Wellpoint • Washington | Apple Health

Provider Manual

Wellpoint

Washington Apple Health

833-731-2274
provider.wellpoint.com/wa

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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 **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

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 **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 enrollees.

Our Washington office

Address:	Wellpoint Foundational Community Supports TPA 705 5th Avenue South, Suite 300 Seattle, WA 98104
Email:	**FCSTPA@Wellpoint.com**
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 Enrollee 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 **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 **provider.wellpoint.com/washington-provider/patient-care/foundational-community-supports**.
Enrollee eligibility	Phone: **844-451-2828** Online: **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	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 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 enrollee's name and ProviderOne (Medicaid) ID number • A listing of disputed claims including the Wellpoint claim number and the date(s) of service(s)

Department	Details
	• 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 community-based housing and employment resources.

FCS services are provided according to an enrollee's choice and preference at all times, including but not limited to choice of FCS provider, preference in housing community, and/or employer, and preferences relating to service engagement. HCBS could be provided to enrollees under a 1915(i) state plan amendment.

1.2 Supportive Housing Services

Supportive Housing services help individuals who are *experiencing* homelessness or *housing instability* live with maximum independence in community-integrated housing *while simultaneously bolstering their engagement in healthcare service.*

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 16 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* o 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 Predictive Risk Intelligence System (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 enrollee. 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, disenrolling from FCS services or for changing FCS service provider
- 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. Collateral services include work such as external care coordination, housing search, landlord engagement on behalf of a specific individual.

Activities include the following:

- Pre-tenancy supports
- Conducting a functional needs assessment identifying the enrollee'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 enrollee), 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 is intended to reimburse for supportive housing services only. It 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.
- Any other expenses not related to the direct provision of CSS

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 enrollee should be prioritized. For enrollee 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 enrollee. Video conferences and video calls are considered face-to-face contact. Text messages and email communications are not billable.

Reauthorization for CSS services
Community Support Services are designed to provide ongoing follow-along supports when necessary. An FCS supportive housing enrollee can reenroll for additional 180-day authorization periods of CSS services using the same health need and risk factor used for initial enrollment.

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 enrollees 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 enrollee 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 enrollees improve their functional recovery.
- There is zero exclusion. Eligibility is based on enrollee 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 enrollees to consider working.
- Services are based on enrollees' preferences and choices rather than providers' judgments. Enrollee 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 enrollees access ongoing guidance regarding Social Security, Apple Health (Medicaid), government entitlements, and other benefits. Fear of losing benefits is a major reason enrollees may not want to seek employment. It is vital that enrollees obtain accurate information and guidance on how income from employment could impact state and federal benefits, so they can make informed decisions about changes in wages and work hours. Providers who do not provide direct benefits counseling services are encouraged to subcontract with providers who can provide benefits counseling services.
- The job search should be rapid. Providers help enrollees seek jobs directly rather than providing extensive pre-employment assessment and training or intermediate work experiences. Beginning the job search process early (in other words, within 30 days) demonstrates to enrollees their desire to work is taken seriously and conveys optimism that there are multiple opportunities available in the community for enrollees to achieve their vocational goals.
- Job development is systematic. Providers develop relationships with employers based on their enrollees' 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 enrollee 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 enrollee

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.

FCS Supported Employment Exclusions

FCS supported employment services are intended to reimburse for the provision of supported employment services only. They do 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.
- Any other expenses not a direct supported employment service.

Note: Supported employment 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 enrollee should be prioritized. For enrollee 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 enrollee. 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.

4. 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.

Supported Employment 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.

Collateral services include work such as external care coordination, employer outreach (for highest fidelity, Individual Placement and Support (IPS) only recognizes employer outreach that is done face to face), work incentive planning and benefit education, and supported education activities such as communicating with college counselors or program staff of other educational programs on behalf of a specific individual.

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 enrollee 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 enrollee 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 enrollee 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 enrollee'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 (in other words, 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 o 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 enrollee 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 enrollee's options for returning to work
- Transportation (only in conjunction with the delivery of an authorized service)
- Asset development — defined as services supporting enrollee's accrual of assets that have the potential to help enrollees 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 enrollee to sustain competitive work in an integrated setting of his or her choice
  - This service is provided for, or on behalf of, an enrollee and can include communicating with the enrollee's supervisor or manager, whether in the presence of the enrollee or not (if authorized and appropriate). There is regular contact and follow-up with the enrollee and employer to reinforce and stabilize job placement. Follow-along support and/or accommodations are negotiated with an employer prior to the enrollee 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.

Benefits Planning and Counseling

If your agency does not directly provide benefits education, planning and counseling services, Wellpoint can assist you in connecting with an agency that does provide these services. If requested, we can provide a sample agreement for subcontracting with a benefits planner.

Reauthorization for supported employment services

FCS supported employment services are designed to provide ongoing follow-along supports when necessary. An FCS supported employment enrollee can reenroll for additional 180-day authorization periods of IPS services using the same health need and risk factor used for initial enrollment without need for revalidation of health need and risk factor as long as the enrollee continues to need these services.

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, enrollee eligibility, claims information, inquiries, requesting interpreter services and recommendations you may have about improving our processes.

Wellpoint will coordinate with contracted 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: dshs.wa.gov/contact-dshs

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

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

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:

  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 enrollees in online searchable format. Since use of these directories is how enrollees 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. ENROLLEEELIGIBILITY AND ENROLLMENT

3.1 General Eligibility Criteria

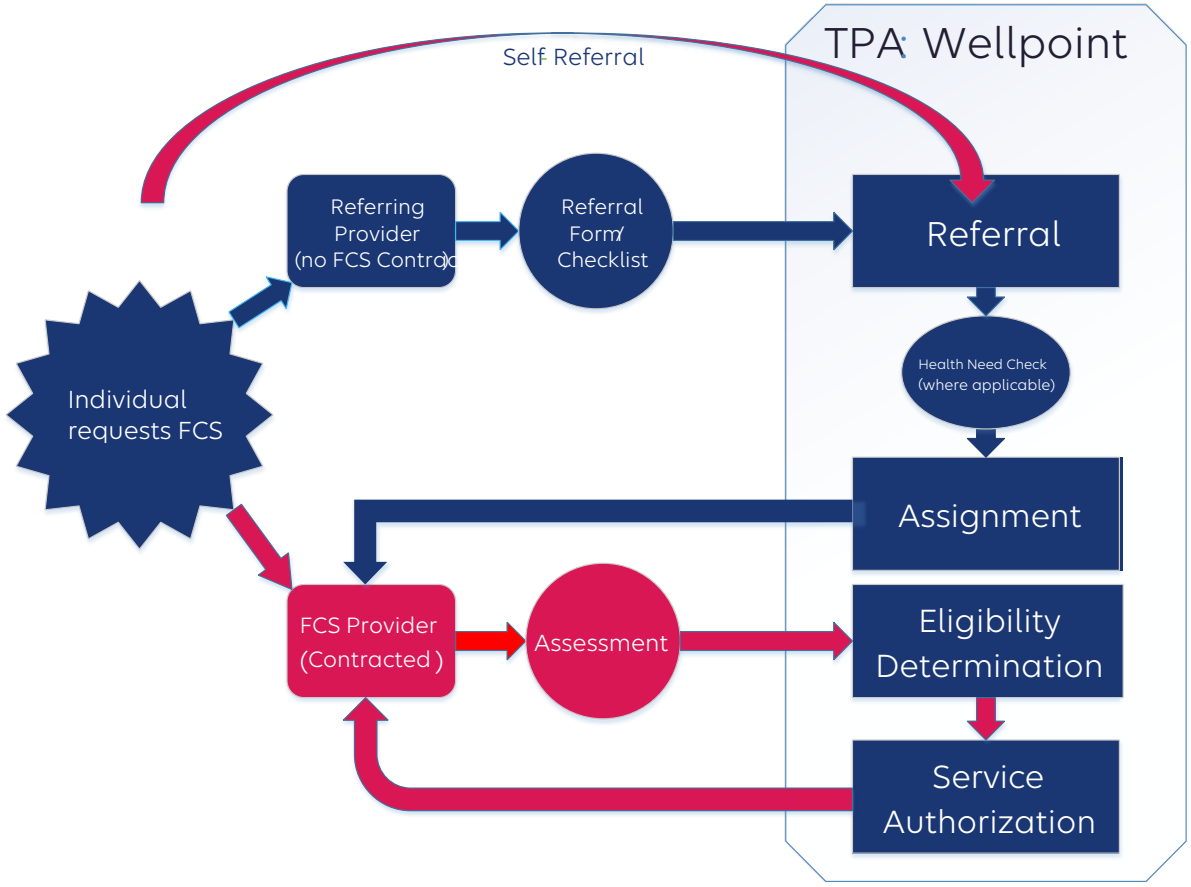
Individuals in the following Apple Health (Medicaid) coverage groups at the time of enrollment are eligible for FCS:

