Chapter 182-559 WAC
FOUNDATIONAL COMMUNITY SUPPORTS PROGRAM

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WAC

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WAC 182-559-100 General. (1) Under the authority of the medicaid transformation project, RCW 71.24.385, and subject to available funds, the medicaid agency covers targeted foundational community supports to eligible medicaid beneficiaries, which include the following benefits:

(a) Community support services; and

(b) Supported employment services.

(2) Community support services include:

(a) Pretenancy supports:

(i) Conducting a functional needs assessment to:

(A) Identify the participant's preferences related to housing (type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences); and

(B) Identify the participant's needs for support to maintain community integration. This includes what type of setting works best for the client, assistance in budgeting for housing/living expenses, assistance in connecting the client with social services to assist with filling out applications and submitting appropriate documentation to obtain sources of income necessary for community living and establishing credit, and in understanding and meeting obligations of tenancy.

(ii) Assisting clients to connect with social services to help with finding and applying for housing necessary to support the clients in meeting their medical care needs;

(iii) Developing an individualized community integration plan based upon the assessment as part of the overall person-centered plan;

(iv) Identifying and establishing short and long-term measurable goal(s), and establishing how goals will be achieved and how concerns will be addressed;

(v) Participating in person-centered plan meetings at redetermination and revision plan meetings, as needed;

(vi) Providing supports and interventions according to the person-centered plan.

(b) Tenancy-sustaining services:

(i) Service planning support and participating in person-centered plan meetings at redetermination and revision plan meetings as needed;

(ii) Coordinating and linking the client to services including:

(A) Primary care and health homes;

(B) Substance use disorder treatment providers;

(C) Mental health providers;

(D) Medical, vision, nutritional and dental providers;

(E) Vocational, education, employment and volunteer supports;

(F) Hospitals and emergency rooms;

(G) Probation and parole;

(H) Crisis services;

(I) End of life planning; and

(J) Other support groups and natural supports.

(iii) Entitlement assistance including assisting clients in obtaining documentation, navigating and monitoring application process and coordinating with the entitlement agency;

(iv) Assistance in accessing supports to preserve the most independent living, including skills coaching, financing counseling, anger management, individual and family counseling, support groups, and natural supports;

(v) Providing supports to assist the client 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;

(vi) Coordinating with the client 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; and

(vii) Connecting the client to training and resources that will assist the client in being a good tenant and lease compliance, including ongoing support with activities related to household management.

(c) The community support services benefit does not include:

(i) Payment of rent or other room and board costs;

(ii) Capital costs related to the development or modification of housing;

(iii) Expenses for utilities or other regular occurring bills;

(iv) Goods or services intended for leisure or recreation;

(v) Duplicative services from other state or federal programs; and

(vi) Services to clients in a correctional institution.

(d) Community support services must be provided:

(i) In an integrated setting of the client's choice; and

(ii) In a manner that ensures the client's individual right of privacy, dignity, respect, and freedom from coercion and restraint;

(iii) Post tenancy, in settings consistent with home and community-based services, as defined in 42 C.F.R. Sec. 441.530, such as those that:

(A) Do not have the qualities of an institution;

(B) Are not located in a building that is also a publicly or privately operated facility providing inpatient institutional treatment;

(C) Are not on the grounds of, or immediately adjacent to a public institution;

(D) Do not have the effect of isolating the client from community members who are not receiving medicaid services; and

(E) Are not a licensed residential care facility such as an adult family home or assisted living facility.

(3) Supported employment, such as individual placement and support (IPS) services, is individualized and includes one or more of the following services:

(a) Preemployment services:

(i) Prevocational/job-related discovery or assessment;

(ii) Person-centered employment planning;

(iii) Individualized job development and placement;

(iv) Job carving;

(v) Benefits education and planning; or

(vi) Transportation (only in conjunction with the delivery of an authorized service).

