eviction in landlord-tenant court. Tenants can remain in their homes as long as the basic requirements of the lease are met.
- **Affordability.** Supportive Housing must meet tenants' affordability standards.
- **Coordination between housing and services.** Property managers and support service staff will stay in regular communication and coordinate their efforts to help prevent evictions and to ensure tenants facing eviction have access to necessary services and supports.
- **Delineated roles.** There will be a functional separation of roles, with the housing elements (rent collection, property maintenance, enforcement of tenancy responsibilities) carried out by different staff than those providing services.

Community Support Services

Community support services (CSS) are services that support individuals with 1) their ability to prepare for and transition to housing, including direct and collateral services, and 2) maintaining tenancy once housing is secured. Activities include the following:

Pre-tenancy supports

- Conducting a functional needs assessment identifying the member's preferences related to housing (for example, type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the member), assistance in budgeting for housing/living expenses, assistance in connecting the individual with social services to assist with filling out applications and submitting appropriate documentation in order to obtain sources of income necessary for community living and establishing credit, and in understanding and meeting obligations of tenancy
- Assisting individuals to connect with social services to help with finding and applying for housing necessary to support the individual in meeting their medical care needs
- Developing an individualized community integration plan based on the functional needs assessment as part of the overall person-centered plan
- Identifying and establishing short and long-term measurable goal(s), how goals will be achieved, and how concerns will be addressed
- Participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed
- Providing supports and interventions per the person-centered plan

Tenancy-sustaining services

- Providing service-planning support and participating in person-centered plan meetings at redetermination and/or revision plan meetings as needed

- Coordinating and linking the recipient to services including primary care and health homes; substance use treatment providers; mental health providers; medical, vision, nutritional and dental providers; vocational, education, employment and volunteer supports; hospitals and emergency rooms; probation and parole; crisis services; end of life planning; and other support groups and natural supports
- Providing entitlement assistance including obtaining documentation, navigating and monitoring the application process, and coordinating with the entitlement agency
- Assisting with accessing supports to preserve the most independent living, such as individual and family counseling, support groups, and natural supports
- Providing supports to assist the individual in the development of independent living skills, such as skills coaching, financial counseling and anger management
- Providing supports to assist the individual in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager
- Coordinating with the tenant to review, update and modify his or her housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers
- Connecting the individual to training and resources that will assist the individual in being a good tenant and lease compliance, including ongoing support with activities related to household management

CSS Minimum Service Levels

CSS encounters are based on a daily rate with a benefit limitation of 30 days over a 180-day authorization period. Any additional time within that 180-day period needs to be authorized as an exception by FCS staff.

CSS Exclusions

The CSS benefit does not include:

- Payment of rent or other room and board costs.
- Capital costs related to the development or modification of housing.
- Expenses for utilities or other regularly occurring bills.
- Goods or services intended for leisure or recreation.
- Duplicative services from other state or federal programs.
- Services to individuals in a correctional institution.

Note: CSS may not be provided or billed prior to an authorization for service.

Telephone Contact

Telephone calls of at least 15 minutes are billable. Whenever possible and appropriate, face-to-face contact with the member should be prioritized. For member contacts, phone calls should not represent the primary means of engagement, and we may reject claims that show an overreliance on phone contact that results in reduced quality of service to the member. Video conferences and video calls are considered face-to-face contact. Text messages and email communications are not billable.

1.3 Supported Employment Services

Supported Employment services assist those individuals who want to work and meet FCS criteria to become employed in integrated community employment. Activities are intended to ensure successful employment outcomes through the utilization of collateral contacts, skills training, cueing, modeling and supervision as identified by the person-centered assessment.

Individualized Supported Employment services include: identifying career and occupational targets, developing ongoing relationships with prospective employers, assisting with the interviewing and hiring process, and, once employed, support with maintaining employment. Coaching and skill-building of interpersonal relationships in the work setting as well as education for self-advocacy and support with the American with Disabilities Act are also included.

Individual Placement and Support

Individual Placement and Support (IPS) are services that help eligible individuals obtain and maintain stable employment. IPS services are based on the following principles and philosophy:

- **Competitive employment is the goal, and providers help clients obtain competitive jobs.** Competitive employment is defined as: paying at least minimum wage and the wage others receive, performing the same work based in community settings alongside others without disabilities, and not reserved for people with disabilities.
- **IPS supported employment is integrated with other behavioral and social services.** IPS supported employment services are closely integrated with the plan of care. When applicable, providers are members of multidisciplinary teams that meet regularly to review client progress. Discussions include clinical and rehabilitation information that is relevant to work, such as medication side effects, persistent symptoms, cognitive difficulties or other rehabilitation needs.
    - They share information and develop ideas to help clients improve their functional recovery.
- **There is zero exclusion.** Eligibility is based on client choice; every covered person who wants to work is eligible for IPS supported employment regardless of psychiatric or other diagnosis, symptoms, work history, or other problems, including substance abuse and cognitive impairment. The core philosophy of IPS supported employment is that all persons with a disability can work at competitive jobs in the community without prior training, and no one should be excluded from this opportunity. Agencies develop a culture of work so all practitioners encourage clients to consider working.
- **Services are based on clients' preferences and choices rather than providers' judgments.** Client preferences help determine the type of job that is sought, the nature of support provided by the employment specialist and team, and whether to disclose the aspects of a person's psychiatric disability to the employer.
- **Benefits counseling is important.** Providers help clients access ongoing guidance regarding Social Security, Apple Health (Medicaid) and other government entitlements. Fear of losing benefits is a major reason clients may not want to seek employment. It is vital that clients obtain accurate information to inform and guide the plan for starting work and, over time, for making decisions about changes in wages and work hours.
- **The job search should be rapid.** Providers help clients seek jobs directly rather than providing extensive pre-employment assessment and training or intermediate work experiences. Beginning the job search process early (i.e., within 30 days) demonstrates to

clients their desire to work is taken seriously and conveys optimism that there are multiple opportunities available in the community for clients to achieve their vocational goals.

- **Job development is systematic.** Providers develop relationships with employers based on their clients' work preferences by meeting face-to-face over multiple visits. Providers learn about the work environment and the employers' work needs. They find out about jobs they may not be aware of at employment sites. They gather information about the nature of job opportunities and assess whether they may be a good job fit. Providers continue to make periodic visits because networking is how people find jobs.
- **Support should be time-unlimited.** Follow-along supports are individualized and continued for as long as the client wants and needs the support. IPS specialists and other members of the treatment team provide work support. In addition, they look for natural supports (for example, family member, coworker) that would be available over time. The goal is to help the client become as independent as possible in his or her vocational role while providing support and assistance as needed. Once a person has worked steadily (for example, one year), they discuss transitioning from IPS.

IPS Exclusions

IPS does not include:

- Generalized employer contacts that are not connected to a specific enrolled individual or an authorized service.
- Employment support for individuals in subminimum or sheltered workshop settings,
- Facility-based habilitation or personal care services.
- Wage or wage enhancements/supplements for individuals.
- Duplicative services from other state or federal programs.

Note: IPS may not be provided or billed prior to an intake and authorization for service.

Telephone Contact

Telephone calls of at least 15 minutes are billable. Whenever possible and appropriate, face-to-face contact with the member should be prioritized. For member contacts, phone calls should not represent the primary means of engagement, and we may reject claims that show an overreliance on phone contact that results in reduced quality of service to the member. Video conferences and video calls are considered face-to-face contact. Text messages and email communications are not billable.

Eligible Target Populations

The individual is at least 16 years of age and meets at least one of the following health needs-based criteria and is expected to benefit from IPS:

1. Enrolled in the state Housing and Essential Needs (HEN), or Aged, Blind or Disabled (ABD) Program. (Please provide the reward letter.)
2. The individual is assessed to have a behavioral health need, which is defined as one or both of the following:
    a. Mental health needs, 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

b. Substance use needs, where an assessment using the American Society of Addiction Medicine (ASAM) criteria indicates the individual meets at least ASAM level 1.0, which indicates the need for outpatient substance use disorder (SUD) treatment. The ASAM is a multidimensional assessment approach for determining an individual's need for SUD treatment.

3. The individual is assessed to have a need for assistance, demonstrated by the need for one or both of the following:
   a. Assistance with three or more activities of daily living (ADLs), defined in *WAC 388-106-0010*, one of which may be body care
   b. Hands-on assistance with one or more ADLs, one of which may be body care.
      i There is objective evidence (as defined by the progressive evaluation process in *Chapter 388-447*) of physical impairments because of which the individual needs assistance with basic work-related activities, including one or more of the following: sitting, standing, walking, lifting, carrying, handling, manipulative or postural functions (pushing, pulling, reaching handling, stooping or crouching), seeing, hearing, communicating, remembering, understanding and following instructions, responding appropriately to supervisors and coworkers, tolerating the pressures of a work setting, maintaining appropriate behavior, using judgment, and adapting to changes in a routine work setting.

AND the individual has at least one of the following risk factors:

1. Unable to be gainfully employed for at least 90 consecutive days due to a mental or physical impairment as demonstrated by eligibility for the **Aged, Blind and Disabled (ABD)** program or the **Housing and Essential Needs (HEN)** program
2. Inability to obtain or maintain employment resulting from age, physical disability or traumatic brain injury
3. More than one instance of inpatient substance use treatment in the past two years
4. At risk of deterioration of mental illness and/or substance use disorder, including one or more of the following:
   a. Persistent or chronic risk factors such as social isolation due to a lack of family or social supports, poverty, criminal justice involvement, or homelessness
   b. Care for mental illness and/or substance use disorder requires multiple provider types, including behavioral health, primary care, long-term services and supports, and/or other supportive services
   c. Past psychiatric history with no significant functional improvement that can be maintained without treatment and/or supports
5. Dysfunction in role performance due to behavioral health condition, including one or more of the following:
   a. Behaviors that disrupt employment or schooling or put employment at risk of termination or schooling suspension
   b. A history of multiple terminations from work or suspensions/expulsions from school
   c. Cannot succeed in a structured work or school setting without additional support or accommodations
   d. Performance significantly below expectation for cognitive/developmental level

The focus is on obtaining competitive employment that reflects the interests and desires of the individual through:

- (H2023) Pre-employment services — activities that assist an individual with obtaining employment.
- (H2025) Employment-sustaining services — activities that support the individual in retaining and maintaining employment.

IPS Minimum Service Levels
Pre-employment and employment-sustaining services are based on 15-minute units that are limited to 120 units over a 180-day period. Any additional time within that 180-day period needs to be authorized as an exception to rule (ETR) by FCS staff.

Pre-Employment Services and Employment-Sustaining Services

Pre-employment services support an individual's ability to prepare for and transition to competitive employment, including direct face-to-face contact with the client as well as collateral service.

Pre-employment services include the following:

- Prevocational/job-related discovery or assessment
- Person-centered employment planning
- Individualized job development and placement
- Job carving — defined as working with the client and employer to modify an existing job description so it contains one or more, but not all, of the tasks from the original job description when a potential applicant for a job is unable to perform all the duties identified in the job description
- Benefits education and planning — defined as counseling to assist the client in fully understanding the range of state and federal benefits he or she might be eligible for, the implications that work and earnings would have for continued receipt of these benefits, and the client's options for returning to work
- Transportation (only in conjunction with the delivery of an authorized service)

Employment-sustaining services include the following:

- Career advancement services — defined as services that expand opportunities for professional growth, assist with enrollment in higher education or credentialing and certificate programs to expand job skills or enhance career development, and assist the individual in monitoring his/her satisfaction with employment and determining the level of interest and opportunities for advancement with the current employer, and/or changing employers for career advancement
- Negotiation with employers — defined as services where a provider identifies and addresses job accommodations or assistive technology needs with the employer on behalf of the individual
- Job accommodations can include the following:
    - Adjusting work schedule to reduce exposure to triggering events (i.e., heavy traffic triggering symptoms of agoraphobia)
    - Providing a private area for individuals to take breaks if they experience an increase in symptoms

    - Access to a telephone to contact a support person if needed while at work
    - Adjusting job schedule to accommodate scheduled appointments
    - Small, frequent breaks as opposed to one long one ○ Assistive technology can include the following:
    - Bedside alarms
    - Electronic medication reminders while at work or at home
    - Use of headset/iPod to block out internal or external distractions
- Job analysis — defined as gathering, evaluating and recording accurate, objective data about the characteristics of a particular job to ensure the specific matching of skills and amelioration of maladaptive behaviors
- Job coaching
- Benefits education and planning — defined as counseling to assist the client in fully understanding the range of state and federal benefits he or she might be eligible for, the implications that work and earnings would have for continued receipt of these benefits, and the client's options for returning to work
- Transportation (only in conjunction with the delivery of an authorized service)
- Asset development — defined as services supporting clients' accrual of assets that have the potential to help clients improve their economic status, expand opportunities for community participation and positively impact their quality of life experience.
    - Assets are defined as something with value owned by an individual, such as money in the bank, property and retirement accounts.
- Follow-along supports — defined as the ongoing supports necessary to assist an eligible client to sustain competitive work in an integrated setting of his or her choice
    - This service is provided for, or on behalf of, a client and can include communicating with the client's supervisor or manager, whether in the presence of the client or not (if authorized and appropriate). There is regular contact and follow-up with the client and employer to reinforce and stabilize job placement. Follow-along support and/or accommodations are negotiated with an employer prior to the client starting work or as circumstances arise.

Additionally, it's important to engage in individualized job development services that support individuals in searching for and securing a job in the community such as:

- Identifying and negotiating jobs.
- Building relationships with employers.
- Customized employment development, job analysis and job carving.
- Linking with community resources to support job search.

2. CONTACT INFORMATION

You can call the FCS Program Line at **844-451-2828** Monday through Friday, 8 a.m. to 5 p.m. Pacific time, to get assistance with TPA network information, referrals, client eligibility, claims information, inquiries, requesting interpreter services and recommendations you may have about improving our processes.

