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State/Territory Name: Washington

1915(i) State Plan Amendment (SPA): WA-24-0001
1932(a) State Plan Amendment (SPA): WA-24-0002
1915(b) Waiver Amendment :WA.0008.R11.02

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

April 3, 2024

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

RE: CMS Concurrent Approval of WA-24-0001 (1915(i) SPA), WA-24-0002 (1932(a) SPA), and WA.0008.R11.02 (1915(b) Amendment)

Dear Director Birch and Dr. Fotinos:

The Centers for Medicare & Medicaid Services (CMS) is approving Washington's request to amend its state plan to add a new 1915(i) home and community-based services (HCBS) benefit, transmittal number WA-24-0001, to add Community Behavioral Health Support Services - Supported Supervision and Oversight. CMS conducted the review of the state's submittal according to statutory requirements in Title XIX of the Social Security Act and relevant federal regulations. Enclosed is a copy of the approved state plan amendment (SPA).

It is important to note that CMS' approval of this 1915(i) HCBS state plan benefit solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, §504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

Per 42 CFR §441.745(a)(1)(i), the state will annually provide CMS with the projected number of individuals to be enrolled in the benefit and the actual number of unduplicated individuals enrolled in the §1915(i) State Plan HCBS in the previous year. Additionally, at least 21 months prior to the end of the five-year approval period, the state must submit evidence of the state's quality monitoring in accordance with the Quality Improvement Strategy in their approved state plan amendment. The evidence must include data analysis, findings, remediation, and describe any system improvement for each of the §1915(i) requirements.

Concurrently, CMS is approving Washington's 1932(a) State Plan Amendment (SPA) Transmittal Number WA-24-0002, submitted on January 8, 2024. We conducted our review of this SPA according to statutory requirements of Title XIX of the Social Security Act and implementing Federal regulations. This SPA authorizes Washington to add the new 1915(i) service, titled Community Behavioral Health Support Services – Supportive Supervision & Oversight to the list of services delivered via managed care in the Integrated Managed Care (IMC) managed care program.

Concurrently, CMS is approving Washington's request to amend its 1915(b) Waiver, with CMS control number WA.0008.R11.02, titled Behavioral Health Services Only (BHSO). This waiver amendment authorizes Washington to add the new 1915(i) service, titled Community Behavioral Health Support Services – Supportive

Supervision & Oversight to the list of services delivered via managed care in the BHSO program. The base 1915(b) waiver is authorized under sections 1915(b)(1) and 1915(b)(4) of the Social Security Act.

Our decision is based on the evidence submitted to CMS demonstrating that the state's proposal is consistent with the purposes of the Medicaid program, will meet all the statutory and regulatory requirements for assuring beneficiaries' access to and quality of services, and will be a cost-effective means of providing services to enrollees under this waiver.

The WA-24-0001 1915(i) SPA is effective for five years beginning July 1, 2024 through June 30, 2029 and operate concurrently with the WA-24-0002 1932(a) SPA and the WA.0008.R11.02 1915(b) waiver amendment. SPA 24-0002 and the 1915(b) waiver amendment WA.0008.R11.02 are effective July 1, 2024. The state may request renewal of these waiver authorities by providing evidence and documentation of satisfactory performance and oversight. Washington's request that the 1915(b) waiver authority be renewed should be submitted to CMS no later than March 31, 2028, which is 90 days prior to the underlying base waiver's expiration. Since the state has elected to target the population who can receive §1915(i) State Plan HCBS, the state must submit a renewal application to CMS at least 180 days prior to the end of the approval period, January 1, 2028.

We appreciate the cooperation and effort provided by you and your staff during the review of these concurrent actions. If you have any questions concerning this information, please contact Nick Sukachevin at (206) 615-2416 or via email at Nickom.Sukachevin@cms.hhs.gov for the 1915(i) SPA or John Kivisaari at (312)-353-0508 or via email at John.Kivisaari@cms.hhs.gov for the 1915(b) waiver amendment or 1932(a) SPA.