(b) Employment sustaining services:

(i) Career advancement services;
(ii) Negotiation with employers;
(iii) Job analysis;
(iv) Job coaching;
(v) Benefits education and planning;
(vi) Transportation (only in conjunction with the delivery of an authorized service);
(vii) Asset development; or
(viii) Follow-along supports.
(c) The IPS benefit does not include:
(i) Generalized employer contacts that are not connected to a specific enrolled individual or an authorized service;
(ii) Employment support for individuals in subminimum wage, or sheltered workshop settings; and
(iii) Facility-based habilitation or personal care services.
(d) Supported employment services must be provided in settings consistent with settings defined in 42 C.F.R. 441.530 (a)(1)(i) through (v) and (a)(2).
(4) Clients who meet the eligibility criteria for both community support services and supported employment services may receive both services concurrently. See WAC 182-559-300 for community support services eligibility criteria and WAC 182-559-350 for supported employment eligibility criteria.
(5) In order to ensure the demand for services remains within available funds, the agency may impose enrollment waitlists for services. The waitlist for foundational community supports services is considered on a first-come first-serve basis using the date the client requests community support services.
(6) Services described in this chapter must be approved under the explicit authority of the medicaid transformation project.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 21-23-052, § 182-559-100, filed 11/10/21, effective 12/11/21; WSR 18-15-007, § 182-559-100, filed 7/6/18, effective 8/6/18. Statutory Authority: RCW 41.05.021, 41.05.160, 2014 c 225 § 9 (1)(i) and 2016 1st sp.s c 36 § 213 (1)(f) and (g). WSR 17-11-136, § 182-559-100, filed 5/24/17, effective 7/1/17.]

WAC 182-559-150 Definitions. The following definitions and those found in chapter 182-500 WAC apply to this chapter.
"Adverse benefit determination" means one or more of the following:
(a) The denial or limited authorization of a requested foundational community support services, including determinations based on the type of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a service;
(b) The reduction, suspension, or termination of a previously authorized service;
(c) The denial, in whole or in part, of payment for a service;
(d) The failure to provide services in a timely manner, as defined by the state; or
(e) The failure of the third-party administrator (TPA) to act within the time frames provided in WAC 182-559-600 for standard resolution of grievances and appeals.
"Community support services (also called supportive housing services)" means active search and promotion of access to, and choice of,

safe and affordable housing that is appropriate to the client's age, culture and needs. These services include:

(a) Providing services to eligible clients who are homeless or at risk of becoming homeless through outreach, engagement and coordination of services with shelter and housing;

(b) Ensuring the availability of community support services, with an emphasis on supporting clients in their own home or where they live in the community; and

(c) Coordinating with public housing entities, homeless continuums of care and affordable housing developers.

"Individual placement and support (IPS)" refers to an evidence-based approach to supported employment services based on the following principles:

(a) Services are open to all eligible clients who wish to work;

(b) Competitive employment is the goal;

(c) Integrated with other services provided to the client;

(d) Personalized benefits planning;

(e) Job search begins soon after the client expresses interest in working;

(f) Job search based on client preferences;

(g) Supports are not time-limited; and

(h) Client preferences are honored.

"Supported employment" means coordination with state and local entities to provide assistance and support, such as skills assessment, training, education and counseling to eligible clients who want to work.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 18-15-007, § 182-559-150, filed 7/6/18, effective 8/6/18. Statutory Authority: RCW 41.05.021, 41.05.160, 2014 c 225 § 9 (1)(i) and 2016 1st sp.s c 36 § 213 (1)(f) and (g). WSR 17-11-136, § 182-559-150, filed 5/24/17, effective 7/1/17.]

WAC 182-559-200 Eligible providers. (1) Providers of community support services and supported employment services under this authority must be:

(a) Health care professionals, entities, or contractors as defined by WAC 182-502-0002;

(b) Agencies, centers, or facilities as defined by WAC 182-502-0002;

(c) Health home providers as described in WAC 182-557-0050;

(d) Behavioral health providers licensed and certified according to chapter 246-809 WAC; or

(e) Housing, employment, social service, or related agencies with demonstrated experience and ability to provide community support services, supported employment, or equivalent services.

(i) Community support services experience may be demonstrated by:

(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) Certification in supportive housing services (WAC 246-341-0722).

(ii) Supported employment experience may be demonstrated by one or more of the following:

(A) Accredited by the commission on accreditation of rehabilitation facilities (CARF) in employment services;

(B) Certified in employment services (WAC 246-341-0720 or 246-341-0722); or

(C) All staff that will be performing supported employment services meet one of the following criteria:

(I) Be a certified employment support professional (CESP) by the employment support professional certification council (ESPCC);

(II) Be a certified rehabilitation counselor (CRC) by the commission of rehabilitation counselor certification (CRCC);

(III) Have a bachelor's degree or higher 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; or

(IV) Have four or more years of demonstrated experience providing supported employment or similar services.