Wellpoint will coordinate with contracted Washington Apple Health (Medicaid) managed care organizations and behavioral health organizations to exchange information about clients who are eligible or potentially eligible for the FCS program. We'll also assist clients in accessing services when they're referred by a managed care organization or behavioral health organization. The following are additional resources you may find useful:

Managed Care Organizations

- Wellpoint: **833-731-2167**
- Molina: **855-322-4082**
- Community Health Plan of Washington: **800-440-1561**
- Coordinated Care WA: **877-644-4613**
- United Healthcare: **800-829-2925**

State and Local Agencies

- Health Care Authority: **800-562-3022**
- Aging and Long-Term Support Administration: **360-725-2300**
- Behavioral Health Administration/Department of Behavioral Health and Recovery: **360-725-1500**
- Department of Commerce: **360-725-4000**
- Department of Social and Health Services: **https://www.dshs.wa.gov/dshs-contact-us**

Wellpoint in Washington

TPA FCS
705 Fifth Ave. S., Suite 300
Seattle, WA 98104
Phone: **844-451-2828**
Fax: **844-470-8859**

Interpreter Services

For interpretation help over the phone or in-person for or during any services, call the FCS Program Line at **844-451-2828** Monday-Friday, 8 a.m.-5 p.m. Pacific time.

Referral Services

- To refer clients to Wellpoint FCS network providers or specialists, call the FCS Program Line at **844-451-2828** Monday-Friday, 8 a.m.-5 p.m. Pacific time or securely email FCSTPA@Wellpoint.com.
- To refer clients to behavioral health services, obtain more information at:

- **https://hca.wa.gov/health-care-services-supports/behavioral-health-recovery/mental-health-services**

Claims Information

Timely filing is within 365 calendar days of the date of service.

Provider Directories

Wellpoint provider directories are available to members in online searchable and hard-copy formats. Since use of these directories is how members identify FCS providers near them, it is important that your contact information is promptly updated when changes occur. You can update your practice information by calling the FCS Program Line at **844-451-2828** Monday through Friday, 8 a.m. to 5 p.m. Pacific time or using your practice letterhead, submit changes to FCSTPA@Wellpoint.com.

3. CLIENT ELIGIBILITY AND ENROLLMENT

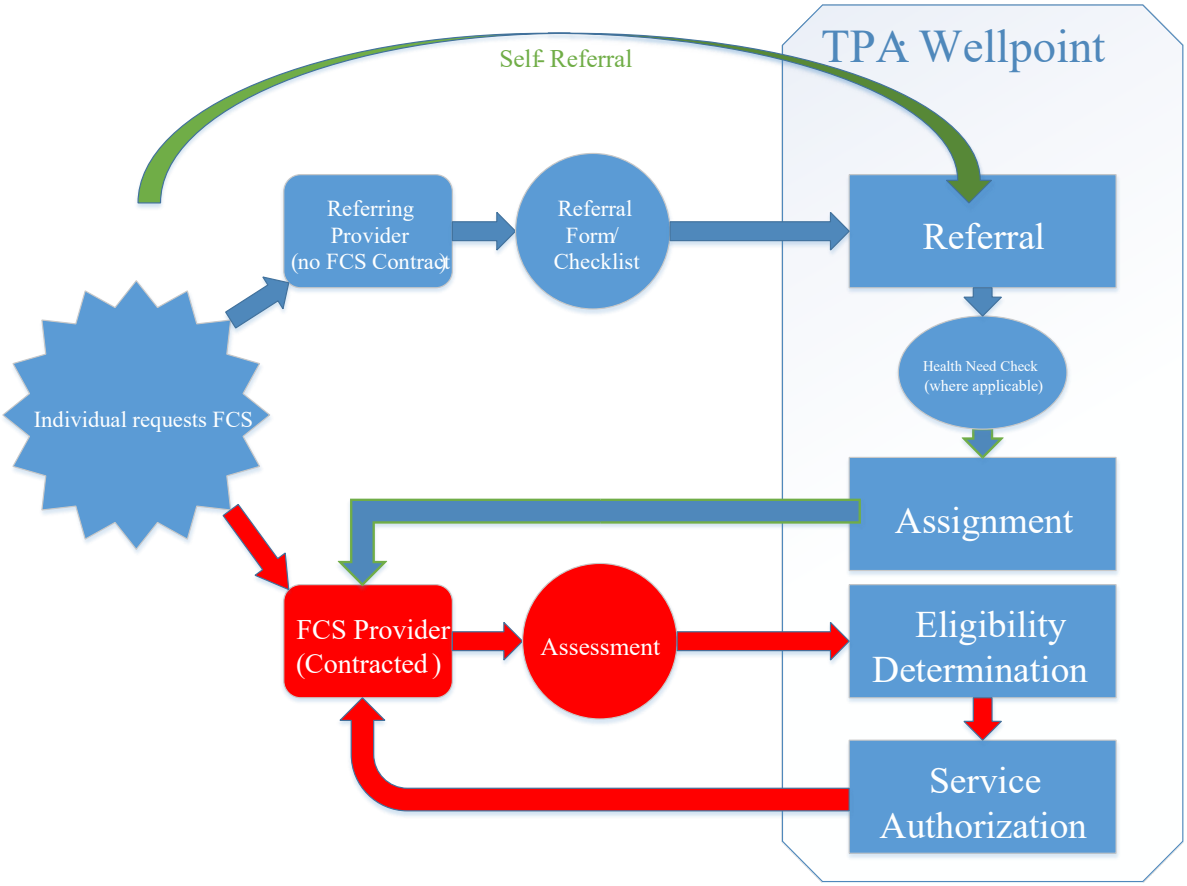
3.1 General Eligibility Criteria

Individuals in the following Apple Health (Medicaid) coverage groups at the time of enrollment are eligible for FCS:

- Categorically Needy (CN) Blind/Disabled — CN Medicaid for persons blind or disabled, including persons Supplemental Security Income (SSI)-related and persons dually eligible for Medicare and Medicaid
- CN Aged — CN Medicaid for persons age 65 and older, including persons SSI-related and persons dually eligible for Medicare and Medicaid
- CN Healthcare for Workers with Disabilities — CN Medicaid coverage for persons SSI-related in the Healthcare for Workers with Disabilities program
- CN Family Medical — CN Medicaid coverage for families, adults or children related to Temporary Assistance for Needy Families (TANF), including extended Medicaid coverage and certain adults in long-term care over 30 days
- Affordable Care Act (ACA) Expansion Adults — Medicaid coverage for adults with modified adjusted gross income (MAGI) income up to 133 percent of the federal poverty level (FPL) under provisions in the ACA effective January 1, 2014
- CN Pregnant Women — CN Medicaid coverage for pregnant women age 19 and older
- CN Children — CN Medicaid coverage for children under age 19 or in federal or state foster care/adoption support under age 21; or under age 26 if in foster care at age 18 and who are age 16 or older per target population criteria
- Children's Health Insurance Program (CHIP) Children — CHIP coverage for children under age 19 and who are age 16 or older per target population criteria

3.2 Referrals

Wellpoint is committed to a no-wrong-door approach. Providers (both contracted and noncontracted) as well as individuals may make referrals to Wellpoint for FCS services. Outlined below is the process for contracted providers for referrals and authorizations.



Referral and Authorization Process

1. Anyone, whether a noncontracted provider, community agency or the individual, submits a referral to Wellpoint via email at FCSTPA@Wellpoint.com.
   a. Providers can contact Wellpoint at **844-451-2828** for additional questions regarding this process.
2. Wellpoint validates the individual's eligibility.
3. Wellpoint refers the individual to a provider based on assignment methodology (provider or Health Care Authority notification of eligibility)
4. The provider conducts outreach to the individual.
5. The provider completes an assessment for service eligibility.
6. The provider notifies Wellpoint. The assessment may not be more than 10 business days old.*
7. Wellpoint authorizes immediate service delivery.**

Contracted providers submit completed assessment forms directly to Wellpoint via the electronic assessment portal at **https://provider.wellpoint.com/washington-provider/patient-care/foundational-community-supports.**

* Subject to change per Wellpoint FCS policy
** Based on availability of resources, the individual may be placed on a wait list for authorization of services in the future.

See Appendix A for the eligibility assessment forms (*Foundational Community Supports: Supported Employment Assessment* and *Foundational Community Supports: Supportive Housing Assessment*).

3.3 Client Requests for Provider Change

Clients can request a change of their FCS provider at any time as long at their authorization is still active. They can choose any FCS provider in the FCS network that serves the area they live in.

Clients can inform Wellpoint of the change by calling the FCS Program Line at **844-451-2828**. Alternatively, the client can complete a *Provider Change Request* form and email it to FCSTPA@Wellpoint.com or mail it to FCS:

FCS TPA
705 Fifth Ave. S., Suite 300
Seattle, WA 98104

3.4 Exception to Rule/Limited Extension Requests

Additional supported employment or supportive housing units above the initial units authorized during a client's period of authorization may be requested for clients when the member has used up most of their units and if it is clinically necessary. Providers can submit an *Exception to Rule/Limited Extension Request (ETR) Form* along with a signed *Single Case Agreement Form* and supporting documentation to be considered for additional units.

The following supporting documentation and explanations should accompany each ETR request:

- Progress notes (from authorization start date to present)
- A description and supporting documentation explaining why it is clinically necessary for this member to receive more units during the current authorization period
- A description of services that have been tried and their outcomes
- The member's person-centered plan for employment/housing
- A description of the additional services that will be needed (number of additional units needed for current authorization period)
- The level of improvement the client has shown to date related to FCS services and what improvements could be reasonably expected if more FCS services are approved for current authorization period
- How a member's condition might worsen if more FCS services are not approved
- Completed and signed FCS TPA *Single Case Agreement Form*

The *Single Case Agreement Form* confirms that Wellpoint authorizes the provider to provide services required by the Wellpoint FCS TPA program based on the terms and conditions set forth for the specific episode of care.

3.5 Disenrollment

Clients can be disenrolled from the FCS program at any time. To officially disenroll, a client can complete a *Disenrollment Form*. The form must be signed by the member indicating their consent to disenroll in FCS services. It can be emailed to FCSTPA@Wellpoint.com or sent directly to the FCS address above.
Alternatively, the client may call the FCS Program Line at **844-451-2828** to request disenrollment. Providers cannot request voluntary termination on behalf of a client.

Possible Disenrollment Reasons

The client:

- Requested the disenrollment.
- Is deceased.
- Has moved out of state.
- Lost Apple Health (Medicaid) eligibility.
- No longer meets criterion for FCS services.

Clients who lose Apple Health (Medicaid) eligibility will be automatically disenrolled.

Involuntary Termination of Enrollment

If a client becomes ineligible due to a change in eligibility status or functional need, his or her enrollment will be terminated as follows:

- If it's processed on or before the HCA cut-off date for enrollment or Wellpoint is informed by HCA of the enrollment termination prior to the first day of the month following the month in which it's processed by HCA, the termination will be effective the first day of the month following the month in which the enrollment termination is processed by the HCA.
- If it's processed after the HCA cut-off date for enrollment and Wellpoint is not informed by HCA of the enrollment termination prior to the first day of the month following the month in which it's processed by HCA, the termination will be effective the first day of the second month following the month in which the enrollment termination is processed by the HCA.

Notification forms with a disenrollment effective date for the first of the month will be processed for the last date of the previous month (for example, a December 1 effective date will be processed for November 30).

4. PROVIDER ROLES, RESPONSIBILITIES AND CREDENTIALING

4.1 General Requirements

All providers must:

- Have an effective mechanism to communicate with clients and potential clients with visual and hearing sensory impairments, including language translation services. This is available from Wellpoint by contacting the FCS Program Line at **844-451-2828**. At a minimum, providers will:
  - Educate and train staff in culturally and linguistically appropriate policies and practices on an ongoing basis (Culturally and Linguistically Appropriate Services CLAS Standard 4).
  - Offer language assistance to individuals who have limited English proficiency and/or other communication needs at no cost to them to facilitate timely access to all services (CLAS Standard 5).
  - Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing (CLAS Standard 6).
  - Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided (CLAS Standard 7).
  - Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area (CLAS Standard 8).
  - Establish culturally and linguistically appropriate goals (CLAS Standard 9).
  - Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into continuous quality improvement activities (CLAS Standard 10).
  - Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery (CLAS Standard 11).
  - Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints (CLAS 14).
- Comply with all applicable statutory and regulatory requirements of the Apple Health (Medicaid) program.
- Render covered services only to the extent and duration indicated on the referral.
- Submit required claims information.
- Submit required outcomes and capacity information.
- Arrange for coverage with network providers while off duty or on vacation.
- Verify client eligibility and prior authorization of services at each visit.
- Coordinate care with other providers as appropriate.
- Not refuse services to or terminate services from eligible clients.
- Not discriminate against eligible clients in any way because of health status, including the existence of a pre-existing physical or mental condition, functional impairment or chemical dependency, pregnancy and/or hospitalization.

- Not discriminate against clients on the basis of race, color, national origin, gender, gender identity, age, veteran or military status, sexual orientation, or the presence of any sensory, mental or physical disability, or the use of a trained guide dog or service animal by a person with a disability, and will not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin.
- Offer hours of operation for clients that are no less than the hours of operation offered to any other patient.
- Allow Wellpoint, the state of Washington (including HCA), the Medicaid Fraud Control Unit (MFCU) and state auditor, CMS, auditors from the federal Government Accountability Office, federal Office of the Inspector General, federal Office of Management and Budget, the Office of the Inspector General, the Comptroller General, and their designees, to access, inspect and audit any records or documents of the subcontractors, and must permit inspection of the premises, physical facilities and equipment where Medicaid-related activities or work is conducted at any time. Providers will make copies of records and deliver them to the requestor, without cost, within 30 calendar days of the request. The right for the parties named above to audit, access and inspect under this section exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

Wait Times

Wellpoint will have contracts in place with FCS providers to ensure access to services are provided appropriately, taking into account the urgency of the need for services. Wellpoint will ensure:

- Network providers offer access comparable to that offered to commercial members and/or Medicaid fee-for-service members.
- Mechanisms are established to ensure compliance by providers.
- Providers are monitored regularly to determine compliance.
- Corrective action is initiated and documented if there is a failure to comply.
- In-office wait time for scheduled appointments should not routinely exceed 45 minutes including time in the waiting room. Each member should be notified immediately if the provider is delayed for any period of time. If the appointment wait time is anticipated to be more than 45 minutes, the member should be offered a new appointment. Walk-in clients should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.

