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State/Territory Name: Washington

1915(k) State Plan Amendment (SPA): WA-23-0007

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

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

Medicaid and CHIP Operations Group

May 17, 2023

Susan Birch, Director
Dr. Charissa Fotinos, Acting Medicaid Director
Health Care Authority
PO Box 45502
Olympia, WA 98504-5010

RE: Washington State Plan Amendment (SPA) Transmittal Number WA-23-0007

Dear Ms. Birch and Dr. Fotinos:

The Centers for Medicare & Medicaid Services (CMS) is approving your request to amend Washington's 1915(k) Community First Choice, Home and Community Based Services (HCBS) State Plan Program. The CMS Control Number for the State Plan Amendment (SPA) is Transmittal Number WA-23-0007.

With this amendment, the state is amending the Community First Choice (CFC) program to add an option that allows level of care assessments to be completed remotely when an in-person visit is not possible and also adds language that allows participants and providers to finalize the person-centered plan with an electronic signature. This SPA is approved with a retroactive effective date of April 1, 2023 as requested by the state. Enclosed is a copy of the CMS-179 summary form, as well as the approved pages for incorporation into the Washington State Plan.

Thank you for your cooperation during the review process. If there are any questions concerning this information, please contact me at (410) 786-7561. You may also contact Nick Sukachevin at Nickom.Sukachevin@cms.hhs.gov or at (206) 615-2416.

Sincerely,

George P. Failla Jr -S
Digitally signed by George P. Failla Jr -S
Date: 2023.05.17 15:01:00 -04'00'

George P. Failla, Jr., Director
Division of HCBS Operations and Oversight

cc: Bea Rector, DSHS
Jamie Tong, ALTSA
Debbie Johnson, ALTSA
Barbara Hannemann, ALTSA
Annie Moua, ALTSA
Ann Myers, HCA

DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23 — 0007

2. STATE: WA

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
1902(a) of the Act; 42 CFR 441.510

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 0
b. FFY 2023 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-K pages 11, 12, 13, 13a (new), 14, 24

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-K pages 11, 12, 13, 14, 24

9. SUBJECT OF AMENDMENT
Community First Choice State Plan Program - Remove Face-to-Face Assessments

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

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME
Charissa Fotinos MD, MSc

13. TITLE
Medicaid and Behavioral Health Medical Director

14. DATE SUBMITTED
February 17, 2023

15. RETURN TO
State Plan Coordinator
POB 42716
Olympia, WA 98504-2716

FOR CMS USE ONLY

16. DATE RECEIVED
February 17, 2023

17. DATE APPROVED May 17, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
April 1, 2023

19. SIGNATURE OF APPROVING OFFICIAL
George P. Failla Jr -S
Digitally signed by George P. Failla Jr -S
Date: 2023.05.17 15:15:16 -04'00'

20. TYPED NAME OF APPROVING OFFICIAL
George P. Failla, Jr.

21. TITLE OF APPROVING OFFICIAL
Division Director, DHCBSO

22. REMARKS

Instructions on Back

c. Empowered to make financial or health-related decisions on behalf of the participant.
d. Someone who would benefit financially from the provision of assessed needs and services.
e. A provider of State Plan Home-and-Community-Based Services (HCBS) for the participant, or has an interest in or is employed by a provider of State Plan HCBS for the participant.

IX. Assessment and Service Plan

The term "Case Manager" may include any of the following job titles: Social Worker, Social Service Specialist, Nurse Case Manager, Case/Resource Manager and Tribal Case Manager. All of these positions may provide assessment of participants for level of care, person-centered service planning, and both initial and ongoing assessment of needs. In this document, the term Case Manager will be used for consistency.

a. **Describe the assessment process or processes the State will use to obtain information concerning the individual's needs, strengths, preferences, goals, and other factors relevant to the need for services:**

The Comprehensive Assessment Reporting Evaluation (CARE) tool is used by case managers to gather information during a face-to-face visit with the participant, and/or using a telephone or another technology medium, when conditions in 42 CFR 441.535(a) are met. The CARE tool is used to document functional ability, determine eligibility for long-term care services and supports, and develop the person-centered service plan. The CARE tool is designed to be an automated, participant-centered assessment system that is the basis for comprehensive person-centered care planning.

The Department assesses the individual's ability to complete Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and Health Related Tasks. The assessment identifies whether or not paid services and supports are necessary to complete those tasks by assessing the participant's ability to self-perform the type of support and how much natural support is available to assist the participant.