- 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
- Recipient Aid Category (RAC) needs to be one of the eligible RACs listed in the table below:

1014	1046	1070	1109	1151	1175	1217	1227	1237	1247	1257	1267
1015	1047	1071	1110	1152	1196	1218	1228	1238	1248	1258	1268
1016	1052	1072	1111	1153	1197	1219	1229	1239	1249	1259	1269
1017	1053	1073	1121	1162	1198	1220	1230	1240	1250	1260	1271
1018	1055	1074	1134	1163	1199	1221	1231	1241	1251	1261	1274
1019	1065	1104	1146	1164	1200	1222	1232	1242	1252	1262	1275
1020	1066	1105	1147	1165	1201	1223	1233	1243	1253	1263	1279
1021	1067	1106	1148	1168	1203	1224	1234	1244	1254	1264	1280
1022	1068	1107	1149	1169	1204	1225	1235	1245	1255	1265	1281
1023	1069	1108	1150	1174	1205	1226	1236	1246	1256	1266	

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.
2. Providers can contact Wellpoint at **844-451-2828** for additional questions regarding this process.
3. Wellpoint validates the individual's eligibility.
4. Wellpoint refers the individual to a provider based on assignment methodology (provider or Health Care Authority notification of eligibility)
5. The provider conducts outreach to the individual.
6. The provider completes an assessment for service eligibility.
7. The provider notifies Wellpoint. The assessment may not be more than 10 business days old.*
8. Wellpoint makes the final determination to authorize service delivery.**

Contracted providers submit completed assessment forms directly to Wellpoint via the electronic assessment portal at 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.

3.3 Enrollee Requests for Provider Change

Enrollees 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, or they will be assigned to one by Wellpoint.

Enrollees can inform Wellpoint of the change by calling the FCS Program Line at **844-451-2828**. Alternatively, the enrollee 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

Provider Change Request forms must be signed by the FCS enrollee to be considered valid. All documentation relating to a voluntary provider change must be maintained in an enrollee's file, and it is subject to review during Wellpoint 's Quality Assurance (QA) process.

3.4 Exception to Rule/Limited Extension Requests

Additional supported employment or supportive housing units above the initial units authorized during an enrollee's period of authorization may be requested for enrollees when the enrollee 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 enrollee to receive more units during the current authorization period
- A description of services that have been tried and their outcomes
- The enrollee'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 enrollee 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 enrollee'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

Enrollees can be disenrolled from the FCS program at any time. To officially disenroll, an enrollee can complete the online *Disenrollment Form*. This form can be found on the FCS provider site, under the Forms section. The form must be signed by the enrollee indicating their consent to disenroll in FCS services.

Alternatively, the enrollee may call the FCS Program Line at **844-451-2828** to request disenrollment. Providers cannot request voluntary termination on behalf of an enrollee, but may submit a request for involuntary disenrollment due to inactivity.

Possible Disenrollment Reasons

The enrollee:

- Requested the disenrollment.
- Is deceased.
- Has moved out of state.
- Lost Apple Health (Medicaid) eligibility.
- No longer meets criterion for FCS services.
- Meets the criteria for Involuntary Disenrollment due to Inactivity.

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

Involuntary Disenrollment Due to Inactivity

When a contracted FCS provider is unable to engage an inactive FCS enrollee after multiple attempts, an FCS provider may disenroll the participant from FCS services following the standardized procedures below. This process includes the submission of the FCS Disenrollment Form due to inactivity by a contracted FCS provider to Wellpoint after the provider takes the steps outlined below.

When a wet signature is not obtainable, contracted FCS providers may only disenroll an enrollee when the following due diligence terms are met:

- At least four attempts at contacting the inactive FCS enrollee must occur over a minimum of six weeks or longer.
  - Each attempt at contacting an enrollee must:
    - Occur at least one week apart from one another,

    - Occur on different days of each week and at different times of the day (to maximize the opportunities for making contact), and
    - Be documented in the enrollee's file.

- At least two methods of communication must be utilized when attempting to contact the inactive FCS enrollee.
  - Approved forms of attempted contact include:
    - In-person
    - Phone
    - Email
    - Letter

Note: While text messages and collateral contacts are not sufficient methods of attempted contact, they can be used to initiate contact with an enrollee so that an approved form of contact can be used.

After the due diligence terms are met, the contracted FCS provider may submit the FCS Disenrollment Form due to inactivity located on the Wellpoint FCS provider website. All documentation relating to disenrollments must be maintained in an enrollee's file, and it is subject to review during Wellpoint 's Quality Assurance (QA) process. The FCS Provider must attest to having completed their Due Diligence prior to initiating the disenrollment process.

All disenrolled enrollees may submit a Request for Reconsideration to Wellpoint through their former FCS provider (FCSTPA@Wellpoint.com) within 30 days of the date of their disenrollment if they feel they've been inappropriately disenrolled.

Disenrolling inactive FCS enrollees is not mandatory. If an FCS enrollee is inactive due to incarceration, inpatient treatment, or for any other reason that warrants keeping them enrolled, please do so.

Each disenrollment will result in a disenrollment start date effective on the first calendar day of the following month.

Involuntary Termination of Enrollment

If an enrollee 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).

3.6 Enrollment Pause and Waitlist

FCS is a pilot program with a limited budget. This budget is primarily driven by the number of enrollments and engaged enrollees in each month. Each year, HCA submits a Decision Package to the Governor's Office and the Office of Financial Management. Decision Packages provide updated, projected enrollments and service utilization trends based on historical data.

When FCS enrollment reaches budgetary limits, enrollment of new enrollees may be paused. Current enrollees may be re-authorized for and receive additional services, as long as they remain eligible for FCS services. During an enrollment pause, the FCS program will have a 30-day window for reauthorizing individuals (after their authorization has expired). If an FCS reauthorization assessment is received more than 30 days after an authorization has expired, an enrollee will not be reauthorized for services. Instead, they will be placed on the waitlist.
If eligible for the other service, currently authorized enrollees may be enrolled in the other service type (in other words, supported employment services, supportive housing services).

New enrollees will not be enrolled or denied but will instead be placed on a waitlist. The waitlist is on a first-come, first-served basis, under Washington Administrative Code (WAC) 182-559-100 based on the date and time an assessment is received. Enrollment will reopen when the number of enrollees reaches the forecasted enrollment target numbers for a given month. As space becomes available, Wellpoint will evaluate the new assessments from the waitlist and follow the standard documentation and eligibility determination process.

4. PROVIDER ROLES, RESPONSIBILITIES AND CREDENTIALING

4.1 General Requirements

All providers must:

- Have an effective mechanism to communicate with enrollees and potential enrollees 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 enrollee 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 enrollees.
- Not discriminate against eligible enrollees 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 enrollees 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 enrollees 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 enrollee 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 enrollee should be offered a new appointment. Walk-in enrollees should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.

4.2 Contracting

To apply to become a contracted Foundational Community Supports (FCS) provider, please email FCSTPA@Wellpoint.com, and we will assign an FCS manager to assist you with the contracting and credentialing process.

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

Qualifications

I. Use 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*
   c. *WAC 388-877b-0740*) by the DSHS Division of Behavioral Health and Recovery.
   d. For contracted providers, one of the following:

      ii. 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 or

iii. 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.

a. Commitment to Supportive Housing quality standards and participation in fidelity reviews
b. 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
c. No history of significant deficiencies as evidenced by monitoring, licensing reports or surveys
d. 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
    i. Note: This also includes any outside agency, person or organization that will do any part of the work defined in the contract.
e. Current staff, including those with unsupervised access to enrollees 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
f. 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 enrollees 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

Agencies contracting to provide FCS services will comply with the Wellpoint contracting and credentialing procedures, which may include:

- Verification of business license, physical address, NPI, and Tax ID
- Verification of general and professional liability insurance
- Disclosures of ownership and control of the FCS provider agency
- Disclosures of information on persons convicted of crimes
- Physical site inspection of any site(s) being used to provide FCS services or house FCS records
- Additional information necessary for contracting and credentialing

To be an FCS provider, you will need the following items:

1. Taxpayer Identification Number (TIN)
2. National Provider Identifier (NPI)
3. ProviderOne Enrollment (aka: Medicaid ID)
4. *FCS Provider Agreement*
5. *FCS Provider Application*
6. *W-9*
7. OneHealthPort (OHP)

Obtain the following items first:

1. Taxpayer Identification Number (TIN)
2. National Provider Identifier (NPI)

Search for your organization and/or create a new account at the NPI Registry. You will first need to create an Identity and Access Management System (I&A) account so you can login to the NPI Registry.