4.2 Enrollment

To apply to become a contracted Foundational Community Supports (FCS) provider, complete the ***Foundational Community Supports Provider Application*** (**https://provider.wellpoint.com/wa** > Patient Care > Washington Foundational Community Supports > Forms) and return to us by email at FCSTPA@Wellpoint.com or by fax to **844-470-8859**.

If you have questions about the WA FCS enrollment process with Wellpoint, call **844-451-2828**.

Qualifications

Preference will be given to providers with the following credentials and/or licenses:

I. Demonstrated capacity to provide Supportive Housing Services

a. Two years' experience in the coordination of Supportive Housing or in the coordination of independent living services in a social service setting under qualified supervision; or

b. Licensed/certified in Supportive Housing Services (*WAC 388-877a-0335* or *WAC 388-877b-0740*) by the DSHS Division of Behavioral Health and Recovery.

c. For contracted providers, one of the following:
   i. Bachelor's degree in a related field with one years' experience in the coordination of Supportive Housing or in the coordination of independent living services in a social service setting
   ii. Two years' experience, including supervision, in the coordination of Supportive Housing or in the coordination of independent living services in a social service setting under qualified supervision. Note: If the services provided require licensure or certification, the employee must have the applicable license or certification, current and in good standing.

d. Commitment to Supportive Housing quality standards and participation in fidelity reviews

e. Demonstrated capacity to ensure adequate administrative and accounting procedures and controls necessary to safeguard all funds and meet program expenses in advance of reimbursement, determined through an evaluation of the agency's most recent audit report or financial review

f. No history of significant deficiencies as evidenced by monitoring, licensing reports or surveys

g. Have sufficient staff qualified to provide services per the contract terms as evidenced by a current organizational chart or staffing plan indicating position titles and credentials as applicable

   Note: This also includes any outside agency, person or organization that will do any part of the work defined in the contract.

h. Current staff, including those with unsupervised access to clients and those with a controlling interest in the organization, with no findings of abuse, neglect, exploitation or abandonment, nor has the agency had any government-issued license revoked or denied related to the care of medically frail and/or functionally disabled persons suspended or revoked in any state

i. Have no multiple cases of lost litigation related to service provision to medically frail and/or functionally disabled persons

II. Demonstrated capacity to provide Supported Employment Services/Individual Placement and Support:

All necessary licenses, registration and certifications, as required by law, must be maintained and meet one of the following criteria:

1. Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) in Employment Services
2. Licensed/certified in Employment Services (*WAC 388-877a-0330* or *WAC 388-877b-0730*) by the DSHS Division of Behavioral Health and Recovery
3. Have all staff that will be performing Supported Employment Services meet one of the following criteria:
   a. Be a certified employment support professional (CESP) by the Employment Support Professional Certification Council (ESPCC)

b. Be a certified rehabilitation counselor (CRC) by the Commission of Rehabilitation Counselor Certification (CRCC)
c. Have a Bachelor's degree in human or social services from an accredited college or university and at least two years of demonstrated experience providing supported employment or similar services
d. Have four or more years of demonstrated experience providing supported employment or similar services
    i Service providers consisting of more than one person must meet one of the following:
        a) Be accredited by the CARF in Employment Services
        b) Be licensed in Employment Services by the DSHS Division of Behavioral Health and Recovery
        c) Have all staff that will be performing supported employment services meet the qualifications identified above
e. Demonstrated capacity to ensure adequate administrative and accounting procedures and controls necessary to safeguard all funds and meet program expenses in advance of reimbursement, determined through an evaluation of the agency's most recent audit report or financial review
f. No history of significant deficiencies as evidenced by monitoring, licensing reports or surveys
g. Have sufficient staff qualified to provide services per the contract terms as evidenced by a current organizational chart or staffing plan indicating position titles and credentials as applicable. This also includes any outside agency, person or organization that will do any part of the work defined in the contract.
h. Current staff, including those with unsupervised access to clients and those with a controlling interest in the organization, have no findings of abuse, neglect, exploitation or abandonment, nor has the agency had any government-issued exclusion, license revoked or denied related to the care of medically frail and/or functionally disabled persons suspended or revoked in any state
i. Have no multiple cases of lost litigation related to service provision to medically frail and/or functionally disabled persons

4.3 Quality Monitoring and Reporting

Providers must:

- Participate in scheduled training, fidelity, peer review and quality assurance review processes and reporting as specified by FCS program requirements.
- Establish and carry out quality improvement activities.
- Follow Wellpoint policies and procedures for the FCS program
- Submit a monthly report on the form provided by Wellpoint by the 10th of the following month.

FCS providers are responsible for establishing a continuous quality improvement program. This includes collecting and reporting on data that permits an evaluation of goal achievement on individual-level clinical outcomes, experience-of-care outcomes and quality-of-care outcomes at the population level.

Quality Management and Outcomes

Quality management is the act of overseeing all activities and tasks needed to maintain a desired level of excellence. This includes creating and implementing quality planning, assurance, control and improvement and fidelity reviews.

FCS providers are responsible for quality improvement activities that promote objective and systematic measurement, monitoring and evaluation of services. Activities include:

- Establishing a consistent framework for measuring and reporting housing and employment outcomes at the individual and overall program level.
- Ongoing monitoring and evaluation of the effectiveness of FCS services via quality measures.
- Assisting in monitoring compliance with program requirements.
- Maintaining compliance with program standards as well as local, state and federal regulatory requirements.
- Participation in Wellpoint access and availability surveys.

Quality improvement teams and methodology are used to develop processes and protocols that result in improved outcomes. Placing an emphasis on the importance of establishing a culture of continuous improvement is a foundational element of your organization's success in meeting defined quality performance measures.

Model for Improvement

Supportive Housing services are intended to reduce homelessness and increase housing stability. Importantly, Supportive Housing services seek to engage the client in self-care and personal management by establishing a personalized housing services plan that is holistic and reflective of his or her preferences and goals. Quality factors consider engagement and access to housing and tenure in housing. An initial quality initiative might track the engagement rate of individuals attributed to FCS and those who become active participants.

FCS providers must develop means to track Supportive Housing services outcomes that show expected program goals are met. Such data elements may cover but are not limited to:

- Number of days from intake to placement in housing.
- Number of days housed in the last 90 days, 180 days, etc.
- Tenure in current housing situation.

- Tenure in the program.
- Number of days hospitalized in the last 90 days.
- Number of hospitalizations in the last 90 days.
- Number of days spent in jail in the last 90 days.
- Mental-health functioning (where applicable).
- Social functioning.
- Self-reported quality of life.
- Self-reported client satisfaction.
- Number of times rehoused.

Supported Employment services are intended to enhance individual's participation in the community and increase individual's confidence and sense of self-worth. Importantly, supported employment services seek to engage the individual in self-care and personal management by establishing a personalized employment services plan that is holistic and reflective of the client's preferences and goals. Quality factors consider engagement and access to competitive employment and maintenance of stable employment.

FCS providers must develop means to track supported employment services outcomes that show expected program goals are met. The FCS program will work with providers on common definitions and specifications. Such data elements may cover but are not limited to:

- Number of days from intake to placement in competitive employment.
- Number of days employed in the last 90 days, 180 days, etc.
- Tenure in current employment.
- Tenure in the program.
- Housing status.
- Number of days hospitalized in the last 90 days.
- Number of hospitalizations in the last 90 days.
- Number of days spent in jail in the last 90 days.
- Mental-health functioning (where applicable).
- Social functioning.
- Self-reported quality of life.
- Self-reported client satisfaction.
- Number of work days and hours.
- Wages earned.
- Number of jobs.

Upon request, Wellpoint will make available the QM program description and information on our progress towards meeting quarterly plans and goals.

4.4 Fraud, Waste and Abuse

We are committed to protecting the integrity of our health care program and the effectiveness of our operations by preventing, detecting and investigating fraud, waste and abuse. Combating fraud, waste and abuse begins with knowledge and awareness.

- **Fraud**: Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it --

or any other person. This includes any act that constitutes fraud under applicable Federal or State law.

- **Waste:** Includes overusing services, or other practices that, directly or indirectly, result in excessive costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- **Abuse:** behaviors that are inconsistent with sound financial, business and medical practices and result in unnecessary costs and payments for services that are not medically necessary or fail to meet professionally recognized standards for health care. This includes any member actions that result in unnecessary costs.

To help prevent fraud, waste and abuse, Providers can assist by educating Members. For example, spending time with Members and reviewing their records for prescription administration will help minimize drug fraud. One of the most important steps to help prevent Member fraud is as simple as reviewing the Member identification card. It is the first line of defense against possible fraud. Learn more at **fighthealthcarefraud.com.**

Presentation of a Member identification (ID) card does not guarantee eligibility; Providers should verify a Member's status by inquiring online or via telephone. Online support is available for Provider inquiries on the website, and telephonic verification may be obtained through the automated Provider Inquiry Line at **833-731-2274**.

Providers should encourage Members to protect their ID cards as they would a credit card, to carry their health benefits card at all times, and report any lost or stolen cards to the company as soon as possible. Understanding the various opportunities for fraud and working with Members to protect their health benefit ID card can help prevent fraudulent activities. Providers should instruct their patients who have lost their ID card to inspect their explanation of benefits (EOBs) for any errors and then contact Member Services if something is incorrect.

Reporting Fraud, Waste and Abuse

If you suspect a Provider (e.g., Provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any Member (a person who receives benefits) has committed fraud, waste or abuse, you have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person and their information, if supplied, who reports the incident is kept in strict confidence by the Special Investigations Unit (SIU).

You can report your concerns by:

- Visiting our **fighthealthcarefraud.com** education site; at the top of the page click "Report it" and complete the "**Report Waste, Fraud and Abuse**" form
- Calling Provider Experience
- Calling Customer Service
- Calling our SIU fraud referral hotline: **866-847-8247**

Any incident of fraud, waste or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you to give as much information as possible. We appreciate your time in referring suspected fraud, but be advised that we do not routinely update individuals who make referrals as it may potentially compromise an investigation.

As an alternative, allegations of fraud can also be reported directly to the Washington Health Care Authority:

Members
Call DHS at **360-725-0934** to report Medicaid member fraud
Email: WAHEligibilityFraud@hca.wa.gov

Providers
800-562-6906 to report Medicaid provider fraud
Email: hottips@hca.wa.gov

Mail to report provider or member fraud:
Health Care Authority
Attention: OMEP
PO Box 45534
Olympia, WA 98504-5534

Examples of Provider Fraud, Waste and Abuse (FWA):

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Overutilization
- Soliciting, offering or receiving kickbacks or bribes
- Unbundling – when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding – when a Provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

When reporting concerns involving a PROVIDER (a doctor, dentist, counselor, medical supply company, etc.) include:

- Name, address and phone number of Provider (for example, the doctor(s) name(s), the hospital, nursing home, home health agency, etc.)
- Medicaid number of the Provider and facility, if you have it
- Type of Provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

Examples of Member Fraud, Waste and Abuse

- Forging, altering or selling prescriptions
- Letting someone else use the Member's ID (identification) card
- Relocating to out-of-service Plan area and not notifying us
- Using someone else's ID card

When reporting concerns involving a **member** include:

- The Member's name
- The Member's date of birth, Member ID, or case number if you have it
- The city where the Member resides
- Specific details describing the fraud, waste or abuse

Investigation Process

Our Special Investigations Unit (SIU) reviews all reports of Provider or Member fraud, waste and abuse for all services. If appropriate, allegations and the investigative findings are reported to all appropriate state, regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with Provider fraud, waste or abuse, which may include, but is not limited to:

- *Written warning and/or education*: We send certified letters to the Provider documenting the issues and the need for improvement. Letters may include education or requests for recoveries or may advise of further action.
- *Medical record review*: We review medical records in context to previously submitted claims and/or to substantiate allegations.
- *Prepayment Review*: A certified professional coder evaluates claims prior to payment of designated claims. This edit prevents automatic claim payment in specific situations.
- *Recoveries*: We recover overpayments directly from the Provider. Failure of the Provider to return the overpayment may result in reduced payment of future claims and/or further legal action.

If you are working with the SIU all checks and correspondence should be sent to:
Special Investigations Unit
740 W Peachtree Street NW
Atlanta, Georgia 30308
Attn: investigator name, #case number

Paper medical records and/or claims are a different address, which is supplied in correspondence from the SIU and is also available in other sections of this manual. If you have questions, contact your investigator. An opportunity to submit claims and/or supporting medical records electronically is an option if you register for an Availity account. Contact Availity Client Services at **800-AVAILITY** (**282-4548**) for more information.

About Prepayment Review

One method we use to detect FWA is through prepayment Claim review. Through a variety of means, certain Providers (Facilities or Professionals), or certain Claims submitted by Providers, may come to our attention for behavior that might be identified as unusual for coding, documentation and/or billing issues, or Claims activity that indicates the Provider is an outlier compared to his/her/its peers.

Once a Claim, or a Provider, is identified as an outlier or has otherwise come to our attention for reasons mentioned above, further review may be conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for unusual coding, documentation, and/or billing practices. If the review results in a determination the Provider's action(s) may involve FWA, unless exigent circumstances exist, the Provider is notified of their placement on prepayment review and given an opportunity to respond.

When a Provider is on prepayment review, the Provider will be required to submit medical records and any other supporting documentation with each Claim so the SIU can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation in accordance with this requirement will result in a denial of the Claim under review. The Provider will be given the opportunity to request a discussion of his/her/its prepayment review status.