The CARE tool is used to assess how physical, psychosocial, cognitive, clinical characteristics impact the individual's ability to perform ADL, IADL, and health-related tasks. The service planning process considers the needs of the participant, the availability of natural supports, and access to services. The Department also considers developmental milestones for children when individually assessing the child's abilities and need for assistance.

Information about the participant's strengths, needs, goals, and preferences is gathered from the individual, and with the individual's permission, from caregivers, family members, and other sources. This information is then addressed in an individualized person-centered service plan. The tool provides a structured, standardized approach for service and support planning that includes data collection, analysis, plan development, plan implementation, and plan evaluations.

When the assessment is complete, the CARE algorithm calculates the participant's classification level, which determines the level of service and support the participant is eligible to receive.

b. **Indicate who is responsible for completing the assessment prior to developing the Community First Choice person-centered service plan. Please provide the frequency the assessment of need will be conducted. Describe the reassessment process the State will use when there is a change in the individual's needs or the individual requests a reassessment. Indicate if this process is conducted in the same manner and by the same entity as the initial assessment process or if different procedures are followed:**

- Initial assessments of all participants are completed by State Case Managers, Social Workers, Tribal Case Managers, or Nurses. Each participant receives the same assessment regardless of the assessor's title.
- Reassessments are done by the following individuals: State Case Managers, Social Workers, Nurses, Mental Health professionals, or Tribal Case Managers.

Qualifications of individuals responsible for completing assessments:

- Registered Nurse (RN) licensed under Chapter 18.79 Revised Code of Washington acting within their scope of practice as defined by state law
- State Social Service Specialist, Mental Health Professional, State Case Manager, or Tribal case manager with the following minimum qualifications:
  - A master's degree in social services, human services, behavioral sciences, or an allied field and two years of paid social service experience performing equivalent functions;
    OR
  - A bachelor's degree in social services, human services, behavioral sciences, or an allied field and three years of paid social service experience performing equivalent functions.
  - Tribal Case Managers will demonstrate knowledge and expertise to provide culturally competent case services to members of federally recognized tribes.

Note: A two-year master's degree in one of the above fields that included a practicum will be substituted for one year of paid social service.

Assessments are conducted at least every 12 months, when the participant's circumstances or needs change significantly, and at the request of the participant.

Significant changes are changes considered likely to result in an adjustment of authorized services or CARE classification level. The same assessors and assessment tool are used for conducting significant change assessments or reassessments requested by participants.

X. Person-Centered Service Plan Development Process

a. **Indicate how the service plan development process ensures that the person-centered service plan addresses the individual's goals, needs (including health care needs), and preferences, by offering choices regarding the services and supports they receive and from whom.**

The person-centered service plan will be developed and implemented in accordance with 42 CFR 441.540 (b). Person-centered service planning includes a review of all available services and supports, both paid and non-paid, that may be selected by the participant to address the goals, service, and support needs identified during the assessment and planning process. Participants may select from all available services and supports for which they have an assessed need and are eligible to receive. Participants may select from all qualified and contracted providers of those services when developing their person-centered service plan.

For individuals residing in provider owned and operated settings, the person-centered plan must be used to inform the Negotiated Care Plan or Negotiated Service Agreement and the Admissions Agreement process.

The person-centered service plan will be understandable to the participant, will indicate the individual and/or entity responsible for monitoring the plan, and will be agreed to in writing by the participant and those responsible for implementing the plan. Signatures may be collected electronically. The plan will be distributed to the participant and any other people involved in the plan.

The assessment process includes identification of risk factors. Risk factors and back-up plans are detailed in the service plan. Case Managers assess participants at least every 12 months and determine the level of service based on how physical, psychosocial, cognitive, clinical characteristics impact the individual's ability to perform ADL, IADL and health-related tasks. The service planning process considers the needs of the participant, the availability of natural supports, and access to services and supports. Participants receive and sign a Rights and Responsibilities form which provides the necessary information and support to ensure that the participant directs the process to the maximum extent possible and is enabled to make informed choices and decisions.

The State elects to permit participants to appoint an individual representative, who is not a paid caregiver consistent with 42 CFR 441.505, to serve as a representative in connection with the provision of CFC services and supports during the service planning process. When the participant's chosen representative is also paid to provide care to the participant and an alternate non-paid representative is unavailable, the participant's Case Manager may assist the participant during the service planning process.

b. **Description of the timing of the person-centered service plan to assure the participant has access to services as quickly as possible, frequency of review, how and when it is updated, mechanisms to address changing circumstances and needs, or at the request of the participant. Access to services:**

There is no lag between the person-centered planning and determination of eligibility. Initial and on-going person-centered service plans are developed in conjunction with the CARE assessment and functional eligibility determination. Access to services begins as soon as the participant selects the services and supports they are eligible to receive and identifies their qualified provider.