3. ProviderOne Enrollment (aka: Medicaid ID)
   Enroll your organization with ProviderOne with Washington State Health Care Authority (HCA) to get a ProviderOne ID (aka: Medicaid ID). Fill out the following two forms and email them to appropriate contact at HCA to expedite:
   - **https://www.hca.wa.gov/assets/billers-and-providers/nonbilling-provider-organizational-form-13-018.pdf**Apple Health (Medicaid) Enrollment Application and Agreement for Non-billing Provider Organizations:
   - Under Section 1 (type of practice) please enter supportive housing and/or supported employment.
   - FCS providers do not need to fill out Section 4 and Section 5.
   - *Organizational Non-billing Provider Agreement*

Please note:

- You need an NPI before you enroll with ProviderOne and get a Medicaid ID.
- There is a separate process for FCS providers to expedite this process. Do not submit the forms directly to Provider Enrollment.
- You will need to revalidate the enrollment every five years with HCA.

Once you have a TIN, NPI, and ProviderOne/Medicaid ID complete, return the following documents to Wellpoint. Contracting and credentialing takes 30 to 60 days from the date Wellpoint receives all the needed documents.

4. *FCS Provider Agreement*:
   - Complete the *FCS Provider Agreement* emailed to you by a Wellpoint FCS manager.
5. *FCS Provider Application*:
   - Complete the online *FCS Provider Application*.
6. *W-9*:
   - Complete and sign the online 2024 *W-9*.

Once you have submitted all the needed documents to Wellpoint, start the OHP registration.

7. OneHealthPort (OHP)
   Register your organization with OneHealthPort (OHP) to access ProviderOne. OHP offers a single sign-on to access ProviderOne. ProviderOne is how you will view your clients' Medicaid eligibility and FCS enrollment.

4.3 Quality Monitoring and Reporting

Providers must:

- Participate in scheduled training, fidelity reviews, 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.
- Share records with Wellpoint to show demonstrated capacity of the organization to provide FCS services if requested.
- Agree to a physical inspection of any facility or site where FCS services are performed or FCS records are kept if requested.

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.

Fidelity reviews/assessments measure whether a program operates according to standardized practices. Fidelity assessments use objective rating systems (also called tools, measures, or instruments) with instructive protocols to determine the extent to which program components adhere to established models, theories, or philosophies. The fidelity measures developed for consumer operated services enable program leaders to pinpoint program departures from standard practices and models (Holter, Mowbray, Bellamy, MacFarlane & Dukarski, 2004; Johnsen, Teague & McDonel-Herr, 2005). Research findings to date indicate that fidelity assessments should be used to inform strategic planning, staff training, program development, and other quality improvement initiatives.

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.

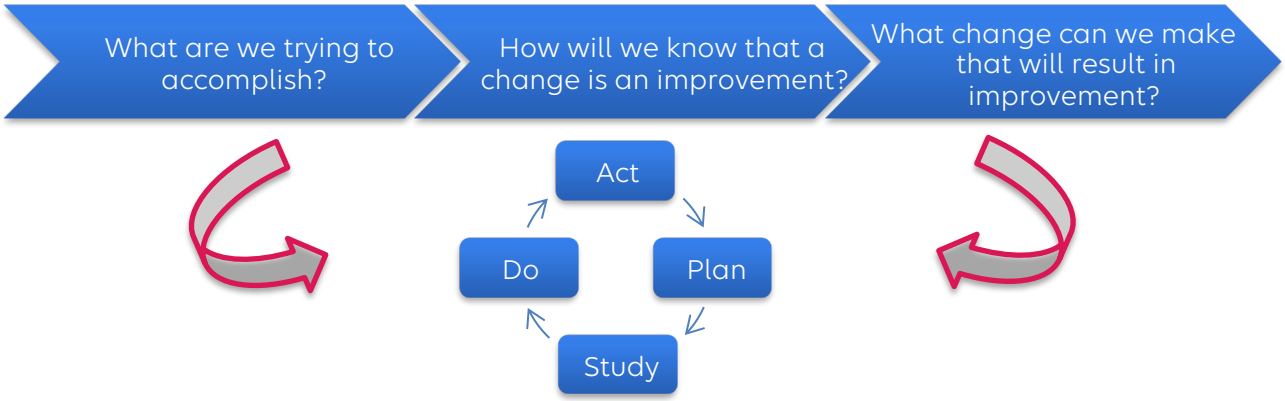
FCS providers are responsible for quality improvement activities that promote objective and systematic measurement, monitoring and evaluation of services. Activities include:

- Adhering to the Evidence-based practices of Supportive Housing (SAMHSA EBP of PSH) and Supported Employment (IPS model).
- 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 enrollee 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 enrollee 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 enrollee'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 enrollee satisfaction.
- Number of work days and hours.
- Wages earned.
- Number of jobs.

Provider Outcome and Capacity Reports are due before the 10th of every month. This information is crucial in illustrating the effectiveness of the FCS program to the State of Washington and Centers for Medicare and Medicaid Services (CMS). The capacity data is needed for us to know which providers are accepting external referrals. A link to the monthly outcome and capacity report can be found on the FCS provider website.

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 healthcare 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 healthcare. This includes any enrollee actions that result in unnecessary costs.

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

Presentation of an enrollee identification (ID) card does not guarantee eligibility; Providers should verify an enrollee'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 enrollees 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 enrollees 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 (for example, Provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any enrollee (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, select "**Report it**" and complete the "**Report Waste, Fraud and Abuse**" form
- 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:
Enrollees Fraud
Call DHS at **360-725-0934** to report Medicaid member fraud
Email: W**AHEligibilityFraud@hca.wa.gov**

Providers Fraud
833-794-2345 to report Medicaid provider fraud
Email: **hottips@hca.wa.gov**

Mail to report provider or member fraud:
Health Care Authority
Attention: DAIO
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 Enrollee'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 an enrollee include:

- The enrollee's name
- The enrollee's date of birth, Provider One ID number, or Member ID number if you have it
- The city where the enrollee 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 FCS enrollees.

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 an enrollee 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 an enrollee 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 an enrollee appears to have committed fraud, waste or abuse or has failed to correct issues, the enrollee may be involuntarily dis-enrolled from the FCS program with state approval.

Offsets.

Wellpoint shall be entitled to offset claims and recoup an amount equal to any overpayments ("Overpayment Amount") or improper payments made by the health plan to Provider or Facility against any payments due and payable by the health plan to Provider or Facility with respect to any Health Benefit Plan under any contract with our company regardless of the cause. Provider or Facility shall voluntarily refund the Overpayment Amount regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by the health plan that an Overpayment Amount is due from Provider or Facility, Provider or Facility must refund the Overpayment Amount within the timeframe specified in letter notifying the Provider or Facility of the Overpayment Amount. If the Overpayment Amount is not received within the timeframe specified in the notice letter, the health plan shall be entitled to offset the unpaid portion of the Overpayment Amount against other Claims payments due and payable by Wellpoint to Provider or Facility under any Health Benefit Plan in accordance with Regulatory Requirements. Should Provider or Facility disagree with any determination, Provider or Facility shall have the right to appeal such determination under Wellpoint procedures set forth in this Provider Manual, on condition that that such appeal shall not suspend Wellpoint's right to recoup the Overpayment Amount during the appeal process unless required by Regulatory Requirements. Wellpoint reserves the right to employ a third-party collection agency in the event of non-payment.

Privacy, Confidentiality and Compliance

We're committed to safeguarding enrollee 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 enrollee 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 healthcare fraud.
- Simplifies the administration of health insurance.