Under the prepayment review program, we may review coding, documentation, and other billing issues. In addition, one or more clinical utilization management guidelines may be used in the review of Claims submitted by the Provider, even if those guidelines are not used for all Providers delivering services to Plan Members.

The Provider will remain subject to the prepayment review process until the health plan is satisfied that all inappropriate billing, coding, or documentation activity has been corrected. If the inappropriate activity is not corrected, the Provider could face corrective measures, up to and including termination from the network at the direction of the State.

Providers are prohibited from billing a Member for services the health plan has determined are not payable as a result of the prepayment review process, whether due to FWA, any other coding or billing issue or for failure to submit medical records as set forth above. Providers whose Claims are determined to be not payable may make appropriate corrections and resubmit such Claims in accordance with the terms of their Provider Agreement, proper billing procedures and state law. Providers also may appeal such a determination in accordance with applicable grievance and appeal procedures.

Acting on Investigative Findings

If, after investigation, the SIU determines a Provider appears to have committed fraud, waste, or abuse the Provider:

- May be presented to the credentials committee and/or peer review committee for disciplinary action, including Provider termination
- Will be referred to other authorities as applicable and/or designated by the State
- The SIU will refer all suspected criminal activity committed by a Member or Provider to the appropriate regulatory and law enforcement agencies.

Failure to comply with program policy or procedures, or any violation of the contract, may result in termination from our plan.

If a Member appears to have committed fraud, waste or abuse or has failed to correct issues, the Member may be involuntarily dis-enrolled from our health care plan, with state approval.

Privacy, Confidentiality and Compliance

We're committed to safeguarding member information. As a contracted provider, you must have procedures in place to demonstrate compliance with *Health Insurance Portability and Accountability Act (HIPAA)* privacy regulations. You must also have safeguards to protect member information, such as locked cabinets clearly marketed and containing only protected health information (PHI).

HIPAA:

- Improves the portability and continuity of benefits.
- Providers greater member rights to access and privacy.
- Ensures greater accountability in health care fraud.
- Simplifies the administration of health insurance.

Member individual privacy rights include the right to:

- Receive a copy of provider notice of privacy practices.
- Request and receive a copy of his or her treatment records and request those records be amended or corrected.
- Get an accounting of certain disclosures of his or her PHI.
- Ask that his or her PHI not be used or shared.
- Ask each provider to communicate with him or her about PHI in a certain way or location.
- File a complaint with his or her provider or the Secretary of Health and Human Services if privacy rights are suspected to be violated.
- Designate a personal representative to act on his or her behalf.
- Authorization disclosure of PHI outside of treatment, payment or health care operations and my cancel such authorizations.

We only request the minimum member information necessary to accomplish our purpose. Likewise, you should only request the minimum member information necessary for your purpose. However, regulations do allow the transfer or sharing of member information to:

- Conduct business and make decisions about care.
- Make an authorization determination.
- Resolve a payment appeal.

Requests for such information fit the *HIPAA* definition of treatment, payment or health care operations.

***42 CFR Part 2* Compliance**

When providers use, disclose, maintain or transmit PHI protected by *42 CFR Part 2*, they acknowledge and agree that in receiving, storing, processing or otherwise dealing with any such records for members, they are fully bound by *42 CFR Part 2*. If necessary, they will resist any efforts to obtain access to such records except as permitted under *42 CFR Part 2*. Providers also acknowledge and agree that any patient information they receive that is protected by *42 CFR Part 2* is subject to protections that prohibit providers from disclosing such information to agents or subcontractors without the specific written consent of the member.

4.5 Data Sharing and Transfers

Providers will participate with and provide data to Wellpoint to facilitate program monitoring and evaluation. The form and content of data transfer will be developed. Data elements may include but not be limited to:

- Eligibility determinations.
- Service utilization.
- Grievances and appeals.

- Client incidents (critical incidents).
- Outcome measures (such as days in housing and employment status).

Reports

Wellpoint will create a data dashboard. The dashboard will collect and maintain de-identified data on members and service usage and provide fully detailed reports to HCA monthly. Required data includes but may not be limited to: regionally based utilization, number of members receiving services, number of members housed or employed, number of members on any waitlist for services, service dollars spent, eligibility determinations, and grievances and appeals.

In addition, FCS providers are required to provide the data elements related to the services they are contracted for so the elements needed for quality monitoring and oversight may be reported. Additional reports will include but are not limited to the following:

- HCA-requested data
- Cost experience data reporting
- Data security and certification
- Member records (with onsite inspection)
- Care plan assessment
- Delegated entity monitoring
- Breach notifications
- Client incidents
- Client outcomes, including the following:
    - Number and percentage of clients housed in the community after 30 and 90 calendar days following service initiation; longevity in housing
    - Number and percentage of clients engaged in employment-seeking activities, supported employment
    - Number and percentage of clients in integrated and competitive employment; longevity of competitive employment
- Client voice and experience — measures satisfaction with services and providers, interpreter utilization, and culturally appropriate activities to support client understanding of services
- Employment — measures hours worked per week, employer-sponsored benefits and increase in personal income
- Housing — measures length of time to achieve housing placement, number and percentage remaining in housing after 12 months, number of clients receiving CSS essential services by type
- (for example, rental deposit, furnishings), and other indicators available (for example, through the Homeless Management Information System [HMIS])
- Access — measures the wait time a client experiences to receive service(s), duration of time a client remains in service(s) and referrals made for applicants who are ineligible for FCS
- Client stability — measures clients having reduced contact with law enforcement, increased social connectedness and decreases in acute health care utilization
- Health services utilization — measures emergency room and inpatient utilization and total health care costs

Additional reports may be created as identified through ongoing collaboration with Wellpoint, HCA and DSHS.

4.6 Grievances, Appeals and Discrimination

Only a member or member's authorized representative may file a grievance with Wellpoint. A provider may not file a grievance on behalf of a member unless the provider is acting on behalf of the member and has the member's written consent.

The FCS program follows *WAC 182-559-600* for appeal processes.

Members who contact us with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when an Wellpoint representative working with a member identifies a potential act of discrimination. We advise the member to submit a verbal or written account of the incident and assist them in doing so if he or she requires assistance. We document, track and trend all alleged acts of discrimination.

Members are also advised to file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights (OCR):

- Through the OCR complaint portal at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**.
- By mail to U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, DC 20201.
- By phone at **800-368-1019** (TTY/TDD: **800-537-7697**).

Wellpoint provides tools and services at no cost to those with disabilities to communicate effectively with us. Wellpoint also provides no-cost language services to people whose primary language isn't English (for example, qualified interpreters and information written in other languages). These services can be obtained by call **844-451-2828.**

If you or your client believe that Wellpoint has failed to provide services or discriminated in any way on the basis of race, color, national origin, age, disability, gender or gender identity, you can file a grievance with us via:

- Mail: 705 5th Ave South, Suite 300 Seattle, WA 98104
- Phone: **844-451-2828**
- Fax: **844-470-8859**

4.7 Equal Program Access on the Basis of Gender

Wellpoint provides individuals with equal access to programs and activities without discriminating on the basis of gender. Wellpoint must also treat individuals consistently with their gender identity and is prohibited from discriminating against any individual or entity on the basis of a relationship with, or association with, a member of a protected class (i.e., race, color, national origin, gender, gender identity, age or disability).

Wellpoint may not deny or limit services that are ordinarily or exclusively available to individuals of one gender, to a transgender individual based on the fact that a different gender was assigned at birth or because the gender identity or gender recorded is different from the one in which health services are ordinarily or exclusively available.

4.8 Support and Training for Providers

Wellpoint will provide regular trainings for FCS providers. All FCS provider groups are expected to participate. Wellpoint will maintain records of the number and type of providers, agencies and support staff participating in provider education, including evidence of assessment of participation satisfaction from the training process.

5. BILLING AND CLAIMS SUBMISSION

5.1 Provider Reimbursement

FCS services are managed by Wellpoint. FCS providers contract with Wellpoint and are reimbursed based on the Health Care Authority fee schedule for FCS services.

For additional information or updates, see the Washington Health Care Authority's *Medicaid transformation FCS* webpage at **https://hca.wa.gov/about-hca/medicaid-transformation-project-mtp/initiative-3-foundational-community-supports-fcs**.

5.2 Claims Submission

FCS providers are encouraged to submit FCS claims electronically. However, Wellpoint will work with FCS providers on a claims submission process based on provider resources and technological capabilities.

Three billing codes are reimbursed for FCS services:

- Supportive Housing services:
  - **H0043** Community Support services: daily rate of $112 with a benefit limitation of 30 days over a 180-day period. Any additional time within that 180-day period would need to be authorized as an exception by FCS staff.
- Supported Employment services:
  - **H2023** Pre-Employment services: supported employment, per unit of 15 minutes
  - **H2025** Employment Sustaining services: ongoing supports to maintain employment, per unit of 15 minutes
  - **Both H2023 and H2025** have a rate of $27 per unit and a benefit limitation of 120 units over a 180-day period. Additional time required above this benefit limitation within the 180-day period would need to be authorized as an exception by FCS staff.

FCS Rate Increase Table

Service Description	**Rate through March 31, 2020**	**Temporary Rate Effective April 1 through June 30, 2020**	**Permanent Rate Increase Effective July 1, 2020**
Pre-employment H2023, per 15 minutes	$25	$33	$27
Employment sustaining H2025, per 15 minutes	$25	$33	$27
Pre-housing and sustaining services H0043, per diem	$105	$137	$112

5.3 Electronic Data Interchange Submission

You can submit electronic claims through electronic data interchange (EDI). You must submit claims within the timely filing guidelines in your contract.

5.4 Availity Essentials

The Availity Portal is a tool to help reduce costs and administrative burden. Availity can help you easily submit claims, process payments, submit claim payment disputes and more.

Availity	• Payer ID: WLPNT • Phone: **877-334-8446** • Website: **https://availity.com**

To initiate the registration process, your primary controlling authority (PCA) — the individual in your organization who is legally entrusted to sign documents — must first complete registration at **https://availity.com**. Once your PCA completes this initial process, your primary access administrator (PAA) — the individual in your organization who is responsible for maintaining users and organization information — will receive a temporary password to gain access. Then, they can add users to specific areas for your organization.

For training, visit **https://availity.com** and select **Availity Learning Center** under *Resources* in the top bar. From there, you can sign up for informative webinars and even receive credit from the American Academy of Professional Coders for many sessions.

For any questions or additional registration assistance, contact Availity Client Services at **800-282-4548**, Monday through Friday from 5 a.m. to 4 p.m. Pacific Time.

5.5 Electronic Claims Submissions

Availity is our exclusive partner for managing all Electronic Data Interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (835) allows for a faster, more efficient, and cost-effective way for providers to do business.

Use Availity for the following EDI transactions:

- Healthcare Claim: Professional (837P)
- Healthcare Claim: Institutional (837I)
- Healthcare Eligibility Benefit Inquiry and Response (270/271)
- Healthcare Services Prior Authorization (278)
- Healthcare Services Inpatient Admission and Discharge Notification (278N)
- Healthcare Claim Payment/Advice (835)
- Healthcare Claim Status Request and Response (276/277)
- Medical Attachments (275)

Availity's EDI submission Options:

- EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software). To register for direct EDI transmissions, visit – **availity.com** > Provider Solutions > EDI Clearinghouse.
- Use your existing vendor for your EDI transactions (work with your vendor to ensure connection to the Availity EDI Gateway)

EDI Response Reports
Claims submitted electronically will return response reports that may contain rejections. If using a Clearinghouse or Billing Vendor, please work with them to ensure you are receiving all reports. It's important to review rejections as they will not continue through the process and require correction and resubmission. For questions on electronic response reports contact your Clearinghouse or Billing Vendor or Availity at **800- AVAILITY** (**800-282-4548**).

Availity EDI Payer ID's

- Payer IDs ensure your EDI submissions are routed correctly when received by Availity.
- Payer ID: WLPNT

Note: If you use a clearinghouse, billing service or vendor, please work with them directly to determine payer ID.

Electronic Remittance Advice (ERA)
The 835 eliminates the need for paper remittance reconciliation.

Use Availity to register and manage ERA account changes with these three easy steps:

- Log in to **availity.com**
- Select **My Providers**
- Select **Enrollment Center** and select **Transaction Enrollment**

Note: If you use a clearinghouse or vendor, please work with them on ERA registration and receiving your ERA's.

Electronic Funds Transfer (EFT)
Electronic claims payment through electronic funds transfer (EFT) is a secure and fastest way to receive payment reducing administrative processes. EFT deposit is assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation. Use EnrollSafe (**https://enrollsafe.payeehub.org/**) to register and manage EFT account changes.

EDI Submission for Corrected Claims
For corrected electronic claims:

- Use frequency type (7) - Replacement of Prior Claim
- Submit original claim number for the corrected claim

EDI segments required:

- Loop 2300- CLM - Claim frequency code
- Loop 2300 - REF - Original claim number

Please work with your vendor on how to submit corrected claims.

5.6 Paper Claims Submissions

You must submit a properly completed *CMS-1450* or *CMS-1500* claim form:

- Within the timely filing guidelines in your provider contract.
- On the original red claim forms (not black and white or photocopied forms).

- Laser printed or typed (not handwritten).
- In a large, dark font.

Submit paper claims to:
Washington Claims
Wellpoint
P.O. Box 61010
Virginia Beach, VA 23466-1010

5.7 Claims Adjudication

We are dedicated to providing timely adjudication of claims. We process all claims according to generally accepted claims coding and payment guidelines determined by the CPT® and ICD-10 manuals.

You must use *HIPAA*-compliant billing codes when billing Wellpoint. When billing codes are updated, you are required to use appropriate replacement codes for submitted claims. We will reject claims submitted with noncompliant billing codes.

5.8 Clean Claim Payments

A clean claim is a request for payment for a service rendered by a provider that:

- Is submitted on time.
- Is accurate.
- Is submitted on a HIPAA-compliant standard claim form.
- Requires no further information, adjustment or alteration to be processed and paid.
- Is not from a provider who is under investigation for fraud or abuse. Is not a claim under review for medical necessity.