Sincerely,

George P. Failla Jr -S

Digitally signed by George P. Failla Jr -S
Date: 2024.04.03 17:57:45 -04'00'

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

Bill Brooks, Director
Division of Managed Care Operations

Cc:

Jessica Diaz, WA HCA
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Kevin Patterson, DLTSS
Deanna Clark, DLTSS

DEPARTMENT OF HEALTH AND HUMAN 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: 24 — 0001

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
January 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
Sections 1932a & 1915i of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 11,956,297
b. FFY 2025 $ 47,981,188

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-i pages 1 - 45 (all new)
Attachment 4.19-B pages 54 - 57 (all new)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

9. SUBJECT OF AMENDMENT
Add 1915i State Plan Home and Community-Based Services

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
Susan E. Birch

12. TYPED NAME
Susan E. Birch, MBA, BSN, RN

13. TITLE
Director and Acting Medicaid Director

14. DATE SUBMITTED
January 8, 2024 originally. March 20, 2024 revised

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

FOR CMS USE ONLY

16. DATE RECEIVED
January 8, 2024

17. DATE APPROVED
April 3, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2024

19. SIGNATURE OF APPROVING OFFICIAL
George P. Failla Jr -S
Digitally signed by George P. Failla Jr -S
Date: 2024.04.03 17:57:17 -04'00'

20. TYPED NAME OF APPROVING OFFICIAL
George P. Failla

21. TITLE OF APPROVING OFFICIAL
Director HCBS Operations and Oversight

22. REMARKS

1915(i) State Plan Home and Community-Based Services

Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below.

1. Services. *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

Community Behavioral Health Support Services – Supportive Supervision and Oversight

2. Concurrent Operation with Other Programs. *Completing this section does not authorize the provision of 1915(i) State plan HCBS under these authorities. In order to operate concurrently with another Medicaid authority, the state must receive CMS approval via that Medicaid authority for the concurrent program which is separate and distinct from this 1915(i) authority.* (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*:

***Select one*:**

○	**Not applicable**
●	**Applicable**
	Check the applicable authority or authorities:
✓	**Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *1915*(i) services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:* *(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);* *(b) the geographic areas served by these plans;* *(c) the specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the 1915(a) contract has been submitted or previously approved.*
	(a) Single Statewide MCO for Foster Care/Adoption Support/Alumni (Voluntary) is Coordinated Care of Washington (b) Geographic areas covered by this plan is Statewide. (c) This plan will provide the 1915i services outlined within this application. (d) Per Member/Per Month capitated arrangement or Service Based Enhancement. (e) Contract amendment to include 1915(i) language not yet submitted. The amendment will have an effective date of 7/1/2024, in alignment with the 1915(i) State Plan HCBS.

	✓	**Waiver(s) authorized under §1915(b) of the Act.**		
		Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:		
		The 1915(b)(1) waiver, WA 00-08.R11.02, will be submitted to CMS by 01/08/2024 for concurrent approval with the 1915(i) State Plan HCBS.		
		Specify the §1915(b) authorities under which this program operates (*check each that applies*):		
		✓ §1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
		☐ §1915(b)(2) (central broker)	☑	§1915(b)(4) (selective contracting/limit number of providers)
	☑	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*		
		(a) Amerigroup (now doing business as Wellpoint), Coordinated Care of Washington, Community Health Plan of Washington, Molina, and United Health Care (b) Geographic areas covered by these plans is Statewide (c) All 5 plans will provide the 1915i services outlined within this application (d) Per Member/Per Month capitated arrangement or Service Based Enhancement In addition to this 1915i HCBS State Plan Amendment (SPA) WA-24-0001, two other SPAs will be submitted by 01/08/2024. SPA WA 24-0002 adds CBBS to the managed care section of the State Plan (3.1-F Part 2) and eligibility SPA WA 24-0003 addresses income disregard language. These SPAs will need to be approved concurrently with this 1915(i) State Plan HCBS SPA WA-24-0001.		
	☐	**A program authorized under §1115 of the Act.** *Specify the program*:		

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one)*:

●	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	●	The Medical Assistance Unit *(name of unit)*:	Washington State Health Care Authority (HCA), Medicaid Programs Division (MPD)
	○	Another division/unit within the SMA that is separate from the Medical Assistance Unit	

		(Name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	
	The State plan HCBS benefit is operated by *(name of agency)*		
	A separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