Enrollee 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.
- Authorize disclosure of PHI outside of treatment, payment or healthcare operations and cancel such authorizations.

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

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.
- Enrollee 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 enrollees 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 enrollees receiving services, number of enrollees housed or employed, number of enrollees 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
- Enrollee records (with onsite inspection)
- Care plan assessment
- Delegated entity monitoring
- Breach notifications
- Enrollee incidents
- Enrollee outcomes, including the following:
  - Number and percentage of enrollees housed in the community after 30 and 90 calendar days following service initiation; longevity in housing
  - Number and percentage of enrollees engaged in employment-seeking activities, supported employment
    - Number and percentage of enrollees in integrated and competitive employment; longevity of competitive employment
- Enrollee voice and experience — measures satisfaction with services and providers, interpreter utilization, and culturally appropriate activities to support enrollee 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 enrollees 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 an enrollee experiences to receive service(s), duration of time an enrollee remains in service(s) and referrals made for applicants who are ineligible for FCS
- Enrollee stability — measures enrollees having reduced contact with law enforcement, increased social connectedness and decreases in acute healthcare utilization
- Health services utilization — measures emergency room and inpatient utilization and total healthcare costs

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

4.6 Grievances, Appeals and Discrimination

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

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

Enrollees who contact us with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when a Wellpoint representative working with an enrollee identifies a potential act of discrimination. We advise the enrollee 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.

Enrollees 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 ocrportal.hhs.gov/ocr/smartscreen/main.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 enrollee 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
- Email: FCSTPA@Wellpoint.com
- 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, an enrollee of a protected class (in other words, 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. It is also recommended that all FCS providers connect with the DBHR FCS training team for ongoing technical assistance and training around Supportive Housing and Supported Employment services and the fidelity of the FCS program. For more information, please email Employment_Assistance@hca.wa.gov or Housing_Assistance@hca.wa.gov.

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 hca.wa.gov/about-hca/programs-and-initiatives/medicaid-transformation-project-mtp/housing-and-employment

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

Availity l 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: **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 **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 **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 Provider and Facility Digital Guidelines

Wellpoint understands that working together digitally streamlines processes and optimizes efficiency. We developed the Provider and Facility Digital Guidelines to outline our expectations and to fully inform Providers and Facilities about our digital platforms.

Wellpoint expects Providers and Facilities will utilize digital tools, unless otherwise prohibited by law or other legal requirements.

Digital guidelines establish the standards for using secure digital Provider platforms (websites) and applications when transacting business with Wellpoint. These platforms and applications are accessible to both participating and nonparticipating Providers and Facilities and encompass Availity.com, electronic data interchange (EDI), electronic medical records (EMR) connections and business-to-business (B2B) desktop integration.
The Digital Guidelines outline the digital/electronic platforms Wellpoint has available to participating and nonparticipating Providers and Facilities who serve its Members. The expectation of Wellpoint is based on our contractual agreement that Providers and Facilities will use these digital platforms and applications, unless otherwise mandated by law or other legal requirements. Digital and/or electronic transaction applications are accessed through these platforms:

- Availity EDI Clearinghouse
- B2B application programming interfaces (APIs)
- EMR connections

Digital guidelines available through Availity Essentials include:

- Acceptance of digital ID cards

- Eligibility and benefit inquiry and response
- Prior authorization submissions including updates, clinical attachments, authorization status, and clinical appeals
- Claim submission, including attachments, claim status
- Remittances and payments
- Provider enrollment
- Demographic updates

Additional digital applications available to Providers and Facilities include:

- Pharmacy prior authorization drug requests
- Services through Carelon Medical Benefits Management, Inc.
- Services through Carelon Behavioral Health, Inc.

Wellpoint expects Providers and Facilities transacting any functions and processes above will use available digital and/or electronic self-service applications in lieu of manual channels (paper, mail, fax, call, chat, etc.). All channels are consistent with industry standards. All EDI transactions use version 5010.

Note: As a mandatory requirement, all trading partners must currently transmit directly to the Availity EDI gateway and have an active Availity Trading Partner Agreement in place. This includes providers using their practice management software & clearinghouse billing vendors. Providers and Facilities who do not transition to digital applications may experience delays when using non-digital methods such as mail, phone, and fax for transactions that can be conducted using digital applications.

Section 1: Accepting digital ID cards

As our Members transition to digital Member ID cards, Providers and Facilities may need to implement changes in their processes to accept this new format. Wellpoint expects that Providers and Facilities will accept the digital version of the member identification card in lieu of a physical card when presented. If Providers and Facilities require a copy of a physical ID card, Members can email a copy of their digital card from their smartphone application, or Providers and Facilities may access it directly from Availity Essentials through the Eligibility and Benefits Inquiry application.

Section 2: Eligibility and benefits inquiry and response

Providers and Facilities should leverage these Availity Clearinghouse hosted channels for electronic eligibility and benefit inquiry and response:

- EDI transaction: X12 270/271 – eligibility inquiry and response
  - Wellpoint supports the industry standard X12 270/271 transaction set for eligibility and benefit inquiry and response as mandated by HIPAA.
- Availity Essentials

  - The Eligibility and Benefits Inquiry verification application allows a Provider and Facility to key an inquiry directly into an online eligibility and benefit look-up form with real-time responses.

- Provider desktop integration via B2B APIs
  - Wellpoint has also enabled real-time access to eligibility and benefit verification APIs that can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration opportunities.

Section 3: Prior authorization submission, attachment, status, and clinical appeals.
Providers and Facilities should leverage these channels for prior authorization submission, status inquiries and to submit electronic attachments related to prior authorization submissions:

- EDI transaction: X12 278 – prior authorization and referral:
  - Wellpoint supports the industry standard X12 278 transaction for prior authorization submission and status inquiry as mandated per HIPAA.
- EDI transaction: X12 275 – patient information, including HL7 payload for authorization attachments:
  - Wellpoint supports the industry standard X12 275 transaction for electronic transmission of supporting authorization documentation including medical records via the HL7 payload.
- Availity Essentials:
  - Authorization applications include the Availity Essentials multi-payer Authorization and Referral application for authorization submissions not accepted through Availity Essentials' multi-payer application.
    - Both applications enable prior authorization submission, authorization status inquiry and the ability to review previously submitted authorizations.
- Provider desktop integration via B2B APIs:
  - Wellpoint has enabled real-time access to prior authorization APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration.

Section 4: Claims: submissions, claims payment disputes, attachments, and status
Claim submissions status and claims payment disputes
Providers and Facilities should leverage these channels for electronic Claim submission, attachments (for both pre- and post-payment) and status:

- EDI transaction: X12 837 – Professional, institutional, and dental Claim submission (version 5010):
  - Wellpoint supports the industry standard X12 837 transactions for all fee-for-service and encounter billing as mandated per HIPAA.
  - 837 Claim batch upload through EDI allows a provider to upload a batch/file of Claims (must be in X12 837 standard format).

- EDI transaction: X12 276/277 – Claim status inquiry and response:
  - Wellpoint supports the industry standard X12 276/277 transaction set for Claim status inquiry and response as mandated by HIPAA.
- Availity Essentials: The Claims & Payments application enables a provider to enter a Claim directly into an online Claim form and upload supporting documentation for a defined Claim.
  - Claim Status application enables a provider to access online Claim status. Access the Claim payment dispute tool from Claim Status. Claims Status also enables online claim payment disputes in most markets and for most claims. It is the expectation of Wellpoint that electronic Claim payment disputes are adopted when and where it is integrated.
- Provider desktop integration via B2B APIs:
  - Wellpoint has also enabled real-time access to Claim Status via APIs, which can be directly integrated within participating vendor's practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration.

Claim attachments

Providers and Facilities should leverage these channels for electronic Claim attachments from Availity.com:

- EDI transaction: X12 275 – Patient information, including HL7 payload attachment:
  - Wellpoint supports the industry standard X12 275 transaction for electronic transmission of supporting Claim documentation including medical records via the HL7 payload.
- Availity Essentials – Claim Status application enables a Provider or Facility to digitally submit supporting Claims documentation, including medical records, directly to the Claim.
  - Digital Request for Additional Information (Digital RFAI) – The Medical Attachments application on Availity Essentials enables the transmission of digital notifications when additional documentation including medical records are needed to process a Claim.