We will adjudicate clean claims to a paid or denied status within 30 calendar days of receipt. If we do not pay the claim within 61 calendar days, we will pay all applicable interest as required by law. The *EOP* shows the status of each claim that has been adjudicated during the previous claim cycle.

If we do not receive all of the required information, we will deny the claim either in part or in whole within 30 calendar days of receipt of the claim. A request for the missing information will appear on your *EOP*.

Once we have received the requested information, we will process the claim within 30 calendar days.

We will return paper claims that are determined to be unclean along with a letter stating the reason for the rejection. We will return electronic claims that are determined to be unclean to the clearinghouse that submitted the claim.

5.9 Claim Status

You can check the status of claims anytime by logging in to Availity Essentials **at** **https://availity.com** and selecting **Claims & Payments > Claim Status** or by calling Provider

Services at **833-731-2274**. You can also use the claims status information for accepted and rejected claims that were submitted through a clearinghouse.

If we do not have the claim on file, resubmit the claim within the timely filing requirements. If filing electronically, check the confirmation reports for acceptance of the claim that you receive from your EDI or practice management vendor. If you have any questions regarding paid, denied or pended claims, call Provider Services at **833-731-2274**.

5.10 Overpayment Process

Claims Overpayment Recovery Procedure

Wellpoint Payment Integrity Division reviews claims for accuracy and request refunds if claims are overpaid or paid in error. Some common reasons for overpayments are, but not limited to:

- Paid wrong provider / Member
- Coordination of Benefits
- Allowance overpayments
- Late credits
- Billed in error
- Duplicate
- Non-covered services
- Claims editing
- Terminated Members
- Total charge overpaid
- Paid wrong Member/ provider number

Refund notifications may be identified by Wellpoint and its contracted vendors or the providers. Wellpoint researches and notifies the provider of an overpayment and requests a refund check. The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

Wellpoint Identified Overpayment (aka "Solicited")

Once an overpayment has been identified by Wellpoint, Wellpoint will notify the provider of the overpayment. The overpayment notification letter will include instructions on how to refund the overpayment. When refunding on a claim overpayment that Wellpoint has requested, use the payment coupon included on the request letter and the following information with the check:

- The payment coupon
- Member ID number
- Member's name
- Claim number
- Date of service
- Reason for the refund as indicated in the refund request letter

As indicated in the Wellpoint refund request letter, provider overpayment refunds not received and applied within the timeframe indicated will result in claim recoupment from any claim the provider submits to Wellpoint.

Providers wishing to submit an overpayment dispute for a solicitated overpayment recoupment request, can submit their request via Availity, by mail, or fax.

The mailing address and fax number are:
Cost Containment — Disputes
PO Box 62427
Virginia Beach, VA. 23466-2437
Fax - 866-920-1874

The processing time once these documents are received is 30 days.

Providers submitting a refund check, should mail the refund to the address below and include a copy of the overpayment letter received, a list of claims are being refunded and the refund amount to be applied to each claim to:

Wellpoint
PO Box 933657
Atlanta, GA. 31193-3657

Provider Self-Identified Overpayments (aka "voluntary" or "unsolicited")
To ensure compliance with contractual requirement 12.5.4.3 and 42 CFR 438.608(d)(2), Wellpoint outlines below our documented mechanism for a Network Provider to report to the Contractor when it has received an overpayment, return the overpayment to the Contractor within sixty (60) calendar days after the date on which the overpayment was identified, and notify the Contractor in writing of the reason for the overpayment.

If a provider identifies an overpayment and submits a refund, a completed Overpayment Refund Notification Form specifying the reason for the return must be included. This form can be found on the provider website at **https://provider.wellpoint.com/washington-provider/resources/forms** under the Claims & Billing tab. The submission of the Overpayment Refund Notification Form will allow Cost Containment to process and reconcile the overpayment in a timely manner. The provider can also complete a Recoupment Notification Form, which gives Wellpoint the authorization to adjust claims and create claim offsets. This form can also be found on the provider website at **https://providers.wellpoint.com/wa**. For questions regarding the refund notification procedure, call Provider Services at **833-731-2274** and select the appropriate prompt.

All provider self-identified overpayment requests must be submitted in writing via US mail, fax, or web submission.

Submission options:

USPS Mail:	Cost Containment – Recoupments P.O. Box 62427 Virginia Beach, VA 23466
Fax:	**866-920-1874**
Web submission:	Availity — **https://availity.com**

All requests should include the following information:

- Name of Provider
- Tax ID
- NPI
- Member's full name
- Member's ID
- List of claims
- Reason for recoupment
- Amount of recoupment
- Include any supporting documentation to validate the reason for the recoupment.
- Signature authorizing the recoupment.

Provider Self-Identified overpayment request turnaround time: Within 30 days of receipt.
**Incomplete requests will cause a delay in processing or the closure of the request with no further action.*

Changes to the overpayment process have taken place with the passage of the *Patient Protection and Affordable Care Act (PPACA)*, commonly known as the *Healthcare Reform Act*. The provision directly links the retention of overpayments to false claim liability. The language of 42 U.S.C.A 1320a-7k makes it explicit that overpayments must now be reported and returned to states or the respective managed care organization (MCO) within 60 days of identification of the overpayment or by the date any corresponding cost report is due, whichever is later. After 60 days, the overpayment is considered a false claim, which triggers penalties under the *False Claims Act*, including treble damages. In order to avoid such liability, health care providers and other entities receiving reimbursement under Medicare or Medicaid should implement policies and procedures on reporting and returning overpayments that are consistent with the requirements in the PPACA.

The provision entitled *Reporting and Returning Overpayments – Deadline for Reporting and Returning Overpayments*, codified at 42 U.S.C.A. 1320a-7k, clarifies the uncertainty left by the *2009 Fraud Enforcement and Recovery Act*. This provision of the *Healthcare Reform Act* applies to providers of services, suppliers, Apple Health (Medicaid) MCOs, Medicare Advantage organizations, and Medicare Prescription Drug Program sponsors. It does not apply to beneficiaries.

Documentation of Claim Receipt

The following information will be considered proof that a claim was received timely. If the claim is submitted:

- By U.S. mail (first class, return receipt requested or by overnight delivery service): The provider must provide a copy of the claim log that identifies each claim included in the submission.
- Electronically: The provider must provide the receipt date from the response reports.
- By fax: The provider must provide proof of transmission.
- By hand delivery: The provider must provide a claim log that identifies each claim included in the delivery and a copy of the signed receipt acknowledging the hand delivery.

The claims log maintained by providers must include the following information:

- Name of claimant
- Address of claimant
- Phone number of claimant
- Claimant's federal tax identification number
- Name of addressee
- Name of carrier
- Designated address
- Date of mailing or hand delivery
- Subscriber name
- Subscriber ID number
- Member name
- Date(s) of service/occurrence
- Total charge
- Delivery method

Good Cause

If the claim or claim dispute includes a written explanation clearly identifying the delay or other evidence that establishes the reason, Wellpoint will determine good cause based primarily on that statement or evidence and/or if the evidence leads to doubt about the validity of the statement. Wellpoint will contact the provider for clarification or additional information necessary to make a good cause determination.

Good cause may be found when a provider claim filing delay was due to:

- Administrative error — incorrect or incomplete information furnished by official sources (for example, carrier, intermediary, CMS) to the provider.
- Incorrect information furnished by the member to the provider, resulting in erroneous filing with another care management organization plan or with the state.
- Unavoidable delay in securing required supporting claim documentation or evidence from one or more third parties, despite reasonable efforts by the provider to secure such documentation or evidence.
- Unusual, unavoidable or other circumstances beyond the provider's control, which demonstrate the provider could not reasonably be expected to have been aware of the need to file timely.
- Destruction or other damage of the providers records, unless such destruction or other damage was caused by the provider's willful act of negligence.

Corrected Claims

When submitting a correction for a previously billed claim on a *CMS 1500* form, include all services on the new submission. If any previously submitted changes or services are not billed on the corrected claim form, they will be removed in the adjustment. Any reduction in payment would result in a negative account balance and/or a refund request. Wellpoint does not accept individual lines for correction on a *CMS 1500* form; this mirrors the process for institutional replacement claims submitted on *CMS 1450* claim forms. Standard timely filing guidelines apply to all corrected and replacement claims.

5.11 Provider Claim Payment Dispute Procedures

Claim Inquiries

A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but the outcome of the claim inquiry may result in the initiation of the claim payment dispute. In other words, once you get the answer to your claim inquiry, you may opt to begin the claim payment dispute process.

Our Provider Experience program helps you with claim inquiries. Just call **1-833-731-2274** and select the claims prompt within our voice portal. We connect you with a dedicated resource team, called the Provider Service Unit (PSU) to ensure:

- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact, issue resolution rates.
- Significantly improved turnaround time of inquiry resolution.
- Increased outreach communication to keep you informed of your inquiry status.

The PSU is available to assist you in determining the appropriate process to follow for resolving your claim issue.

The provider payment dispute process consists of two steps. You will **not** be penalized for filing a claim payment dispute, and no action is required by the member.

5.12 Claim payment reconsideration

This is the first step in the provider payment dispute process. The reconsideration represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.

We will consider reimbursement of a claim that has been denied due to failure to meet timely filing if you can 1) provide documentation the claim was submitted within the timely filing requirements or 2) demonstrate good cause exists.

5.13 Claims Payment Reconsideration

The first step in the claim payment dispute process is called the reconsideration. It is your initial request to investigate the outcome of a finalized claim. Please note, we cannot process a reconsideration without a finalized claim on file.

We accept reconsideration requests in writing, verbally and through our secure provider website within 24 months from the date on the *EOP* (see below for further details on how to submit). Reconsiderations filed more than 24 months from the *EOP* will be considered untimely and denied unless good cause can be established.

When submitting reconsiderations, please include as much information as you can to help us understand why you think the claim was not paid as you would expect. If a reconsideration requires clinical expertise, the appropriate clinical Wellpoint professionals will review it.

Wellpoint will make every effort to resolve the claims payment reconsideration within 30 calendar days of receipt. If additional information is required to make a determination, the

determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar day.

We will send you our decision in a determination letter, which will include:

- A statement of the provider's reconsideration request.
- A statement of what action Wellpoint intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes or provider manual references.
- An explanation of the provider’s right to request a claim payment appeal within 30 calendar days of the date of the reconsideration determination letter.
- An address to submit the claim payment appeal.
- If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

5.14 Claim Payment Appeal

This is the second step in the provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal. A claim payment dispute may be submitted for multiple reason(s) including:

- Contractual payment issues.
- Disagreements over reduced or zero-paid claims.
- Post-service authorization issues.
- Other health insurance denial issues.
- Claim code editing issues.
- Duplicate claim issues.
- Claim data issues.
- Timely filing issues.

If you are dissatisfied with the outcome of a reconsideration determination, you may submit a claim payment appeal. We accept claim payment appeals through our provider website or in writing within 30 calendar days of the date on the reconsideration determination letter, or 30 calendar days of the date of the *EOP* if no reconsideration was requested previously. Claim payment appeals received more than 30 calendar days after the claims reconsideration determination letter will be considered untimely and upheld unless good cause can be established. When submitting a claim payment appeal, please include as much information as you can to help us understand why you think the reconsideration determination was in error. If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate clinical Wellpoint professionals.

Wellpoint will make every effort to resolve the claim payment appeal within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days. We will send you our decision in a determination letter, which will include:

- A statement of the provider's claim payment appeal request.
- A statement of what action Wellpoint intends to take or has taken.

- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes or provider manual references.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

5.15 Claim Correspondence

Claim correspondence is different from a payment dispute. Correspondence is when we require more information to finalize a claim. Typically, we make the request for this information through the *EOP*. The claim or part of the claim may, in fact, be denied, but it is only because more information is required to process the claim. Once the information is received, we will use it to finalize the claim.

The following table provides examples of the most common correspondence issues along with guidance on the most efficient ways to resolve them.

Type of Issue	What do I need to do?
Rejected claim(s)	Contact Availity Client Services at **800-AVAILITY** (*800-282-4548*) when your claim was submitted electronically but was never paid or was rejected. We're available to assist you with setup questions and help resolve submission issues or electronic claims rejections.
***EOP* requests for supporting documentation**	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the supporting documentation to: Claims Correspondence Wellpoint
Type of Issue	What do I need to do?
	P.O. Box 61599 Virginia Beach, VA 23466-1599
Need to submit a corrected claim due to errors or changes on original submission	**EDI Submission for Corrected Claims** For corrected electronic claims: • Use frequency type (7) - Replacement of Prior Claim • Submit original claim number for the corrected claim EDI segments required: • Loop 2300- CLM - Claim frequency code • Loop 2300 - REF - Original claim number

	Please work with your vendor on how to submit corrected claims. Submit a *Claim Correspondence Form* and your corrected claim to: Claims Correspondence Wellpoint P.O. Box 61599 Virginia Beach, VA 23466-1599 Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Standard timely filing guidelines apply to all corrected and replacement claims.

5.16 Claim Payment Dispute

We have several options to file a claim payment dispute:

- **Verbally** (for reconsiderations only): Call Provider Services at **833-731-2274**.
- **Online (for reconsiderations and claim payment appeals):** Use the secure provider Availity Appeal application at **https://availity.com**.* Through Availity, you can upload supporting documentation and receive immediate acknowledgement of your submission.
- **Written** (for reconsiderations and claim payment appeals): Mail all required documentation (see below for more details), including the *Claim Payment Appeal Form* or the *Reconsideration Form*, to:
  Payment Dispute Unit
  Wellpoint
  P.O. Box 61599
  Virginia Beach, VA 23466-1599

Submit reconsiderations on the ***Claim Payment Reconsideration Submission Form***. Submit written claim payment appeals on the ***Claim Payment Appeal Submission Form***.