4. Distribution of State plan HCBS Operational and Administrative Functions.

✓ *(By checking this box, the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non- State Entity
1 Individual State plan HCBS enrollment	☑	☐	☐	☐
2 Eligibility evaluation	☑		☐	☐
3 Review of participant service plans	☑	☑	☑	☐
4 Prior authorization of State plan HCBS	☑	☐	☑	☐
5 Utilization management	☑	☐	☑	☐
6 Qualified provider enrollment	☑	☐	☑	☐
7 Execution of Medicaid provider agreement	☑	☐	☐	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☐	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☐	☐	☐
10Quality assurance and quality improvement activities	☑	☑	☐	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

HCA, as the Medicaid State Agency, will maintain accountability, directly perform, and/or otherwise monitor all administrative functions of the State Plan HCBS benefit.

The other State Operating Agency is the Aging and Long-term Support Administration (ALTSA), within the Department of Social and Health Services (DSHS), or their delegated entity, the Area Agencies on Aging (AAA). The contracted entities are Managed Care Organizations (MCOs) contracted with the State Medicaid Agency. Many functions entail a partnership, with HCA maintaining ultimate oversight functions.

Function 3 and 5 – Service Plan Reviews and Utilization Management: Review of service plans will be a partnership, with HCA holding ultimate accountability and oversight from a quality assurance standpoint. For managed care, Utilization Management (UM) will be a function performed by the Managed Care Organizations. For fee for service (FFS), HCA program staff will be performing UM

functions. Oversight activities of Service Plan reviews corresponds to Quality Measure #1 Service Plans, a) address assessed needs of 1915(i) participants; b) are updated annually; and c) document choice of services and providers. Monitoring is on an annual basis or more frequently. For MCO UM, HCA's TEAMonitor and EQRO process does an annual file review and an additional policy/desk review on a three-year cycle. For FFS UM, the HCA program manager will do an annual review.

Function 4 – Prior Authorization: HCA determines eligibility. Once eligibility is determined, HCA approves enrollment into the HCBS program using a system edit indicator for HCBS services. For managed care, authorization will be a function of the MCOs. For FFS, HCA program staff will be accountable for authorization functions. Enrollment and eligibility functions are monitored annually (see #2 under quality measures). HCA system edits will deny/reject any FFS claims or MCO encounters on a monthly basis for HCBS services that do not have the HCBS program indicator indicating eligibility. Prior Authorization processes: for MCOs, the TEAMonitor and EQRO process does an annual review and an additional policy/desk review on a three-year cycle; for FFS, the HCA program manager will do an annual review.

Functions 6 – Qualified Provider Enrollment: For all Medicaid programs, providers are required to successfully complete the provider enrollment process and core provider agreements with HCA. For managed care, providers must also complete the credentialing process with the MCOs and must re-credential every three years. Monitoring: Monthly system edits will deny/reject any FFS provider claims or MCO encounters on a monthly basis from providers who are not properly enrolled with HCA into the ProviderOne system. For both FFS and managed care, ProviderOne enrollment entails a core provider agreement or equivalent and provider identification so that the provider is considered a known Medicaid provider. Credentialing - For MCOs, the TEAMonitor and EQRO process does a file review every three years. Credentialing is also reviewed by NCQA and all the MCOs are NCQA-accredited. For FFS, the HCA program manager will do al review on a 3-year cycle.

Function 10 – Quality Assurance/Improvement: – HCA will maintain oversight, coordination, and accountability for overall quality assurance of the HCBS benefit. However, roles and responsibilities often entail a close partnership between HCA and ALTSA, leveraging many existing pathways that ALTSA already has in place due to their role in delivering Long Term Services and Supports (LTSS). Corresponds to the Quality Improvement Strategy section. Quarterly HCBS committee meetings and annual Quality Review Report will be key to monitoring.

(By checking the following boxes, the State assures that):

5. ☑**Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict-of-interest protections the state will implement):*

6. ☑ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☑ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. Projected Number of Unduplicated Individuals to Be Served Annually.