Section 5: Electronic remittance advice and electronic claims payment

Electronic remittance advice

Electronic remittance advice (ERA) is an electronic data interchange (EDI) transaction of the explanation of payment of your claims. Wellpoint supports the industry standard X12 835 transaction as mandated per HIPAA.
Providers and Facilities can register, enroll and manage ERA preference through **Availity.com.**
Printing and mailing remittances will automatically stop thirty (30) days after the ERA enrollment date.

- Viewing an ERA on Availity Essentials is under Claims & Payments, Remittance Viewer. Features of remittance viewer, include the ability to search a two (2) year history of remittances and access the paper image.
- Viewing a portable document format (PDF) version of a remit is under Payer Spaces which provides a downloadable PDF of the remittance.

To stop receiving ERAs for your claims, contact Availity Client Services at **800-AVAILITY** (**282-4548**).

To re-enable receiving paper remittances, contact Provider Services.

Electronic claims payment

Electronic claims payment is a secure and fast way to receive payment, reducing administrative processes. There are several options to receive claims payments electronically.

- Electronic Funds Transfer (EFT)

Electronic funds transfer (EFT) uses the automated clearinghouse (ACH) network to transmit healthcare payments from a health plan to a Provider's or Facility's bank account at no charge for the deposit. Health plans can use a Provider's or Facility's banking information only to deposit funds, not to withdraw funds. The EFT deposit is assigned a trace number (TRN) to help match the payment to the correct 835 electronic remittance advice (ERA), a process called reassociation.

To enroll in EFT: Providers and Facilities can register, enroll, and manage account changes for EFT through EnrollSafe at enrollsafe.payeehub.org. EnrollSafe enrollment eliminates the need for paper registration. EFT payments are deposited faster and are generally the lowest cost payment method. For help with enrollment, use this convenient EnrollSafe User Reference Manual.

To disenroll from EFT: Providers and Facilities are entitled to disenroll from EFT.
Disenroll from EFT payments through EnrollSafe at enrollsafe.payeehub.org.

- Virtual Credit Card (VCC)

For Providers and Facilities who don't enroll in EFT, and in lieu of paper checks, Wellpoint is shifting some reimbursements to virtual credit card (VCC). VCC allow Providers and Facilities to process payments as credit card transactions. Check with your merchant processor regarding standard transaction fees that will apply.
Note that Wellpoint may receive revenue for issuing a VCC.

Opting out of virtual credit card payment. Providers and Facilities are entitled to opt out of electronic payment. To opt out of virtual credit card payment, there are two (2) options:

- Enrolling for EFT payments automatically opts you out of virtual credit card payments. To receive EFT payments instead of virtual credit cards payments, enroll for EFT through EnrollSafe at enrollsafe.payeehub.org.

  OR

- To opt out of virtual credit card payments, call **800-833-7130** and provide your taxpayer identification number.

- Zelis Payment Network (ZPN) electronic payment and remittance combination

The Zelis Payment Network (ZPN) is an option for Providers and Facilities looking for the additional services Zelis can offer. Electronic payment (ACH or VCC) and Electronic Remittance Advice (ERA) via the Zelis portal are included together with additional services. For more information, go to Zelis.com. Zelis may charge fees for their services.
Note that Wellpoint may receive revenue for issuing ZPN.
ERA through Availity is not available for Providers and Facilities using ZPN.

To disenroll from ZPN payment, there are two (2) options:

- Enrolling for EFT payments automatically removes you from ZPN payments. To receive EFT payments instead of ZPN payments, enroll for EFT through EnrollSafe at enrollsafe.payeehub.org.

  OR

- To disenroll from ZPN payments, update your Zelis registration on the Zelis provider portal or contact Zelis at **877-828-8770**.

Not being enrolled for EFT, VCC, or ZPN will result in paper checks being mailed.

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 (**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 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 / enrollee
- Coordination of Benefits
- Allowance overpayments
- Late credits
- Billed in error
- Duplicate
- Non-covered services
- Claims editing
- Terminated enrollees
- Total charge overpaid
- Paid wrong enrollee / 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
- Enrollee ProviderOne ID number
- Enrollee'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 **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 **provider.wellpoint.com/washington-provider/resources/forms.** 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 — **Availity.com**

All requests should include the following information:

- Name of Provider
- Tax ID
- NPI
- Enrollee's full name
- Enrollee's ProviderOne 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, healthcare 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
- Enrollee 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 enrollee 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 **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 enrollee.

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?
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 **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 enrollee's name and his or her ProviderOne (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

6.1 Best Practices for Medicaid Documentation

Thorough documentation is essential to ensuring continuity of care, providing accountability to both the enrollee and the service provider, and providing the ability to track service outcomes and enrollee progress.

Treatment Records

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

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

Please ensure that treatment records include:

- Enrollee 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 enrollees, 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.

Assessments

Assessments are crucial for understanding the enrollee's needs to inform the development of the service/care plans.

Service/Care Plans

Person-centered care plans are enrollee driven living documents that should be changed based on enrollee needs, choices, strengths and goals. Each interaction with an enrollee should be informed by their service/care plan for the sake of quality of care and providing a medically necessary intervention.

Elements of a treatment plan include:

- Goals, objectives, and action steps that include enrollee and provider responsibility and target and completion date.
  - Goals should be done in the SMART format, meaning that all goals are Specific, Measurable, Achievable, Relevant, and Time-Bound.
- Enrollee strengths and barriers.
- Members and parties of the enrollee's support team, including natural supports.
- Evidence that the enrollee is the primary author of the service/care plan, such as direct quotes from the enrollee, cultural and linguistic considerations and language that the enrollee uses and understands.
- Clear medical necessity and reason for services/interventions.
- Dated signatures of enrollee and service provider.

For service plan example template see Appendix C.

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.

Progress Notes

Each progress note must illustrate the enrollee's story (medical necessity, goals, services and interventions) on a standalone basis. It is helpful to utilize a template for documenting enrollee interactions. The DARP (Description, Assessment, Response, Plan) format is commonly used and contains all elements required for effective documentation. See each section detailed below.

- Description:
  - Objective and factual observations.
    - Date, exact start and end times (not rounded), and location
    - Name of enrollee
    - Enrollee's statements, behaviors, and relevant observations, including direct quotes and descriptions of the enrollee's behavior.

        - For example, “Enrollee stated ‘I can’t stand my neighbor. He always gives me dirty looks.’” And “Enrollee was pacing back and forth and clenching their fists.”
    - Subjective assessment of the service provider’s observations, including emotional state, progress towards service goals, and potential issues or barriers.
        - For example, “Client appears to be experiencing heightened anxiety, as evidenced by her body language. Client has expressed anxiety around interacting with her neighbors in the past, making statements like ‘I think they want me out of here.’”
- Action: Detailing the interventions or actions taken by the service provider, including techniques used and issues and options discussed.
    - For example, “Housing specialist discussed anxiety management techniques including deep breathing, coloring or drawing, and listening to calming music”.
- Response: The enrollee’s response to the interventions and actions including verbal feedback, changes in mood or behavior, and nonverbal cues.
    - For example, “Enrollee appeared open to the idea of using coloring pages as a relaxation strategy and asked if I could help her get some colored pencils and paper.”
- Plan: Outlining the next steps, including follow-up appointments, goals, and future interventions. This will set a clear direction for the next interaction, thereby ensuring continuity of care.
    - For example, “Our next meeting is scheduled for Wednesday, June 3rd at 3pm at enrollee’s apartment. We will check in regarding the effectiveness of anxiety management techniques.”
    - The plan section must also clearly tie the interaction back to a specific goal in the enrollee’s service/care plan. For example, if this enrollee’s goal is to feel comfortable in their apartment, the service provider might say, “Helping the enrollee find positive coping strategies for anxiety will help her feel comfortable in her apartment and more equipped to maintain her housing.”

Each progress note must have the dated signature, name, and title of the individual providing the service.

6.2 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:

- Pathways to Housing: fortress.wa.gov/dshs/pathwaystohousing/P2H_Main.html
- The Substance Abuse and Mental Health Services Administration (SAMHSA)’s *Permanent Supportive Housing Evidence-Based Practices (EBP) Kit:*

store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4509

- The Corporation for Supportive Housing: csh.org/resources
- The Downtown Emergency Service Center's *Vulnerability Assessment Tool* — measuring individual's vulnerability to continued instability: 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: commerce.wa.gov
- CSD guidelines

6.3 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 enrollees into becoming *perfect workers*, extensive prevocational assessment as systematic job development is used to offer enrollees help finding and keeping jobs that capitalize on their personal strengths and motivation. Thus, the primary goal of supported employment is not to change enrollees but to find a natural fit between enrollees' strengths and experiences and jobs in the community.