(2) Providers of community support services or supported employment services must:

(a) Obtain a core provider agreement in accordance with WAC 182-502-0005;

(b) Enroll with the medicaid agency as a nonbilling provider in accordance with WAC 182-502-0006; or

(c) Be qualified to bill for home and community living administration services to provide community support services or supported employment services.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 25-22-083, s 182-559-200, filed 11/4/25, effective 12/5/25; WSR 21-23-052, § 182-559-200, filed 11/10/21, effective 12/11/21; WSR 18-15-007, § 182-559-200, filed 7/6/18, effective 8/6/18. Statutory Authority: RCW 41.05.021, 41.05.160, 2014 c 225 § 9 (1)(i) and 2016 1st sp.s c 36 § 213 (1)(f) and (g). WSR 17-11-136, § 182-559-200, filed 5/24/17, effective 7/1/17.]

WAC 182-559-300 Eligibility for community support services. To be eligible for community support services, a client must:

(1) Be age 16 or older;

(2) Be eligible for Washington apple health (medicaid);

(3) Meet at least one of the following health criteria and be expected to benefit from community support services:

(a) Clients assessed by a licensed behavioral health agency, under chapter 246-341 WAC, to have a behavioral health need, which is defined as one or both of the following criteria:

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

(ii) Substance use needs determined by an assessment using the American Society of Addiction Medicine (ASAM) criteria indicates that the client meets at least ASAM level 1.0, indicating the need for outpatient substance use disorder (SUD) treatment. The ASAM is a multidimensional assessment approach for determining a client's need for SUD treatment.

(b) Clients assessed via a CARE assessment, per WAC 388-106-0050, to have a need for assistance demonstrated by:

(i) The need for assistance with at least three activities of daily living (ADLs) defined in WAC 388-106-0010, one of which may be body care; or

(ii) The need for hands-on assistance with at least one ADL which may include body care.

(c) Clients assessed to be a homeless person with a disability, according to 24 C.F.R. 578.3, 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).

(4) Exhibit at least one of the following risk factors:

(a) Homeless clients who:

(i) Have been homeless for at least 12 months; or

(ii) Have been homeless on at least four separate occasions in the last three years, as long as the combined occasions equal at least 12 months.

Homeless is defined as living in a safe haven, an emergency shelter, or a place not meant for human habitation. See 24 C.F.R. 578.3.

(b) A history of frequent or lengthy institutional contact.

(i) Institutional care facilities include jails, substance use disorder or mental health treatment facilities, hospitals, or other similar facilities, as defined in 24 C.F.R. 578.3, or skilled nursing facilities as defined in WAC 388-97-0001.

(ii) Frequent means more than one contact in the past 12 months.

(iii) Lengthy means 90 or more consecutive days within an institutional setting in the past 12 months.

(c) A history of frequent stays at adult residential care facilities as defined by WAC 388-110-020 or residential treatment facilities as defined by WAC 246-337-005. Frequent means more than one contact in the past 12 months.

(d) Have frequent turnover of in-home caregivers as defined by WAC 388-106-0040, where within the last 12 months the client utilized three or more different in-home caregiver providers and the current placement is not appropriate for the client.

(e) Have a predictive risk score of 1.5 or above. See WAC 182-557-0225.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 23-24-012, § 182-559-300, filed 11/27/23, effective 12/28/23; WSR 21-23-052, § 182-559-300, filed 11/10/21, effective 12/11/21; WSR 18-15-007, § 182-559-300, filed 7/6/18, effective 8/6/18. Statutory Authority: RCW 41.05.021, 41.05.160, 2014 c 225 § 9 (1)(i) and 2016 1st sp.s c 36 § 213 (1)(f) and (g). WSR 17-11-136, § 182-559-300, filed 5/24/17, effective 7/1/17.]

WAC 182-559-350 Eligibility for supported employment services. To be eligible for supported employment services, a client must:

(1) Be age sixteen or older;

(2) Be eligible for apple health (medicaid);

(3) Desire to obtain employment;

(4) Meet at least one of the following health criteria and is expected to benefit from supported employment services:

(a) Clients assessed by a licensed behavioral health agency, under chapter 246-341 WAC, to have a behavioral health need, which is defined as one or both of the following criteria:

(i) Mental health needs, including 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; or

(ii) Substance use needs determined by an assessment using the American Society of Addiction Medicine (ASAM) criteria indicates that the client meets at least ASAM level 1.0, indicating the need for outpatient substance use disorder (SUD) treatment. The ASAM is a multidimensional assessment approach for determining a client's need for SUD treatment.