Frequency of review: Assessments are conducted at least every 12 months, when the participant's circumstances or needs change significantly, and at the request of the participant. The person-centered service plan is reviewed at each assessment.

Mechanisms to address changing circumstances and needs or when a new assessment is requested by the participant: During the assessment process, participants are encouraged to contact the Case Manager immediately if a problem arises with the plan or there is a change in their condition. Providers are also bound by contract to notify the Case Manager when there are changes in the participant's condition or needs. As described previously, re- assessments are conducted at least every 12 months, when the participant's circumstances or needs change significantly, and at the request of the participant.

Updates to the service plan such as changes in providers, adding services or items that address needs identified in the individual assessment, documenting changes of address or availability of informal supports may be made without a new assessment.

c. **Description of the strategies used for resolving conflict or disagreement within the process, including the conflict of interest standards for assessment of need and the person-centered service plan development process that apply to all participants and entities, public or private.**

Participants may register complaints about anything the Department is responsible for that they perceive as negatively affecting them. All participants receive the document "Your Rights and Responsibilities When You Receive Services." This document informs participants that they have a right to make a complaint and also have the right to separately file for an administrative hearing if they do not agree with an action the Department has taken. Complaints can be received and addressed at any level of the organization. However, the Department always strives to address grievances or complaints at the lowest level possible. Upon receipt at any level, there is a requirement to respond by telephone, in writing, or in-person. Complaints are referred to the Case Manager for action unless the participant requests that it not be. If the Case Manager is unable to resolve the complaint, the person is referred to the Case Manager's supervisor or a designee. If the person feels the complaint was not resolved, they are referred to the

Regional Administrator or AAA Director. If the person continues to feel their complaint is not resolved, they are referred to State headquarters staff, who notifies the person of the outcome.

To protect participants' rights, some types of complaints are immediately directed to other formal systems rather than being addressed through a grievance process. These complaints are: allegations of abuse, neglect, or financial exploitation, which go directly to the protective services agencies; complaints involving fraud, which go directly to the Medicaid Fraud Control Unit; and disputes regarding services that have been denied, reduced, suspended or terminated, which are referred to the administrative hearing process.

All participants receive a written Planned Action Notice (PAN) informing them of actions taken by the Department and outlining the participant's right to appeal any decision action made by the Department. The PAN includes an administrative hearing request form and informs the participant of the timeline for filing their request and of their right to continuing benefits pending the outcome of the administrative hearing.

Participants receiving CFC services are informed of their right to request a review of their service plan when there is a change in their condition or other concerns about health and welfare are identified. Consistent with statute, the recipient supervises their individual care provider and is given information on how to contact their case manager if there are concerns about service delivery. When care is provided by a staff employed by a home care agency or a residential setting, care is supervised by the employer agency. Recipients or their representatives report to Case Managers when services are not received or there are concerns about any aspect of service provision.

Assessments include identifying the participant's ability to self-direct and supervise their service providers. Participants are expected to choose a representative should they need one. When there are no available representatives, the participant is encouraged to use an agency care provider or hire a second individual provider in order to increase opportunities for oversight. When there is no representative the method of oversight is identified in the participant's assessment.

All providers of personal care and other CFC services are contractually obligated to report to the Case Manager any changes in the participant's condition or service needs, including health and welfare concerns. Washington State law requires mandatory reporting of suspected abuse, neglect, or exploitation of a vulnerable adult which offers additional protection to recipients who may not be receiving needed services. All providers of CFC services are mandatory reporters and are legally required to report any allegations of abuse or neglect.

The Case Manager documents and addresses health and safety interventions for participants such as the use of back-up care, a Personal Emergency Response System (PERS), evacuation in an emergency, and referrals to other community or Medicaid-funded services. Case management staff review the health and welfare of participants receiving CFC services at each assessment and client contact. Registered Nurses respond to referrals by Case Managers when nursing indicators have been identified in the CARE assessment. When nursing indicators have been identified in the CARE assessment, Nurses document nursing service activities and collaborate with Case Managers on follow up recommendations.

The annual quality assurance review includes a review of the health and welfare of participants. These reviews may also result in proficiency improvement plans on a local or state-wide basis.

i. **The methods for assuring that participants are given a choice between institutional and community-based services.**

Case Managers inform participants who are eligible for services under CFC about all available community and institutional services. Participants are given a choice about which type of service to receive. The choice of institutional or home-and-community-based services is documented in each participant's record when the CFC program has been selected.