You may find the following resources helpful:

- Pathways to Employment: fortress.wa.gov/dshs/pathways/(S(zp1wgldldh1gldlom4zgvrjn))/p2emain.aspx
- SAMHSA's *Supported Employment Evidence-Based Practices (EBP) Kit:* 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*)
- IPS Employment Center: ipsworks.org

7. TRANSITION ASSISTANCE PROGRAM

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 manage TAP funds for FCS. Wellpoint provides administrative oversight of TAP for FCS including contracting, authorizations, payments, 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 the TAP inbox at TransitionAssistanceFCS@Wellpoint.com.

7.2 TAP Enrollee 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 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 provider.wellpoint.com/washington-provider/patient-care/foundationalcommunity-supports > Additional Resources.
- Experiencing a behavioral health treatment need
- Making a housing transition

7.3 Expenses Payable with TAP Funding

An ETP can be requested if an item is not listed on the approved list below 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. An ETP is also required when a request for an approved item is above the allowed amount in the grid below.

The following expenses are items that can be covered up to the amount in the Can Spend column with pre-approval. All TAP expenditures require pre-approval from Wellpoint before TAP funds can be utilized. These items require an ETP if the amount requested is above the amount in the Can Spend column:

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

TAP for FCS funding category:	Items covered:	Can spend:
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

7.4 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 rental arrears is $1,500
Home modifications	• Reasonably priced home modifications approved by landlords	ETP required

7.5 Requesting TAP Funding

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

- The FCS provider can submit a TAP request to Wellpoint using the online FCS TAP Request Form, found on the FCS provider website.
- 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, the FCS provider receives payment through electronic funds transfer (EFT) or paper check.

7.6 FCS TAP Quality Assurance

FCS Supportive Housing providers who request TAP funds 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 funds, 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, leases, moving attestation, etc.), if appropriate. Please ensure that progress notes reflect necessity for TAP requests.

7.7 FCS TAP Contact Information

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

8. APPLE HEALTH AND HOMES RENTAL ASSISTANCE PROGRAM

The Apple Health and Homes Rental Assistance Program (AHAH-RAP) connects supportive housing support services with rental assistance. A drawing will be conducted for an opportunity to provide selected awardees with a chance to receive a Tenant-Based Rental Assistance (TBRA) voucher through the Department of Commerce Office of Apple Health and Homes Permanent Supportive Housing (AHAH-PSH).

As the Coordinating Entity, Wellpoint acts as an intermediary between an FCS provider and Department of Commerce Office of AHAH-PSH. Commerce is the payer of rental assistance.

8.1 Eligibility

An individual must meet all the following AHAH criteria to be eligible for AHAH-RAP as stated in RCW 74.09.886:

- 18 years or older
- Active FCS-eligible Medicaid. See the FCS Medicaid Eligibility Check at WAWA_WLP_CAID_FCSMedicaidEligibilityCheck.pdf (Wellpoint.com)
- Authorized by Wellpoint to receive FCS supportive housing services under one of the following risk factors:
  - Chronic homelessness
  - Frequent or lengthy institutional contacts
  - Frequent adult residential care stays
- Experiencing homelessness as defined in RCW 43.185c.010

8.2 Rental Assistance Subsidy

The AHAH Rental Assistance Program Tenant-Based Rental Assistance (TBRA) voucher will cover up to 130% of Fair Market Rent (*FMR). The awardee is responsible for approximately 30% of their income towards their monthly rent. The subsidy covers the remainder of the monthly rent. The AHAH Rental Assistance Program (AHAH-RAP) awardees aren't required to have an income to be eligible for AHAH-RAP.

8.3 Drawing

FCS-SH providers will work with their FCS-SH AHAH-eligible enrollees to complete an AHAH Assessment. The AHAH Assessment provides additional information about the person and their current circumstances. Wellpoint is incorporating the AHAH Assessment questions into the FCS-SH Assessment.

AHAH-eligible enrollees with a completed AHAH Assessment will be added to the drawing pool. Enrollees must be enrolled in FCS-SH services at the time of the drawing to receive the AHAH-RAP voucher, if selected. There will be a quarterly drawing for each of the 10 regions.

The drawing process is outlined below:

1. Wellpoint compiles a list of current Foundational Community Supports-Supportive Housing (FCS-SH) enrollees and sends each provider a list of their potential Apple Health and Homes Rental Assistance Program (AHAH-RAP) eligible enrollees.
2. Wellpoint sends a link to the AHAH Assessment (this process will eventually be absorbed into the current Supportive Housing assessment).
3. Providers have four weeks to complete the AHAH Assessment.
4. Wellpoint compiles data received for the AHAH-RAP drawing weighting purposes.
5. Wellpoint conducts a drawing for each region (10 regions) in collaboration with state partners.
6. Randomized, regional drawing performed using Excel's random selection function.
7. The awardees are selected for the AHAH-RAP Tenant-Based Rental Assistance voucher.
8. Wellpoint sends a welcome letter to the awardee and provider.
9. Wellpoint sends the AHAH Awardee Profile link to the provider.
10. The provider completes the AHAH Awardee Profile with the awardee.
11. The provider submits the AHAH Awardee Profile to Wellpoint.
12. Wellpoint enters this information into Commerce's data system.
13. The shopping letter is generated, and the voucher is reserved.
14. Wellpoint sends the shopping letter to the awardee and provider.
15. Wellpoint sends the voucher packet to the provider.
16. Has the awardee found housing?
    1. Yes
    2. No
17. If no, the FCS-SH provider works with the awardee to find housing.
18. If yes, the FCS-SH provider works with the awardee to fill out the voucher packet.
19. Provider sends the voucher packet to Wellpoint.
20. Wellpoint enters the information into Commerce's data system.
21. The voucher is submitted to Commerce.
22. Wellpoint enters any awardee profile changes (for example, income change) into Commerce's data system.

8.4 Provider Roles and Responsibilities

Provider to work with awardee and future landlord to complete the Voucher Packet. Providers are responsible to maintain documentation in awardee's treatment record.

Voucher Packet documents include:

- Conflict of Interest Form
- Intent to Rent Form
- Income Verification Worksheet
- Verification of Short-Term Subsidy
- AHAH Housing Health and Safety Inspection Form
- Lead Based Paint Form & Pamphlet Disclosure

- Landlord Packet

There will be an annual recertification review for the vouchers awarded by the Department of Commerce Office of AHAH-PSH. The recertification will review the tenant's portion of the rent, ensure the tenancy is intact, review potential changes to the lease or changes in the monthly rent, and review any vouchers that have not been used. Providers need to submit an AHAH Change Request Form to Wellpoint if the awardee's income changes.

8.5 Withdrawal

Awardees can withdraw from AHAH-RAP at any time. To officially withdraw, an awardee can complete a Withdrawal Form. The form must be signed by the awardee indicating their consent to withdraw from AHAH-RAP. It can be emailed to AHAH@Wellpoint.com or sent directly to the FCS address above.

Alternatively, the awardee may call the FCS Program Line at **844-451-2828** to request withdrawal.

8.5 AHAH-RAP Contact Information

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

APPENDIX A: FCS ENROLLEE RELEASE OF HMIS INFORMATION AND INFORMED CONSENT FORM

Use the FCS Enrollee Release of HMIS Information and Informed Consent form only when sending supporting documents to validate a health need or risk factor with information from the HMIS system.

Foundational Community Supports Enrollee 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), Wellpoint, 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 seven years. If you have questions about the collection of data or your rights regarding your personally identifying information, contact Wellpoint at 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 Wellpoint at 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.

_____ _____

Enrollee Signature Date

_____ _____ _____

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

Enrollee 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

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 online version of the form here: prod.aws-providerexperience.anthem.com/SupportedEmploymentAssessment/EN/#/

Potential Enrollee Information

◯ Initial Assessment ◯ Reauthorization

Last Name*

Middle Initial

First Name*

Gender

Select

Date of Birth*

mm/dd/yyyy

Date Received

07/08/2024

Date Assessment Completed*

mm/dd/yyyy

Is experiencing homelessness?