(b) Clients assessed via a CARE assessment, per WAC 388-106-0050, to have a need for assistance demonstrated by:

(i) The need for assistance with at least three activities of daily living (ADLs) defined in WAC 388-106-0010, one of which may be body care; or

(ii) The need for hands-on assistance with at least one ADL which may include body care.

(c) There is objective evidence, as defined by the sequential evaluation process in chapter 388-449 WAC or the progressive evaluation process in chapter 388-447 WAC, of physical or mental impairments because of which the client 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.

(5) Exhibit at least one of the following risk factors:

(a) Unable to be gainfully employed for at least ninety consecutive days due to a mental or physical impairment, as demonstrated by eligibility for the aged, blind, or disabled program as defined in WAC 388-449-0001, or the housing and essential needs program as defined in WAC 388-447-0001;

(b) More than one instance of treatment for a substance use disorder within the past two years;

(c) At risk of deterioration of mental illness and substance use disorder, or both, including one or more of the following:

(i) Persistent or chronic risk factors such as social isolation due to a lack of family or social supports, poverty, criminal justice involvement, or homelessness;

(ii) Care for mental illness and substance use disorder, or both, requires multiple provider types, including behavioral health, primary care, long-term services and supports, or other supportive services; or

(iii) Past psychiatric history, with no significant functional improvement that can be maintained without treatment and/or supports.

(d) Dysfunction in role performance due to a behavioral health condition, 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; or

(iv) Performance significantly below expectations for cognitive/developmental level.

(e) An inability to obtain or maintain employment resulting from age, physical disability, or traumatic brain injury.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 21-23-052, § 182-559-350, filed 11/10/21, effective 12/11/21; WSR 18-15-007, § 182-559-350, filed 7/6/18, effective 8/6/18.]

WAC 182-559-400 Payment. The medicaid agency pays for community support services and supported employment described in WAC 182-559-100 when no other public funds are already dedicated to providing comparable services to the client, unless the provider can demonstrate that the client requires services that are:

(1) Outside the scope of services provided by the program already in place or for which the client is otherwise eligible; and

(2) Within the scope of the services identified as reimbursable in this section.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 18-15-007, § 182-559-400, filed 7/6/18, effective 8/6/18. Statutory Authority: RCW 41.05.021, 41.05.160, 2014 c 225 § 9 (1)(i) and 2016 1st sp.s c 36 § 213 (1)(f) and (g). WSR 17-11-136, § 182-559-400, filed 5/24/17, effective 7/1/17.]

WAC 182-559-500 Foundational community supports program—Limitation of scope of benefits. Nothing in this chapter shall be construed as providing a legal right to any individual to any of the services referenced in this chapter. The services provided under this chapter are strictly limited to the authority granted to the state under the medicaid transformation project and available funds, as determined solely by the authority. Nothing in this section is intended to limit the right of an applicant or a beneficiary to request an administrative hearing under applicable law.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2014 c 225 § 9 (1)(i) and 2016 1st sp.s c 36 § 213 (1)(f) and (g). WSR 17-11-136, § 182-559-500, filed 5/24/17, effective 7/1/17.]

WAC 182-559-600 Grievance and appeals system. (1) This section contains information about the third-party administrator (TPA) grievance and appeal system and the medicaid agency's administrative hearing process for clients under the foundational community supports program.

(a) The TPA must have a grievance and appeal system and access to an agency administrative hearing to allow clients to file grievances and seek review of a TPA adverse benefit determination as defined in WAC 182-559-150.

(b) The agency's administrative hearing rules in chapter 182-526 WAC apply to agency administrative hearings requested by a client to review the resolution of a client's appeal of a TPA adverse benefit determination.

(c) If a conflict exists between the requirements of this chapter and specific program rules, the requirements of this chapter prevail.

(d) The TPA's policies and procedures regarding the grievance system must be approved by the agency.

(e) The TPA must maintain records of grievances and appeals.

(2) TPA grievance and appeal system. The TPA grievance and appeal system includes:

(a) A grievance process for addressing complaints about any matter that is not an adverse benefit determination;

(b) A TPA appeals process to address a client's request for review of a TPA adverse benefit determination;

(c) Access to the agency's administrative hearing process for review of a TPA's resolution of an appeal; and

(d) Allowing clients and the client's authorized representatives to file grievances and appeals orally or in writing. The TPA cannot require clients to provide written follow up for a grievance or an appeal that the TPA received orally.