5.17 Required Documentation for Claim Payment Disputes

Wellpoint requires the following information when submitting a claim payment dispute (reconsideration or claim payment appeal):

- Your name, address, phone number, email, and either your NPI or TIN
- The member's name and his or her Apple Health (Medicaid) ID number
- A listing of disputed claims, which should include the Wellpoint claim number and the date(s) of service(s)
- All supporting statements and documentation

6. PROGRAM APPROACH AND RESOURCES

Wellpoint requires treatment records to be current, detailed and organized for effective, confidential member care and quarterly review. Your treatment records must conform to good professional practice and be permanently maintained at the primary care site.

Members are entitled to one copy of their treatment record each year, and the copy is provided at no cost to the member. Members or their representatives should have access to these records.

Please ensure that treatment records include:

- Member identification information shown on each page or electronic file
- Personal/biographical data: age, sex, address, phone number(s)
- Date and corroboration: dated and identified by the author
- Legible to someone other than the author
- Date, start time, end time and duration of services provided
- Contains entries in the treatment record that are dated and include author identification (for example, handwritten signatures, unique electronic identifiers or initials)
- Reflects all aspects of services.

Wellpoint may request that you submit additional documentation, including records or other documentation not directly related to the member, to support claims you submit. If documentation is not provided following the request or notification, or if documentation does not support the services billed for the services, we may:

- Deny the claim.
- Recover and/or recoup monies previously paid on the claim.

Wellpoint is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.

Person-centered Care Plan

While working with members in Supportive Housing and/or Supported Employment, the FCS provider will create person-centered planning to identify members':

- Needs and the resources available to meet those needs
- Additional service and support needs.

Person-centered planning will be documented into care plans, health need care plans or Supportive Housing/Supported Employment care plans. The overall success of care plan metrics will be documented and reported in the Quality Assurance & Performance Improvement (QAPI). This will include FCS provider findings such as:

- An evaluation of the impact of interventions, including any planned follow-up actions or interventions.
- A written assessment of the success of contractually required performance improvement projects.

6.1 Supportive Housing Services

Helping people with complex health needs live in the community means helping them take pride in and responsibility for their homes and helping them choose the supportive services they need. As such, educating tenants and increasing their involvement in planning are important to the success of permanent Supportive Housing.

You may find the following resources helpful:

- The Substance Abuse and Mental Health Services Administration (SAMHSA)'s *Permanent Supportive Housing Evidence-Based Practices (EBP) Kit:* https://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4509
- The Corporation for Supportive Housing**: www.csh.org/resources**
- The Downtown Emergency Service Center's *Vulnerability Assessment Tool* — measuring individual's vulnerability to continued instability: **https://www.desc.org/what-we-do/vulnerability-assessment-tool**
- The Health Care Authority's *Foundational Community Supports: Supportive Housing Assessment* (see Appendix A)
- Department of Commerce: **www.commerce.wa.gov**
- CSD guidelines

6.2 Supported Employment Services

The overriding philosophy of supported employment is the belief that every person with complex health needs is capable of working competitively in the community if the right matching job and work environment can be found. Rather than trying to sculpt clients into becoming *perfect workers*, extensive prevocational assessment as systematic job development is used to offer clients help finding and keeping jobs that capitalize on their personal strengths and motivation. Thus, the primary goal of supported employment is not to change clients but to find a natural fit between clients' strengths and experiences and jobs in the community.

You may find the following resources helpful:

- SAMHSA's *Supported Employment Evidence-Based Practices (EBP) Kit:* **https://store.samhsa.gov/product/Supported-Employment-Evidence-Based-Practices-EBP-Kit/SMA08-4364**
- The Health Care Authority's *Foundational Community Supports: Supported Employment Assessment* (see Appendix A)
- **https://ipsworks.org**

7. TRANSITION ASSISTANCE PROGRAM (TAP)

The FCS Transition Assistance Program (TAP) is a program designed to support Foundational Community Supports Supportive Housing (FCS-SH) enrollees. It is a time-limited, flexible funding assistance that covers housing-related fees, including short-term rents, move-in costs, and non-refundable fees. TAP aligns with the Community Behavioral Health Rental Assistance program (CBRA), Section 8 (project-based and Housing Choice Voucher), and other longer-term rental assistance programs

As the TPA of the FCS program, Wellpoint will be TAP funds for FCS. Wellpoint provides administrative oversight of TAP for FCS including contracting, authorizations, reimbursement, quality assurance, and reporting.

7.1 TAP Provider Credentialing

All current FCS Supportive Housing providers in good standing are eligible to become Transition Assistance Program providers. An FCS TAP contract amendment must be signed and additional credentialing completed before requesting TAP funding. For a copy of the contract amendment and additional documentation, please reach out to your FCS manager or email FCSTPA@Wellpoint.com.

7.2 TAP Client Eligibility and Enrollment

In order to be eligible for TAP for FCS, an FCS-SH enrollee must meet the following criteria:

- Active FCS-eligible Medicaid. See the FCS Medicaid Eligibility Check at **https://provider.wellpoint.com/washington-provider/patient-care/foundationalcommunity-supports** > Additional Resources.
- Authorized by Wellpoint to receive FCS supportive housing services and active FCS-SH enrollment segments in Provider One. See the FCS Enrollment Inquiry Process Guide at **https://provider.wellpoint.com/washington-provider/patient-care/foundationalcommunity-supports** > Additional Resources.
- Experiencing a behavioral health treatment need

7.3 Expenses Reimbursable with TAP Funding

An ETP can be requested if an item is not listed on the approved list above and is a barrier to housing transition or if seeking funding beyond $5,000 per 12-month period, with up to $1,500 available to cover certain home essentials and sustainability items, and rental arrears.

The following expenses require an ETP:

TAP for FCS funding category:	Items covered:	Can spend:
IDs and other documentation	• Identification documents/cards • Birth certificates • Social Security cards	**Up to $80 each**
Application fees	• Rental application fees • Background check • Credit check	**Up to $100 each**
Transitional housing fees	• Fees associated with entering certain transitional housing such as urinalysis	**Up to $100 each**
Moving expenses *Can be used once per 12-month period	• Moving vehicle rental • Moving supplies	**Up to $300 total**
Move-in assistance *Can be used once per 12-month period	• Security, pet, and/or damage deposits • First and last month's rent • Any appropriate and reasonable non-refundable fees (fees may be annualized)	**Up to $5,000 total:** • Monthly rent *must* be under 120% Fair Market Rent (FMR) • Enrollee must have ability to pay ongoing rent with or without long-term rental assistance

7.3 FCS TAP Exception to Policy (ETP)

An ETP can be requested if an item is not listed on the approved list above and is a barrier to housing transition or if seeking funding beyond $5,000 per 12-month period.

The following expenses require an ETP:

TAP for FCS funding category:	Items covered:	Can spend:
Home essentials & sustainability items	• Mattress • Small household appliances • Light furnishings • Cleaning supplies	**ETP required** • Maximum spending amount for any combination of these items: $1,500

TAP for FCS funding category:	Items covered:	Can spend:
Arrears Note: A rent ledger reflecting the amount requested must be sent to TransitionAssistanceFCS@Wellpoint.com at the time of the request	• Utility • Rental • Storage	**ETP required** • Maximum spending amount for any combination of these items: $1,500
Home modifications	• Reasonably priced home modifications approved by landlords	**ETP required**

7.4 Requesting TAP Funding

To request TAP funding for an active FCS supportive housing enrollee:

- the FCS provider agency can submit an **FCS TAP Request Form** to Wellpoint. These can be submitted by fax to **844-470-8859** or securely emailed to TransitionAssitanceFCS@Wellpoint.com.
- Wellpoint responds to the FCS provider regarding the TAP request within five business days with an approval, denial, or rejection requesting more information.
- Once approved, FCS provider receives reimbursement through electronic funds transfer (EFT) or paper check.
- The latest copy of the **FCS TAP Request Form** and additional details of the TAP funding request process will be available on **https://provider.wellpoint.com/washington-provider/patient-care/foundationalcommunity-supports**.

7.5 FCS TAP Quality Assurance

FCS Supportive Housing providers who request TAP reimbursement will participate in auditing and quality assurance procedures developed by Wellpoint to minimize fraud, waste and abuse.

As an FCS Supportive Housing provider who has requested TAP reimbursement, it is your responsibility to maintain receipts for each requested item on the TAP request form which include date and dollar amount. Please maintain additional documentation related to TAP request (landlord correspondence, invoices, supplemental data regarding expenses), if appropriate. Please ensure that progress notes reflect necessity for TAP requests.

7.6 FCS TAP Contact Information

- Phone: **844-451-2828**
- Fax: **844-470-8859**
- Email: TransitionAssistanceFCS@Wellpoint.com
- FCS provider website: **https://provider.wellpoint.com/washington-provider/patient-care/foundationalcommunity-supports**

APPENDIX A: FCS HMIS DATA CONSENT FORM

Foundational Community Supports Client Release of HMIS Information and Informed Consent

This agency participates in the Foundational Community Supports (FCS) program, providing supportive housing services to eligible individuals. The purpose of this form is to authorize the one-time release of personal information, including information about your housing history, collected from HMIS to the FCS Third Party Administrator (TPA), Amerigroup, for the purposes of confirming FCS program eligibility.

- We need to confirm your eligibility for this program. Specifically, we need information about your housing history from HMIS as part of verifying your Chronic Homelessness status. Your information will be stored in our database for 7 years. If you have questions about collection of data or your rights regarding your personally identifying information, contact Amerigroup at 1-844-451-2828.

- We use strict security policies designed to protect your privacy. Our computer system is highly secure and uses up-to-date protection features such as data encryption, passwords, and identity checks required for each system user. As with any system, there is a risk of security breach but we believe it is small. If there is a security breach, someone might obtain and use your information inappropriately. If you ever suspect the data has been misused, immediately contact the Amerigroup at 1-844-451-2828.

- Your decision to release this information to the TPA does not guarantee eligibility for FCS services, nor does your refusal guarantee that you will not receive FCS services from this agency.

- Signing this form only authorizes a one-time release of information for the purpose of confirming eligibility for FCS services. Any additional release of HMIS information to the TPA will require an additional signed release.

I understand the above statements and consent to the sharing of personal information in HMIS listed above with the TPA. I understand that my personal information will not be made public and will only be used with strict confidentiality.

_____ _____

Client Signature Date

_____ _____ _____

Client Name (Print clearly) Date of Birth Agency Staff Name (Print clearly) Initials

Client refused consent _____ (Agency Staff Initials)

This form may not be amended except by approval of the Washington State Department of Commerce
Approved as to form by Sandra Adix, Assistant Attorney General, 12/20/2017

APPENDIX B: ELIGIBILITY ASSESSMENT FORMS

This page left intentionally blank. Eligibility assessment forms begin on the following page.

Foundational Community Supports: Supported Employment Assessment Form Access the fillable version of this form here: **https://provider.wellpoint.com/washington-provider/patient-care/foundationalcommunity-supports**.

Foundational Community Supports: Supported Employment Assessment

☐ Initial assessment ☐ Reauthorization

**Indicates a required field.*

*Date:	*Name:	*ProviderOne ID:	*DOB:

Address (not required if homeless):	*City, State ZIP:
Phone number:	**Email:**
Member of a federally recognized American Indian/Alaska Native tribe? ☐ Yes ☐ No *If Yes, specify which tribe:*	**Veteran:** ☐ Yes ☐ No
	***Provider agency name:**

Part A: Complex needs eligibility requirements
Information in this section is necessary in order to determine eligibility for supported employment services.

***Health need (must select at least one)**
The client meets one of the following criteria (as determined by a licensed behavioral health agency):

☐ Enrolled in the state Housing and Essential Needs (HEN), or Aged, Blind or Disabled (ABD) Program. (*Please provide the reward letter.)*

☐ Diagnosed with a mental illness resulting in the need for improvement, stabilization or prevention of deterioration of functioning resulting from the presence of a mental illness

☐ Diagnosed with a substance use disorder, as determined by meeting a one or higher level on the American Society of Addiction Medicine Criteria

☐ Needs assistance with three or more activities of daily living (ADL) or one or more hands-on ADL (as determined by a *Comprehensive Assessment and Resource Evaluation (CARE) Assessment*)

***Risk factors to be approved by a qualified licensed professional (must select at least one):**
Document any conditions and diagnoses that contribute to one or more of the following risk factors.

☐ **At risk for deterioration of mental illness and/or substance use disorder, including one or more of the following:** *persistent or chronic risk factors, such as social isolation due to a lack of family or social supports; poverty; criminal justice involvement; homelessness; care for mental illness and/or substance use disorder requiring multiple provider types, including behavioral health, primary care, long-term services and supports; or a past psychiatric history with no significant functional improvement that can be maintained without treatment and supports*

☐ **Dysfunction in role performance:** *frequently disruptive or struggling in work or school/training settings resulting in termination or suspension/expulsion; unable to work, attend school or meet other developmentally appropriate responsibilities; difficulty with daily living, communication, interpersonal skills, self-care and self-direction*

☐ **Substance use treatment:** *has substance use disorder with two or more episodes of residential and/or inpatient treatment in the past two years*

☐ An inability to obtain or maintain employment resulting from age, physical disability or traumatic brain injury (*must be the result of a CARE Assessment)*

☐ Unable to be gainfully employed for at least 90 consecutive days due to a mental or physical impairment (*must be the result of a HEN/ABD Progressive Evaluation process)*

Please provide any additional details (if applicable):

Part B: Employment assessment

Please fill out to the best of your ability. Information in this section assesses the individual's employment needs, preferences and capacities. This information is required, but does not impact eligibility.