◯ Yes ◯ No

Address (not required if homeless)

City*

County*

State

Washington

Zip

Phone Number

Phone Number Type

Select

Name

Email

name@domainname.com

ProviderOne ID*

WA

Member of a federally recognized American Indian/Alaska tribe?

◯ Yes ◯ No

Veteran

◯ Yes ◯ No

If yes, please specify which tribe:

If yes, which military branch:

Complex needs eligibility requirements

Information in this section is required in order to determine eligibility for supported employment services.

Health Needs* (must select at least one)

The client meets one of the following criteria:

- [ ] 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 (as determined by a licensed behavioral health agency).
- [ ] Diagnosed with a substance use disorder (SUD), by meeting a one or higher level on the American Society of Addiction Medicine (ASAM) Criteria (as determined by a licensed behavioral health agency).
- [ ] 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 (CARE).

Complex needs eligibility requirements

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

Risk Factors* (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):

500 Character max

Employment Assessment

Please fill out to the best of your ability. Information in this section assess 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
- ☐ Family discussion (or legal guardian or designated representative)
- ☐ Referral from clinician/case manager/other
- ☐ Other:

Employment status*

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

Income source*

- ☐ Social Security (SSA)
- ☐ Social Security Disability Insurance (SSDI)
- ☐ Aged, Blind, or Disabled (ABD)
- ☐ Pension
- ☐ Temporary Assistance for Needy Families (TANF)
- ☐ Employment
- ☐ Supplemental Security Income (SSI)
- ☐ Housing and Essential Needs (HEN)
- ☐ None
- ☐ 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)
- ☐ Evicted or foreclosure within 30 days with no future residence identified
- ☐ Homeless but admitted to a hospital or other institution for less than 30 days
- ☐ In an emergency shelter
- ☐ At imminent risk of losing housing
- ☐ Couch surfing or doubled up
- ☐ Other:

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.

Individual Benefit *(please identify what information indicates the individual would benefit from supported employment services; select 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:

500 Character max

Documentation

Please fill out to the best of your ability.

Documentation Available (please check all boxes for documentation client has made available to you. Note: you do not need to include documentation with assessment.)

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

Additional supporting documentation sent?* ◯ Yes ◯ No

Send any supporting documents that validate a health need or a risk factor for the potential enrollee to the FCS team via email (FCSTPA@Wellpoint.com) or fax (844.470.8859). Documentation needs to be sent to the FCS team the same date the assessment is submitted. Be sure to include the potential enrollee's name and ProviderOne ID.

Notes:

500 Character max

Signatures

Please fill out to the best of your ability.

Assessment Reporter

Last Name*

First Name*

Position/Credentials*

Provider Agency Name*

Signature

Date*

mm/dd/yyyy

Email Address*

name@domainname.com

Phone Number*

Assessment Supervisor *(if applicable)*

Last Name

First Name

Position/Credentials

Signature

Date

mm/dd/yyyy

Enrollee consent for services

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

Last Name*

First Name*

Date*

mm/dd/yyyy

Time Consent Received*

--:-- --

Signature

☐ Verbal consent was received from the potential enrollee. Note: Please print and retain this assessment form, signed by the potential enrollee, on file

Notes:

500 Character max

Back

Review and Submit

Foundational Community Supports: Supportive Housing Assessment Form. Access the online version of this form here: **prod.aws-providerexperience.anthem.com/SupportiveHousingAssessment/EN/#/**

Potential Enrollee Information

◯ Initial Assessment ◯ Reauthorization

Last Name*

Middle Initial

First Name*

Gender

Select

Date of Birth*

mm/dd/yyyy

Date Received

07/08/2024

Date Assessment Completed*

mm/dd/yyyy

Is experiencing homelessness?

◯ Yes ◯ No

Address (not required if homeless)

City*

County*

State

Washington

Zip

Phone Number

Phone Number Type

Select

Name

Email

name@domainname.com

ProviderOne ID*

WA

Member of a federally recognized American Indian/Alaska tribe?

◯ Yes ◯ No

Veteran

◯ Yes ◯ No

If yes, please specify which tribe:

If yes, which military branch:

Complex needs eligibility requirements

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

Health Needs* (must select at least one)

The client meets one of the following criteria:

- [ ] 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 (as determined by a licensed behavioral health agency)
- [ ] Diagnosed with a substance use disorder (SUD), by meeting a one or higher level on the American Society of Addiction Medicine (ASAM) Criteria (as determined by a licensed behavioral health agency)
- [ ] 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 (CARE)
- [ ] 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.)

Complex needs eligibility requirements

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

Risk Factors* (must select at least one)

☐ 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

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
☐ Detox center
☐ Inpatient substance use treatment facility
☐ 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 predictive risk score of 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:

500 Character max

Housing Assessment

Please fill out to the best of your ability. This information is required but does not impact eligiblity

Employment status*

- [ ] Unemployed
- [ ] Employed part time
- [ ] Employed full time
- [ ] Nonpaid employment activities
- [ ] Enrolled in training/education program

Income source*

- [ ] Social Security (SSA)
- [ ] Pension
- [ ] Supplemental Security Income (SSI)
- [ ] Social Security Disability Insurance (SSDI)
- [ ] Temporary Assistance for Needy Families (TANF)
- [ ] Housing and Essential Needs (HEN)
- [ ] Aged, Blind, or Disabled (ABD)
- [ ] Employment
- [ ] None
- [ ] 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
- [ ] Other:
- [ ] Evicted or foreclosure within 30 days with no future residence identified
- [ ] At imminent risk of losing housing
- [ ] Homeless but admitted to a hospital or other institution for less than 30 days
- [ ] Couch surfing or doubled up

Housing assessment

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.

Strengths *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
- ☐ Taking medication
- ☐ Other:

Housing Assessment

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.

Housing preference setting

- ☐ Urban/Downtown
- ☐ Urban/Residential Neighborhood
- ☐ Suburban
- ☐ Rural/Small Town

Close To

- ☐ Transportation
- ☐ Recreation/Cultural
- ☐ Shopping
- ☐ Medical Services
- ☐ Family/Friends
- ☐ Place of Worship
- ☐ 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:

500 Character max

Housing Assessment

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.

Personal information related to housing placement

Does the client use a wheelchair? ◯ Yes ◯ No

If yes, please list:

Width (inches):

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, list relationship, name and contact information:

Family/partner/friend

Live-in aid

Please describe other relevant personal information related to housing placement:

300 Character max

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

Housing Assessment

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.

Transportation Information

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

Does the client have a vehicle? ◯ Yes ◯ No

Please describe the client's transportation needs:

250 Character max

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
- ☐ Non-elderly disabled
- ☐ Veteran's Assistance Supportive Housing
- ☐ Family Unification Program
- ☐ Housing Opportunities for Persons With AIDS (HOPWA)
- ☐ Other:

Project-based rental subsidy

- ☐ HUD 811 (supportive housing for persons with disabilities)
- ☐ HUD 202 (supportive housing for the elderly)
- ☐ Low-Income Housing Tax Credit
- ☐ Other:

Continuum of care

- ☐ Shelter care
- ☐ Homelessness Prevention and Rapid Re-Housing Program (HPRP)
- ☐ Permanent supportive housing
- ☐ Transitional housing
- ☐ Other:

Department of Commerce subsidized:

Other HUD or USDA subsidy:

County/city program:

Other:

Documentation

Please fill out to the best of your ability.

Documentation Available (please check all boxes for documentation client has made available to you. Note: you do not need to include documentation with assessment.)

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

Additional supporting documentation sent?* ◯ Yes ◯ No

Send any supporting documents that validate a health need or a risk factor for the potential enrollee to the FCS team via email (FCSTPA@Wellpoint.com) or fax (844.470.8859). Documentation needs to be sent to the FCS team the same date the assessment is submitted. Be sure to include the potential enrollee's name and ProviderOne ID.

Notes:

500 Character max

Signatures

Please fill out to the best of your ability.

Assessment Reporter

Last Name*

First Name*

Position/Credentials*

Provider Agency Name*

Signature

Date*

mm/dd/yyyy

Email Address*

name@domainname.com

Phone Number*

Assessment Supervisor *(if applicable)*

Last Name

First Name

Position/Credentials

Signature

Date

mm/dd/yyyy

Enrollee consent for services

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

Last Name*

First Name*

Date*

mm/dd/yyyy

Time Consent Received*

--:-- --

Signature

☐ Verbal consent was received from the potential enrollee. Note: Please print and retain this assessment form, signed by the potential enrollee, on file.