(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	7/1/2024	6/30/2025	1200
Year 2			
Year 3			
Year 4			
Year 5			

2. ☑ **Annual Reporting.** *(By checking this box, the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☑ **Medicaid Eligible.** *(By checking this box, the state assures that):* Individuals receiving State Plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy** (*Select one*):

☑ The State does not provide State Plan HCBS to the medically needy.
☐ The State provides State Plan HCBS to the medically needy. (*Select one*):
☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services. ☐ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State Plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State Plan HCBS benefit are performed (*Select one*):

●	Directly by the Medicaid agency
○	By Other (*specify State agency or entity under contract with the State Medicaid agency*):

2. **Qualifications of Individuals Performing Evaluation/Reevaluation**. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

State Agency staff reviewing eligibility for 1915i services will have at a minimum a bachelor's degree in a health or social service field, with a history of direct services or training in community behavioral health. Staff are trained in the needs-based criteria outlined for this 1915(i) State Plan service and have demonstrated capacity to evaluate documentation to determine whether each referral meets these criteria. Staff will have access to state systems to verify that individuals are Medicaid-eligible and a current Washington resident.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State Plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The evaluation and reevaluation process for determining the needs-based State Plan HCBS eligibility criteria for the 1915i program will be completed annually, unless a significant change in the participant's condition is determined, which would require an additional reevaluation. The process will utilize a two-step system for eligibility. This process is the same each year.

The functional information gathering will be completed by a Case Manager, completely independent and employed by the State or its delegate the Area Agencies on Aging (AAA), during an assessment that is conducted face-to-face, through telemedicine, or other information technology medium when warranted, using the Comprehensive Assessment Reporting Evaluation (CARE) tool. Individuals provide informed consent for the type of assessment that is conducted. Telemedicine or other technology medium is available for all individuals, and individuals are provided the opportunity for an in-person assessment in lieu of telemedicine or other technology.

The CARE tool includes an indicator that may trigger a referral by the Case Manager based on the identified needs- based criteria for 1915(i) services. If the individual meets the needs-based eligibility criteria under this State Plan and the individual agrees to the referral, the Case Manager will send the assessment and a referral to the MCO for review or directly to HCA for participants not in managed care.

For any assessment completed, the state elects to permit individuals to appoint a representative, who is not a paid caregiver to serve as a representative in connection with the provision of services and supports during the planning process. This includes the use of necessary on-site support staff. When the individual's chosen representative is also paid to provide care to the individual, and an alternate

non-paid representative is unavailable, the participant's Case Manager may assist the individual during the evaluation process.

The MCO will review the CARE assessment and referral and collect other relevant information to confirm completeness of information. The MCO will provide this information to the State Medicaid Agency, which will make the determination of eligibility for 1915(i) services.

The State Medicaid Agency staff will review the submission for accuracy and completeness and make the determination as to whether the individual meets eligibility criteria. After the individual is found eligible, the MCO will authorize 1915i services to a qualified provider. For re-evaluation, this same process will occur no less than annually. For FFS, this process is the same, except that the State Medicaid Agency clinical program manager staff take the role of the MCO.

4. ☑ **Reevaluation Schedule**. *(By checking this box, the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☑ **Needs-based HCBS Eligibility Criteria.** *(By checking this box, the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

Needs Based Criteria:
The Individual is assessed to have a need for assistance, demonstrated by the need for:
a) Hands on assistance with at least one Activities of Daily Living (ADLs) defined in WAC 388-106-0210, one of which may be body care and may include one or more of the following:

A. Bathing: Self-Performance is Physical Help/part of bathing and support provided is one personal physical assist
B. Personal Hygiene: Self-Performance is Extensive Assistance, support provided is one-person physical assist
C. Body Care: Self-Performance is Needs or Received/Needs
D. Eating: Self-Performance is Supervision, support provided is one-person physical assist
E. Toileting: Self-Performance is Extensive Assistance, support provided is one-person physical assist
F. Dressing: Self-Performance is Extensive Assistance, support provided is one-person physical assist
G. Transfers: Self-Performance is Extensive Assistance, support provided is one personal physical assist
H. Bed Mobility and Turning and Repositioning: Self- Performance is Limited Assistance, support provided is one-person physical assist

I. Walk in Room, Locomotion in Room, or Locomotion Outside: Self-Performance is Extensive Assistance: support provided is one-person physical assist
J. Medication Management: Self-Performance is Assistance Required Daily

or

b) supervision with three or more qualifying ADLs

If any of these activities did not occur because the individual was unable or there was no provider available, this counts toward eligibility.