Is the client interested in seeking employment? ☐ Yes ☐ No *If yes, what is the source of this answer:*

☐ Client statement
☐ Referral from clinician/case manager/other
☐ Family discussion (or legal guardian or designated representative) ☐ Other:

***Employment status:**

☐ Unemployed
☐ Employed part time
☐ Employed full time
☐ Nonpaid employment activities
☐ Enrolled in training/education program

***Income source (check all that apply):**

☐ Social Security
☐ Pension
☐ Social Security Income
☐ Social Security Disability Income
☐ Temporary Assistance for Needy Families
☐ Aged, Blind and Disabled
☐ Employment
☐ Other:

***Total income:**

☐ Less than $10,000
☐ $10,000-$14,999
☐ $15,000-$19,999
☐ $20,000-$24,999
☐ $25,000-$29,999
☐ $30,000-$34,999
☐ $35,000 or more

***Housing type:**

☐ Transitional/temporary housing
☐ Permanent housing

☐ Not housed (homeless)

*If homeless, choose type:
☐ Living in a place not meant for human habitation (e.g., car)
☐ In an emergency shelter
☐ Homeless but admitted to a hospital or other institution for less than 30 days
☐ At imminent risk of losing housing
☐ Evicted or foreclosed within 30 days with no future residence identified ☐ Couch surfing or doubled up
☐ Other:

Please identify what information indicates the individual would benefit from supported employment services (check all that apply):
☐ Work history with gaps and poor job tenure
☐ Unclear vocational goals
☐ Poor prevocational skills (no resume, lacking interviewing skills, etc.)
☐ Client self-assessment of readiness for employment is low
☐ Major health issues have affected employment consistently in past or potentially may affect in future
☐ Client's stated request for ongoing support

The above assessment information was obtained by (check all that apply):
☐ Client direct statements
☐ Clinician/case manager/other assessment in referral to employment services
☐ Other:

Client strengths in terms of employment (check all that apply):
☐ Motivation
☐ Natural supports from family and friends
☐ Flexible in terms of job
☐ Has own transportation
☐ Educational attainment
☐ Previous good experience in job of choice
☐ Good references
☐ Has good job search skills
☐ Relates well interpersonally

Client barriers that need to be addressed in terms of employment (check all that apply):
Note: These are areas for support, not disqualifiers or screen-out mechanisms for employment. ☐ Little family and friend support
☐ Lacks own transportation
☐ Poor educational attainment
☐ Little prior work experience
☐ Poor prior work experience
☐ Ongoing substance abuse

Notes:

Assessment completed by:	Position/credentials:	Date:
Signature:	*Provider agency name:	
Assessment supervised by (if applicable):	Position/credentials:	Date:
Signature:		
*Enrollee consent for services (print name):		
*Please indicate verbal consent in the notes below if signature was not attainable (required if no signature).		
*Enrollee signature:		*Date:
Notes:		

Foundational Community Supports: Supportive Housing Assessment Form

Foundational Community Supports: Supportive Housing Assessment

**Indicates a required field.*

* Date:	* Name:	* ProviderOne ID #:	* DOB:

Address (not required if homeless):	* City, State ZIP:
Phone number:	**Email:**
Member of a federally recognized American Indian/Alaska Native tribe? ☐ Yes ☐ No *If yes, specify which tribe:*	**Veteran:** ☐ Yes ☐ No ***Provider agency name:**

Part A: Complex needs eligibility requirements

Information in this section is required in order to determine eligibility for supportive housing services.

*** Health need (must select at least one)**

The client meets one of the following criteria (as determined by a licensed behavioral health agency):

☐ Mental health need where there is a need for improvement, stabilization or prevention of deterioration to functioning resulting from the presence of a mental illness

☐ Diagnosed with a substance use disorder, as determined by meeting a one or higher level on the *American Society of Addiction Medicine Criteria*

☐ Needs assistance with three or more activities of daily living (ADL) or one or more hands-on ADL (as determined by a Comprehensive Assessment and Reporting Evaluation)

☐ The client is a homeless individual with a disability, determined by a coordinated entry assessment. *(Individual assessed to have a complex 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]).*

* **Risk factors (to be approved by a qualified professional; must select at least one risk factor):**

☐ **Chronically homeless:** an individual with a disabling condition who has been homeless for a period of at least one year, or an individual with a disabling condition who has had at least four episodes of homelessness, as long as the combined occasions equal at least 12 months.

Note: *This definition also includes individuals who previously met the U.S. Department of Housing and Urban Development (HUD) definition of chronic homelessness but have been housed in the last 60 days (Time housed may not exceed 60 days).*

☐ **Frequent or lengthy institutional contacts (frequent, as in two or more instances in the past 12 months, or lengthy, as in lasting 90 days or more)**

Is the client transitioning out of an institutional setting? ☐ Yes ☐ No

If yes, select all that apply:

- ☐ Nursing
- ☐ Inpatient psychiatric hospital
- ☐ Inpatient medical hospital
- ☐ Correctional program or institution
- ☐ Foster care facility or other youth facility

Note: *Services will not be authorized if the client is currently placed in an institution for mental disease (IMD) or correctional facility until they transition out of the setting.*

Has the client resided within one of the previously listed institutional settings multiple times in the past year? ☐ Yes ☐ No *If yes, number of times:* _____

☐ **Frequent residential care stays (two or more occurrences in the past 12 months)** Has the client resided within a residential care facility two or more times in the past 12 months? ☐ Yes ☐ No

If yes, select all that apply:

- ☐ Evaluation and treatment facility
- ☐ Inpatient substance use treatment facility
- ☐ Detox center
- ☐ Adult residential care, assisted living or adult family home (AFH)

☐ **Frequent turnover of in-home caregivers (three or more occurrences in the past 12 months)**
Within the last 12 months, has the client used three (or more) different in-home caregiver providers (Please provide supporting documentation with the assessment)? ☐ Yes ☐ No

☐ ***PRISM*** **score (1.5 or above)** *(Contact the TPA, MCO, BHO, Health Home or HCS case manager to obtain the PRISM risk score.)*

Additional details on risk factors:

Part B: Housing assessment
Please fill out to the best of your ability. This information is required but does not impact eligibility.

* **Employment status:**
☐ Unemployed
☐ Employed part time
☐ Employed full time
☐ Nonpaid employment activities
☐ Enrolled in training/education program

***Income source:**
☐ Social Security
☐ Pension
☐ Social Security Income
☐ Social Security Disability Income
☐ Temporary Aid for Needy Families
☐ Housing and Essential Needs
☐ Aged, blind or disabled
☐ Employment
☐ Other: _____

***Total income:**
☐ Less than $10,000
☐ $10,000 to $14,999
☐ $15,000 to $19,999
☐ $20,000 to $24,999

- [ ] $25,000 to $29,999
- [ ] $30,000 to $34,999
- [ ] $35,000 or more

*Housing type:

- [ ] Transitional/temporary housing
- [ ] Permanent housing
- [ ] Not housed (homeless)

*If homeless, choose type:

- [ ] Living in a place not meant for human habitation (for example, car)
- [ ] In an emergency shelter
- [ ] Homeless but admitted to a hospital or other institution for less than 30 days
- [ ] At imminent risk of losing housing
- [ ] Evicted or foreclosed within 30 days with no future residence identified
- [ ] Couch surfing or doubled up
- [ ] Other: _____

Strengths

Please fill out to the best of your ability. Information in this section assesses the individual's housing preferences, needs and assets. This information does not impact eligibility.

Identify individual traits that support the client's ability to obtain and maintain housing. Select all that apply:

- [ ] Arranging apartment repairs
- [ ] Desire to work or engage in community activities
- [ ] Driving/using public transportation
- [ ] Filling prescriptions
- [ ] Getting along with neighbors, landlords, etc.
- [ ] Housekeeping
- [ ] Hygiene
- [ ] Lease compliance
- [ ] Long-term rental history
- [ ] Maintaining benefits
- [ ] Managing health care needs
- [ ] Managing/using caregivers
- [ ] Meal preparation
- [ ] Money management
- [ ] Motivated to obtain housing
- [ ] Motivated to resolve legal/credit issues
- [ ] Paying bills
- [ ] Paying rent/utilities
- [ ] Shopping for food and necessities
- [ ] Support from family/friends
- [ ] Support from family/friends
- [ ] Taking medication
- [ ] Other: _____

Housing preference Setting:

☐ Urban/downtown ☐ Urban/residential neighborhood ☐ Suburban ☐ Rural/small town

Close to:

☐ Transportation ☐ Shopping ☐ Medical services ☐ Family/friends ☐ Place of worship
☐ Recreation/cultural ☐ Other: _____

Living space:

☐ Studio ☐ 1 bedroom ☐ 2 bedroom ☐ Onsite laundry ☐ Nonsmoking
☐ Smoking allowed ☐ Pets allowed ☐ Bottom floor/elevator ☐ Accessible unit ☐ Parking

Please describe other relevant housing preferences:

Personal information related to housing placement Does the client use a wheelchair? ☐ Yes ☐ No

If yes, please list:
Width: _____ Manual or electric: _____
Does the client have a pet? ☐ Yes ☐ No

Does the client have a service animal? ☐ Yes ☐ No

Does the client smoke? ☐ Yes ☐ No

Does the client use medical marijuana? ☐ Yes ☐ No

Has the client served in the U.S. military with a qualified discharge? ☐ Yes ☐ No

Has the client ever been arrested? ☐ Yes ☐ No

If yes, was the client charged and convicted of a crime? ☐ Yes ☐ No

Is the client a registered sex offender or been convicted of manufacturing methamphetamines?
☐ Yes ☐ No
(*If yes, no federal subsidies allowable*)

Will anyone else be living with the client? ☐ Yes ☐ No

If yes, select type, and list name and contact information: ☐ Family/partner/friend:
☐ Live-in aide:

Please describe other relevant personal information related to housing placement:

Housing history

Does the client have any rental history? ☐ Yes ☐ No

Has the client ever received subsidized housing from a public housing authority? ☐ Yes ☐ No

Does the client owe anyone or any public housing authority past-due rent? ☐ Yes ☐ No

Has the client ever been evicted from rental housing? ☐ Yes ☐ No

If yes, please list dates:

Transportation information

Does the client rely on public transportation? ☐ Yes ☐ No

Does the client have a vehicle? ☐ Yes ☐ No

Describe the client's transportation needs:

Housing options to review/explore

Are any of the options below available and appropriate for the individual? ☐ Yes ☐ No

If yes, select all that apply:

Tenant-based rental assistance:

☐ Housing choice
☐ Nonelderly disabled
☐ Veteran's Assistance Supportive Housing
☐ Family Unification Program
☐ HOPWA
☐ Other: _____

Project-based rental subsidy:

☐ HUD 811
☐ HUD 202
☐ Low-Income Housing Tax Credit
☐ Other: _____

Continuum of care:

☐ Shelter care
☐ HPRP
☐ Permanent supportive housing
☐ Transitional housing
☐ Other: _____

Department of Commerce subsidized:	
Other HUD or USDA subsidy:	
County/city program:	
Other:	

Documentation available:

- ☐ Social Security card
- ☐ Background check results
- ☐ Proof of income
- ☐ Documentation of other assets
- ☐ Birth certificate
- ☐ Legal resident status
- ☐ Protective payee

Notes:

Assessment completed by:	Position/credentials:	Date:

Signature:	* Provider name:

Assessment supervised by (if applicable):	Position/credentials:	Date:

Signature:

* Enrollee consent for services (print name):

Please indicate verbal consent in the notes below if signature was not attainable (required if no signature)

* Enrollee signature:	* Date:

Notes:

APPENDIX C: GOAL SETTING AND ACTION PLANNING

The following is an example of goal setting and action planning:

1. **Long-term goal:** "Obtain a permanent housing — my own place to live."

2. **Short-term goal:** "Complete a housing assistance application."

a. What I will do:

b. Where I will do it:

c. How long it will take me:

3. **Possible barriers to success:**

4. **Plan to overcome barriers:**

5. **How important is it for you to work on the goal you identified above?**

1	2	3	4	5	6	7	8	9	10
		Not at all important							Extremely important

6. **How confident are you that you will be successful in reaching the goal you identified above?**

1	2	3	4	5	6	7	8	9	10
		Not at all confident							Extremely confident

APPENDIX D: APPROVED FCS PROTOCOLS

This page left intentionally blank. Approved FCS Protocols begin on the following page.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

NOV 2 1 2017

MaryAnne Lindeblad
Medicaid Director
Washington State Health Care Authority
626 8th Avenue SE
P.O. Box 45502
Olympia, Washington 98504-5502

Dear Ms. Lindeblad:

This letter is to inform you that Washington State's Foundational Community Supports (FCS) Protocol has been approved, as submitted by the state and as modified through our discussions. This protocol has been found to be in accordance with the Special Terms and Conditions (STC) of the state's section 1115 demonstration, entitled "Medicaid Transformation Project" (No. 11-W-00304/0). This protocol is approved for the period starting with the date of this approval letter through December 31, 2021—and is hereby incorporated into the STCs as Attachment I.

Your project officer for this demonstration is Mr. Adam Goldman. He is available to answer any questions concerning your section 1115 demonstration. Mr. Goldman's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-2242
E-mail: Adam.Goldman@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Mr. Goldman and to Mr. David Meacham, Associate Regional Administrator in our Seattle Regional Office. Mr. Meacham's contact information is as follows:

Centers for Medicare & Medicaid Services
Office of the Regional Administrator
701 Fifth Avenue, Suite 1600
Seattle, WA 98104
Telephone: (206) 615-2356
E-mail: David.Meacham@cms.hhs.gov

We look forward to working closely with the Health Care Authority on this demonstration.

Sincerely,

Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure

cc: David Meacham, Associate Regional Administrator, Seattle Regional Office

ATTACHMENT I
Foundational Community Supports Program

Per STC's 59-67, the following protocol outlines the services and payment methodologies for the Foundational Community Supports (FCS) Program. Under this program, the state will provide a set of Home and Community Based Services (HCBS), including Community Support Services (CSS), and Supported Employment-Individual Placement and Support (IPS), to populations that meet the needs-based criteria specified below. These services include HCBS that could be provided to the individual under a 1915(i) state plan amendment (SPA).

Community Support Services (CSS)

Target Criteria

CSS eligibility is available to Medicaid clients age 18 or older who meet the following needs-based criteria that would otherwise be allowable under a 1915(i) SPA:

Needs-Based Criteria

Individual meets at least one of the following health needs-based criteria and is expected to benefit from CSS:

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. The ASAM is a multi-dimensional assessment approach for determining an individual's need for SUD 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).