(3) Notice requirements. The TPA must follow notice and timeline requirements under chapter 182-518 WAC. The TPA sends written notice when they:

(a) Approve the client's foundational community supports eligibility and authorize the delivery of services;

(b) Deny the client's foundational community supports eligibility; and

(c) Approve the client's foundational community supports eligibility without authorization of services due to necessary funding being unavailable. Clients must be notified of placement on a waitlist until funding becomes available.

(4) The TPA grievance process.

(a) A client or client's authorized representative may file a grievance with the TPA. A provider may not file a grievance on behalf of a client without the client's written consent.

(b) Clients do not have a right to an agency administrative hearing regarding the resolution of a grievance.

(c) The TPA must acknowledge receipt of each grievance either orally or in writing within two business days.

(d) The TPA must notify clients of the resolution of grievances within five business days of determination.

(5) The TPA appeals process.

(a) A client, the client's authorized representative, or a provider acting on behalf of the client with the client's written consent may appeal a TPA adverse benefit determination.

(b) The TPA treats oral inquiries about appealing an adverse benefit determination as an appeal to establish the earliest possible filing date for the appeal. The TPA confirms the oral appeal in writing.

(c) The TPA must acknowledge in writing the receipt of each appeal to both the client and the requesting provider within five calendar days of receiving the appeal request. The appeal acknowledgment letter sent by the TPA serves as written confirmation of an appeal filed orally by a client.

(d) The client must file an appeal of a TPA action within sixty calendar days of the date on the TPA's notice of adverse benefit determination.

(e) The TPA must continue services pending the results of an appeal or subsequent agency administrative hearing.

(f) The TPA internal appeal process:

(i) Provides the client a reasonable opportunity to present evidence and allegations of fact or law, both in person and in writing;

(ii) Provides the client and the client's representative the client's case file, other documents and records, and any new or additional evidence considered, relied upon, or generated by the TPA (or at

the direction of the TPA) in connection with the action. This information must be provided free of charge in advance of the resolution time frame for appeals as specified in this section; and

(iii) Includes as parties to the appeal:

(A) The client and the client's authorized representative; and

(B) The legal representative of the deceased client's estate.

(g) The TPA ensures that the people making decisions on appeals were not involved in any previous level of review or decision making.

(h) Time frames for resolution of appeals.

(i) The TPA resolves each appeal and provides notice as expeditiously as the client's health condition requires and no longer than three calendar days after the day the TPA receives the appeal.

(ii) The TPA may extend the time frame by an additional fourteen calendar days if it is necessary in order to complete the appeal.

(i) Notice of resolution of appeal. The notice of the resolution of the appeal must:

(i) Be in writing and be sent to the client and the requesting provider;

(ii) Include the results of the resolution of the appeal process and the date it was completed; and

(iii) Include information on the client's right to request an agency administrative hearing and how to do so as provided in the agency hearing rules under WAC 182-526-0095, if the appeal is not resolved wholly in favor of the client.

(j) Deemed completion of the TPA appeal process. If the TPA fails to adhere to the notice and timing requirements for appeals, the client is deemed to have completed the TPA's appeals process and may request an agency administrative hearing under WAC 182-526-0095.

(6) Agency administrative hearing.

(a) Only a client or the client's authorized representative may request an agency administrative hearing. A provider may not request a hearing on behalf of a client.

(b) If the client does not agree with the TPA's resolution of an appeal at the completion of the TPA appeal process, the client may file a request for an agency administrative hearing based on the rules in this section and the agency hearing rules in chapter 182-526 WAC. The client must request an agency administrative hearing within ninety calendar days of the notice of resolution of appeal.

(c) The TPA is an independent party and responsible for its own representation in any administrative hearing, appeal to the board of appeals, and any subsequent judicial proceedings.

(7) Effect of reversed resolutions of appeals. If the TPA or a final order as defined in chapter 182-526 WAC reverses a decision to deny or limit services, the TPA must authorize or provide the disputed services promptly and as expeditiously as the client's health condition requires.

(8) Funding unavailable. When a client receives approval for services and funding is unavailable, the client may appeal the determination that funding is unavailable.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 18-15-007, § 182-559-600, filed 7/6/18, effective 8/6/18.]