AND also meets Risk Criteria below:

Risk Criteria:
Individual has the following combination of risk factors:

1. Has behavioral or clinical complexity that requires the level of supplementary or specialized services and staffing available only under the Community Behavioral Health Support services benefit, as evidenced by at least one or more of the following within the past year:

    a. Multiple assaultive incidents related to a behavioral health condition during inpatient or long-term care that can only be prevented with a high level of staffing and/or skilled staff intervention.

    b. Self-endangering behaviors related to a behavioral health condition that would result in bodily harm if not prevented with a high level of staffing and/or skilled staff intervention.

    c. Intrusiveness (e.g., rummaging, unawareness of personal boundaries) related to a behavioral health condition that places the individual at risk of assault by others if not prevented with a high level of staffing and/or skilled staff intervention.

    d. Chronic psychiatric symptoms that cause distress to and escalate the individual and/or other residents to crisis if not monitored and redirected by staff. Without intervention, this could result in institutional care within a psychiatric inpatient setting.

    e. Sexual inappropriateness related to a behavioral health condition that requires skilled staff intervention to redirect to maintain safety of the individual and other vulnerable adults.

    f. A history of any of the above behaviors, which are currently only prevented by additional skilled staff intervention.

AND also meets #2 and/or #3 below:

2. History of being unsuccessful in community living settings, as evidenced by at least one or more of the following:

    a. History of multiple failed stays in residential settings within the past 2 years.

    b. In imminent danger of losing a current community living setting due to behaviors related to behavioral health condition(s).

    c. Frequent caregiver turnover due to behaviors related to behavioral health condition(s) within past 2 years.

    d. Without current Community Behavioral Health Support services would be at imminent risk of losing long-term care placement setting.

AND/OR

3. Past psychiatric history, where significant functional improvement has not been effectively maintained due to the lack of Community Behavioral Health Support services and/or supports, as evidenced by at least one or more of the following:

    a. 2 or more inpatient psychiatric hospitalizations in the last 12 months

    b. An inpatient stay in a community hospital (acute or psychiatric) or free-standing evaluation and treatment facility for 30 days or more in the last 12 months, with barriers to discharge related to behavioral health condition(s)

    c. Discharge from a state psychiatric hospital or long term 90/180-day inpatient psychiatric setting in the last 12 months

    d. Without Community Behavioral Health Support services would likely be at imminent risk of requiring inpatient level of care

6. ☑ **Needs-based Institutional and Waiver Criteria.** *(By checking this box, the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State Plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State Plan HCBS needs-based eligibility criteria	**NF (& NF LOC** waivers)**	**ICF/IID (& ICF/IID LOC waivers)**	**Applicable Hospital* (& Hospital LOC waivers)**
Needs Based Criteria: The Individual is assessed to have a need for assistance, demonstrated by the need for: a) Hands on assistance with at least one Activities of Daily Living (ADLs) defined in WAC 388-106-0210, one of which may be body care and may include one or more of the following: A. Bathing: Self-Performance is Physical Help/part of bathing and support provided is one personal physical assist B. Personal Hygiene: Self-Performance is Extensive Assistance, support provided is one-person	individual meets nursing facility level of care is fully specified in WAC 388-106-0355 Nursing Facility Level of Care (NFLOC) is based on the following factors: 1. one of the following applies: a. Care is required to be provided by or under the supervision of a registered nurse or a licensed practical nurse on a daily basis; or b. The individual has an unmet or	ICF/IID Level of Care as described in Washington Administrative Code (WAC) Chapter 388-828-4400 for adults (16 years of age and older) and Chapter 388-828-3080 for children (birth through 15 years of age). For individuals age birth to fifteen, DDA determines ICF/IID Level of Care score by adding the acuity scores for each question in the ICF/IID Level of Care Assessment for Children. DDA determines you to be eligible for ICF/IID Level of care when you meet at least one of the following: 1. You are age birth through five years old and the total of your acuity scores are five or more; or 2. You are age six through fifteen years old and the total of your acuity scores are seven or more. For ages sixteen or older, DDA	Admission criteria for an inpatient psychiatric stay: Managed Care Organizations follow NCQA standards and utilize nationally recognized level of care utilization management tools to authorize inpatient psychiatric stays. Inpatient psychiatric admission criteria include the need for inpatient treatment because: • The individual is in imminent