AND

Individual has at least one of the following risk factors:

1) Homelessness, defined as living in a place not meant for human habitation, a safe haven, or an emergency shelter, as these terms are understood or defined in 24 CFR 578.3:
   a) For at least 12 months, or
   b) On at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months.

2) History of frequent and/or lengthy stays in the settings defined in 24 CFR 578.3, or from, a skilled nursing facility as defined in WAC 388-97-0001.
   a) Frequent is defined as more than one contact in the past 12 months.
   b) Lengthy is defined as 90 or more consecutive days within an institutional care facility.
3) History of frequent adult residential care stays, where
   a) Frequent is defined as more than one contact in the past 12 months.
   b) Adult residential care includes
      i) Residential treatment facilities defined in WAC 246-337-005,
      ii) Adult residential care, enhanced adult residential care, or assisted living facilities defined in WAC 388-110-020, and
      iii) Adult family homes defined in WAC 388-76-10000.
4) History of frequent turnover of in-home caregivers, where within the last 12 months the individual utilized 3 or more different in-home caregiver provider agencies and the current placement is not appropriate for the individual.
5) A Predictive Risk Intelligence System (PRISM) Score of 1.5 or above
   a) The PRISM Risk Score uses diagnosis, prescription, age, and gender information from claims and encounter data to create an index of a client's expected future medical expenditures relative to the expected future medical expenditures of a comparison group (disabled Medicaid adults). The algorithm uses risk factor categories developed at University of California, San Diego known as the Chronic Illness and Disability Payment System (CDPS) and MedicaidRx, which were deemed by the Society of Actuaries to be effective methods of risk adjustment. The PRISM risk score is updated on a monthly basis by the Washington State Department of Social and Health Services' Research and Data Analysis division using the past fifteen months of claims, encounter, and demographic data. A risk score of 1.5 means that an individual's expected future medical expenditures will be 50 percent greater than that of the average Medicaid disabled client. The PRISM risk score was approved by CMS for targeting clients for the Health Home Program and Financial Alignment Dual Demonstration.

Service Definitions for HCBS That Could Be Provided under a 1915(i) SPA

Community Support Services (CSS) benefits package. CSS includes services that would otherwise be allowable under a Section 1915(i) authority, are determined to be necessary for an individual to obtain and reside in an independent community setting, and are tailored to the end goal of maintaining individual recipients' personal health and welfare in a home and community-based setting. CSS may include one or more of the following components:

Pre-tenancy supports:

a. Conducting a functional needs assessment identifying the participant's preferences related to housing (e.g., type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual), assistance in budgeting for housing/living expenses, assistance in connecting the individual with social services to assist with filling out applications and submitting appropriate documentation in order to obtain sources of

income necessary for community living and establishing credit, and in understanding and meeting obligations of tenancy.

b. Assisting individuals to connect with social services to help with finding and applying for housing necessary to support the individual in meeting their medical care needs. .
c. Developing an individualized community integration plan based upon the functional needs assessment as part of the overall person centered plan. Identifying and establishing short and long-term measurable goal(s), and establishing how goals will be achieved and how concerns will be addressed.
d. Participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed.
e. Providing supports and interventions per the person-centered plan.

Tenancy sustaining services:

a. Service planning support and participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed.
b. Coordinating and linking the recipient to services including primary care and health homes; substance use treatment providers; mental health providers; medical, vision, nutritional and dental providers; vocational, education, employment and volunteer supports; hospitals and emergency rooms; probation and parole; crisis services; end of life planning; and other support groups and natural supports.
c. Entitlement assistance including assisting individuals in obtaining documentation, navigating and monitoring application process, and coordinating with the entitlement agency.
d. Assistance in accessing supports to preserve the most independent living such as individual and family counseling, support groups, and natural supports.
e. Providing supports to assist the individual in the development of independent living skills, such as skills coaching, financial counseling, and anger management.
f. Providing supports to assist the individual in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager.
g. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
h. Connecting the individual to training and resources that will assist the individual in being a good tenant and lease compliance, including ongoing support with activities related to household management.

The CSS benefit does not include:

a. Payment of rent or other room and board costs;
b. Capital costs related to the development or modification of housing;
c. Expenses for utilities or other regular occurring bills;
d. Goods or services intended for leisure or recreation;
e. Duplicative services from other state or federal programs
f. Services to individuals in a correctional institution or an IMD (other than services that

meet the exception to the IMD exclusion).

Supported Employment – Individual Placement and Support

Target Criteria

IPS eligibility include Medicaid clients age 16 or older who meet the following criteria that would otherwise be allowable under a 1915(i) SPA:

Needs-based criteria

Individual meets at least one of the following health needs-based criteria and is expected to benefit from IPS:

1) Individual assessed to have a behavioral health need, which is defined as one or both of the following:
    a) Mental health needs, 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.
    b) Substance use needs, 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. The ASAM is a multi-dimensional assessment approach for determining an individual's need for SUD 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) There is objective evidence of physical impairments because of which the individual needs assistance with basic work-related activities, including one or more of the following: Sitting, standing, walking, lifting, carrying, handling, manipulative or postural functions (pushing, pulling, reaching handling, stooping or crouching), seeing, hearing, communicating, remembering, understanding and following instructions, responding appropriately to supervisors and co-workers, tolerating the pressures of a work setting, maintaining appropriate behavior, using judgment, and adapting to changes in a routine work setting.

AND

Individual has at least one of the following Risk Factors:

1) Unable to be gainfully employed for at least 90 consecutive days due to a mental or physical impairment.
2) An inability to obtain or maintain employment resulting from age, physical disability, or traumatic brain injury.
3) More than one instance of inpatient substance use treatment in the past two years.
4) At risk of deterioration of mental illness and/or substance use disorder, including one or more of the following:
    a) Persistent or chronic risk factors such as social isolation due to a lack of family or social supports, poverty, criminal justice involvement, or homelessness.

b) Care for mental illness and/or substance use disorder requires multiple provider types, including behavioral health, primary care, long-term services and supports, and/or other supportive services.
c) Past psychiatric history, with no significant functional improvement that can be maintained without treatment and/or supports.

5) Dysfunction in role performance, including one or more of the following:
   i) Behaviors that disrupt employment or schooling, or put employment at risk of termination or schooling suspension.
   ii) A history of multiple terminations from work or suspensions/expulsions from school.
   iii) Cannot succeed in a structured work or school setting without additional support or accommodations.
   iv) Performance significantly below expectation for cognitive/developmental level.

Service Definitions for HCBS That Could Be Provided under a 1915(i) SPA

Supported Employment – Individual Placements and Support (IPS) benefit package: The IPS benefit package will be offered to eligible clients through a person-centered planning process where eligible services are identified in the plan of care. IPS includes services that would otherwise be allowable under a Section 1915(i) authority, and are determined to be necessary for an individual to obtain and maintain employment in the community. IPS services are individualized and may include any combination of the following services:

Pre-employment services

a. Pre-vocational/job-related discovery or assessment
b. Person-centered employment planning
c. Individualized job development and placement
d. Job carving
   - Job carving is defined as working with client and employer to modify an existing job description— containing one or more, but not all, of the tasks from the original job description when a potential applicant for a job is unable to perform all of the duties identified in the job description.
e. Benefits education and planning
   - Benefits education and planning is defined as counseling to assist the client in fully understanding the range of state and federal benefits they might be eligible for, the implications that work and earnings would have for continued receipt of these benefits, and the client's options for returning to work.
f. Transportation (only in conjunction with the delivery of an authorized service)

Employment sustaining services

a. Career advancement services
   - Career advancement services are defined as services that expand opportunities for professional growth, assist with enrollment in higher education or credentialing and certificate programs to expand job skills or enhance career development, and assist the individual in monitoring his/her satisfaction with employment, and

determining level of interest and opportunities for advancement with current employer, and/or changing employers for career advancement.

b. Negotiation with employers
    - Negotiation with employers is defined as services where a provider identifies and addresses job accommodations or assistive technology needs with the employer on behalf of the individual. Job accommodations can include the following: adjusting work schedule to reduce exposure to triggering events (i.e., heavy traffic triggering symptoms of agoraphobia); providing a private area for individuals to take breaks if they experience an increase in symptoms; access to telephone to contact support person if needed while at work; adjusting job schedule to accommodate scheduled appointments; and small, frequent breaks as opposed to one long one. Assistive Technology can include the following: bedside alarms, electronic medication reminders while at work or at home, and use of headset/iPod to block out internal or external distractions.
c. Job analysis
    - Job analysis is defined as the gathering, evaluating, and recording of accurate, objective data about the characteristics of a particular job to ensure the specific matching of skills and amelioration of maladaptive behaviors.
d. Job coaching
e. Benefits education and planning
    - Benefits education and planning is defined as counseling to assist the client in fully understanding the range of state and federal benefits they might be eligible for, the implications that work and earnings would have for continued receipt of these benefits, and the clients' options for returning to work.
f. Transportation (only in conjunction with the delivery of an authorized service)
g. Asset development
    - Asset development is defined as services supporting the client's accrual of assets that have the potential to help clients improve their economic status, expand opportunities for community participation, and positively impact their quality of life experience. Assets as defined as something with value that is owned by an individual, such as money in the bank, property, and retirement accounts.
h. Follow-along supports
    - Follow-along supports are defined as on-going supports necessary to assist an eligible client to sustain competitive work in an integrated setting of their choice. This service is provided for, or on behalf of, a client, and can include communicating with the client's supervisor or manager, whether in the presence of the client or not (if authorized and appropriate). There is regular contact and follow-up with the client and employer to reinforce and stabilize job placement. Follow along support and/or accommodations are negotiated with an employer prior to client starting work or as circumstances arise.

The IPS benefit does not include:

a. Generalized employer contacts that are not connected to a specific enrolled individual or an authorized service
b. Employment support for individuals in sub-minimum wage, or sheltered workshop settings
c. Facility-based habilitation or personal care services

d. Wage or wage enhancements for individuals
e. Duplicative services from other state or federal programs

HCBS Supported Employment

IPS services defined in this protocol shall adhere to 42 CFR 440.180(c)(2)(iii), 441.302(i) and 441.303(h).and shall not include habilitation services such as facility-based day habilitation or personal care. Furthermore, services are to be provided in conjunction with a client's existing services and supports, and are therefore separate from special education or related services defined under sections 602 (16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401 (16 and 17)) or as services under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. section 730).

HCBS requirements

a. **Person-Centered Planning.** The state agrees to use person-centered planning processes to identify eligible clients' Foundational Community Supports needs and the resources available to meet those needs, and to identify clients' additional service and support needs.
b. **Conflict of Interest.** The state agrees that the entity that authorizes the services is external to the agency or agencies that provide FCS services. The state also agrees that appropriate separation of assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies.
c. **Home and Community-Based Setting Requirements.** The state will assure compliance with the home and community-based settings requirements for those services that could be authorized under section 1915(i).

Provider Qualifications
Contracted providers must ensure staff providing FCS services maintain appropriate qualifications in order to effectively serve FCS enrollees. Below are typical provider qualifications, however they may be substituted with appropriate combination of education, experience and skills, as determined by the provider contract.

Provider	Education (typical)	Experience (typical)	Skills (preferred)	Services
Community Support Services Providers	Bachelor's degree in a human/social services field; may also be an Associate's degree in a relevant field, with field experience.	1 year case management experience, or Bachelor's degree in a related field and field experience.	Knowledge of principles, methods, and procedures of services included under community support services (as outlined above), or comparable services meant to support client ability obtain and maintain residence in independent community settings.	Pre-tenancy supports; tenancy sustaining services (as outlined above).
Supported Employment – IPS Providers	Bachelor's degree in a human/social services field; may also be an Associate's degree in a relevant field, with field experience.	1 year case management experience, or Bachelor's degree in a related field and field experience.	Knowledge of principles, methods and procedures of services included under supported employment – individual placement and support (as outlined above), or comparable services that support client ability to obtain and maintain employment.	Pre-employment services; employment sustaining services (as outlined above).

Payment Methodologies
HCA will reimburse a Third Party Administrator (TPA) for the CSS and IPS services provided at the CSS and IPS rates. The rates shall not exceed the amount expended by the TPA for the direct service costs incurred by the provider. Rates may vary by region and may be developed based on a target cost per CSS and IPS service, along with variables such as geographic location, FCS-related travel costs, intensity of services, and duration of services or contracted provider per unit costs.

The TPA is required to submit quarterly reports and an annual report to HCA. Ongoing quarterly/annual reporting will include, at a minimum: (i) Number of FCS beneficiaries broken out by program (CSS and IPS supported employment); (ii) Number of new CSS and IPS supported employment person-centered service plans; (iii) Percent of clients receiving CSS and/or IPS supported employment services whose needs are re-assessed annually; and (iv) Amount of funds spent on CSS and IPS supported employment services. The purpose of the reports is to demonstrate that the program is conducted in compliance with the requirements set forth in the STCs and post-approval protocols, attachments, any agreement between HCA and the TPA, and policy letters and/or guidance from HCA.

The TPA will invoice HCA for FCS services provided to a specific Medicaid beneficiary. As

part of this invoicing process, the TPA must submit documentation to HCA of the Medicaid beneficiary's eligibility status, the dates of service, and the types of service that were provided.

The TPA is required to ensure FCS providers meet minimum documentation standards and cooperate in any evaluation activities by HCA, CMS, or their contractors. The state assures that there is no duplication of federal funding and the state has processes in place to ensure there is no duplication of federal funding.

APPENDIX E: CHAPTER 182-559 WAC

This page left intentionally blank. Chapter 182-559 WAC begins on the following page.

Link to Chapter 182-559 WAC **https://apps.leg.wa.gov/wac/default.aspx?cite=182-559-600**.

provider.wellpoint.com/wa

Services provided by Wellpoint Washington, Inc.

WAWP-CD-PM-047972-23