Notes:

500 Character max

Back

Review and Submit

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

The following is an example of a housing stability plan:

Housing Stability Plan

A Housing Stability Plan (STP) is mutually created between the program participant and assigned staff. The HSP is participant centered and is a constantly changing document to guide future steps together.

Name:

Address:

Contact information:

Date: Review Date(s):

Remember to make sure the goals are SMART!

Ask these questions as you partner to develop the goal(s). Sometimes it can be helpful to start with Action Steps and work backwards

Specific: What exactly do you want to do?

Measureable: How will you know you have met your goal?

Achievable: How confident are you in your ability to meet this goal? What do you need? How can I help?

Relevant: Why is this goal important to you?

Timely: When do you want this to happen?

"Results from a review of laboratory and field studies on the effects of goal setting on performance show that in 90% of the studies, specific and challenging goals led to higher performance than easy goals, "do your best" goals, or no goals." *

Categories

Selecting categories for each objective helps align and group action steps together. Categories also help auditors understand the nexus between action steps, objectives, and the overall goal.

Each category reflects frequent types of activities that occur in housing case management.

Categories: Pre-Tenancy, Income/Benefit Planning, Education, Legal, Tenancy Sustaining, Mental Wellness, Physical Wellness, Social Connection, Employment, Other (ex. Life skills, transportation, coping skills)

- Please select a category for each goal. A HSP is most effective with one or two goals paired with one to three objectives that include less than 3 action steps each.

Signatures

Signatures and initials from the participant and housing specialist are used to verify both parties have worked together to develop goals, objectives, and action steps.

While signatures also help meet Medicaid requirements, the intention is to provide true informed consent of the practices and interventions that will occur with or on the behalf of the participant.

*Locke, E. A., Shaw, K. N., Saari, L. M., & Latham, G. P. (1981). Goal setting and task performance: 1969–1980. *Psychological Bulletin, 90*(1), 125–152. https://doi.org/10.1037/0033-2909.90.1.125

Name: HMIS #: Program:

Housing Stability Plan

Participant Name:	Date	Program	HMIS #	Staff Name:
Review Date(s):				
Staff Name:				
Reason for Review				

Other care team members				
	Agency/Organization	Copy of treatment plan?	Release of Information	Contact Information:
1		☐ Yes ☐No	☐ Yes ☐No	
2		☐ Yes ☐No	☐ Yes ☐No	
3		☐ Yes ☐No	☐ Yes ☐No	

Goal Development

Problem Statement (participants direct words):

Goal in collaboration with participant:

Start Date	Target Date	Adjusted Target Date	Reason for adjustment	Participant Agrees ☐ Yes ☐No	Participant Initials

Strengths and how they will be used to meet this goal:

Skills/Knowledge Needed:

Natural/Community Supports Needed:

What might get in the way?

Desired Results (how will you know you met this goal):
Participant direct quote here

Staff Signature: Date:
Participant Signature: Date:

Name: HMIS #: Program:

Objectives				
Category:				Start Date
Objective # _____:				Expected Duration:
Action Step	Frequency	Person Responsible	Target Date	Completion Date

Objectives				
Category:				Start Date
Objective # _____:				Expected Duration:
Action Step	Frequency	Person Responsible	Target Date	Completion Date

Staff Signature: Date:
Participant Signature: Date:

Name: HMIS #: Program:

Goal Development

Problem Statement (participants direct words):

Goal in collaboration with participant:

Start Date	Target Date	Adjusted Target Date	Reason for adjustment	Participant Agrees ☐ Yes ☐No	Participant Initials

Strengths and how they will be used to meet this goal:

Skills/Knowledge Needed:

Natural/Community Supports Needed:

What might get in the way?

Desired Results (how will you know you met this goal):
Participant direct quote here

Objectives

Category:	Start Date
Objective # _____:	Expected Duration:

Action Step	Frequency	Person Responsible	Target Date	Completion Date

Staff Signature: Date:
Participant Signature: Date:

Name: HMIS #: Program:

Housing Stability Plan Notes:

Staff Signature: Date:

Participant Signature: Date:

The following is an example of an emergency plan:

My Contact Information

Name:
Address:
Phone: (preferred)_____ (message)_____(cell)_____
Employer:

Emergency Contact

Name: Phone:

Name: Phone:

Preferred Provider Contact Information

What is their relationship to you?
Provider's Name:
Address:
Phone: (office)_____ (emergency)_____ (other)_____
Do we have a release of information? Yes No

If my doctor is not available, contact these medical professionals:

My Health Care Information

Where would I prefer to be treated or hospitalized if that is necessary?

Preferred Hospital:

Second Choice Hospital:

Which facilities would I like to avoid if possible?

Facilities:

Medications:

Allergies to/intolerance of any medication:

Insurance or Medicaid information:

5 Wishes/Advanced Directive on file: YES NO

Medical Conditions that emergency responders need to know?

Support Information

PRE:

What are the signs that I am in crisis?

What are the signs that I need to go to the hospital?

How will we know something is off? Warning signs such as talking very fast, paranoia, lack of sleep, slowed down movement, excessive alcohol or drug us.

What makes it worse? Things that might trigger an episode, such as life events, travel, physical illness, or work stress.

ACTIVE:

Things people can say that are calming and reassuring:

Things people should do in crisis such as take away car keys and lock up anything dangerous such as weapons and medications:

Things emergency staff can do, such as explain things, talk slowly, observe personal space, or write things:

Reasons life is worthwhile and recovery is important:

Which person or people would I prefer to help me in crisis?

Which medications or treatments are most helpful if a crisis occurs? Which should be avoided?

Does anyone need to be contacted?

Employer Landlord Peer Support

POST:

What can others do for me that would help reduce my symptoms or make me more comfortable?

How will I know when I have recovered from a crisis?

Things that I need to do for myself every day while I am recovering from a crisis:

Things that can wait until I feel better:

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 S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

October 28, 2020

MaryAnne Lindeblad
Medicaid Director
Health Care Authority
626 8th Avenue SE
P.O. Box 45502
Olympia, Washington 98504-5010

Dear Ms. Lindeblad:

Thank you for your request to modify the Foundational Community Supports (FCS) protocol in Washington's section 1115(a) demonstration, titled "Medicaid Transformation Project" ("MTP") (Project No. 11-W-00030/1). These changes will allow the state to distribute pre-paid mobile phones to beneficiaries, when the phones are part of the beneficiary's care plan and tied to the individual's need to access services. Specifically, Washington will distribute the phones through the Accountable Communities of Health to FCS providers under contract with the third-party administrator. The FCS providers will then distribute the phones to individuals whose need to remotely access services is included in the plan of care. Additionally, with the approved changes to the protocol, Washington will also be permitted to deliver Community Support Services (CSS) to beneficiaries transitioning from an Institution for Mental Disease (IMD) into the community. As previously discussed, these approaches comport with what is currently permissible under a 1915(c) waiver and 1915(i) state plan amendment.

If you have any questions, please contact your CMS project officer, Mr. Eli Greenfield. Mr. Greenfield is available to answer any questions concerning your section 1115(a) demonstration and his contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-6157
E-mail: Eli.Greenfield@cms.hhs.gov

We look forward to our continued partnership on the MTP section 1115(a) demonstration.

Sincerely,

[redacted]

Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure

cc: Nicole Lemmon, State Lead, Medicaid and Chip Operations Group

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:
    - Including the purchase of pay-as-you-go cell phone devices as a means to access telehealth services for pre-tenancy supports.

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.
    - Including the purchase of pay-as-you-go cell phone devices as a means to access telehealth services for pre-tenancy 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. Ongoing minutes or data plans for cell phone devices;
c. Capital costs related to the development or modification of housing;
d. Expenses for utilities or other regular occurring bills;

e. Goods or services intended for leisure or recreation;
f. Duplicative services from other state or federal programs
g. Services to individuals in a correctional institution.

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
   - Including the purchase of pay-as-you-go cell phone devices as a means to access telehealth services for pre-employment services.
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.
        - Including the purchase of pay-as-you-go cell phone devices as a means to access telehealth services for follow-along supports.

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
f. Ongoing minutes or data plan for cell phone devices

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 app.leg.wa.gov/wac/default.aspx?cite=182-559

provider.wellpoint.com/wa

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