physical assist

C. Body Care: Self-Performance is Needs or Received/Needs

D. Eating: Self-Performance is Supervision, support provided is one-person physical assist

E. Toileting: Self-Performance is Extensive Assistance, support provided is one-person physical assist

F. Dressing: Self-Performance is Extensive Assistance, support provided is one-person physical assist

G. Transfers: Self-Performance is Extensive Assistance, support provided is one personal physical assist

H. Bed Mobility and Turning and Repositioning: Self- Performance is Limited Assistance, support provided is one-person physical assist

I. Walk in Room, Locomotion in Room, or Locomotion Outside: Self-Performance is Extensive Assistance: support provided is one-person physical assist

J. Medication Management: Self-Performance is Assistance Required Daily

or

b) supervision with three or more qualifying ADLs

AND meets Risk Criteria Below:

Risk Criteria:

Individual has the following combination of risk factors:

1. Has behavioral or clinical complexity that requires the level of

partially met need with at least three of the following activities of daily living. For each ADL a minimum level of assistance is required in self-performance and/or support provided (self-performance and support provided is defined below).

The minimum level of assistance required for each ADL is:
-Eating: Support provided is setup; or
-Toileting and bathing: Self performance is supervision; or
-Transfer, bed mobility, and ambulation: Self performance is supervision and support provided is setup; or
-Medication management: Self performance is assistance required; or
-If the need for assistance in any activities listed in this section did not occur because the individual was unable or no provider was available to assist, that need is counted for the purpose in determining functional eligibility; or

c. The individual has an unmet or partially met need with at least two of the following

determines eligibility for ICF/IID level-of-care from your SIS scores. Eligibility for ICF/IID level-of-care requires that scores that meet at least one of the following:
(1) A percentile rank over nine percent for three or more of the six subscales in the SIS support needs scale.
(2) A percentile rank over twenty-five percent for two or more of the six subscales in the SIS support needs scale.
(3) A percentile rank over fifty percent in at least one of the six subscales in the SIS support needs scale.
(4) A support score of one or two for any of the questions listed in the SIS exceptional medical support needs scale.
(5) A support score of one or two for at least one of the following items in the SIS exceptional behavior support needs scale:
(a) Prevention of assaults or injuries to others.
(b) Prevention of property destruction (e.g., fire setting, breaking furniture).
(c) Prevention of self-injury.
(d) Prevention of PICA (ingestion of inedible substances).
(e) Prevention of suicide attempts.
(f) Prevention of sexual aggression; or
(g) Prevention of wandering.
(6) A support score of two for any of the questions listed in the SIS exceptional behavior support needs scale; or
(7) Any of the qualifying scores for one or more of the following SIS questions:

Question # of SIS support needs scale	Text of question	Your score for "Type of support" is:	And your score for "Frequency of support" is:
A2	Bathing and take care of personal hygiene and grooming needs	2 or more	4
		3 or more	2
A3	Using the toilet	2 or more	4
		3 or more	2
A4	Dressing	2 or more	4
		3 or more	2
A5	Preparing food	2 or more	4
		3 or more	2
A6	Eating food	2 or more	4

danger to self or others (as evidenced by imminent risk of additional attempt of suicide/ homicide or to seriously harm self or others, current plan for suicide/homicide or serious harm to self or others, command auditory hallucinations for suicide/homicide or serious harm to self or others, etc.);

- The individual is 'gravely disabled' in which a person, as a result of a behavioral health disorder is (a) in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety; or the individual has a behavioral health disorder characterized by

supplementary or specialized services and staffing available only under the Community Behavioral Health Support services benefit, as evidenced by at least one or more of the following within the past year:

a. Multiple assaultive incidents related to a behavioral health condition during inpatient or long-term care that can only be prevented with a high level of staffing and/or skilled staff intervention,

b. Self-endangering behaviors related to a behavioral health condition that would result in bodily harm if not prevented with a high level of staffing and/or skilled staff intervention,

c. Intrusiveness (e.g. rummaging, unawareness of personal boundaries) related to a behavioral health condition that places the individual at risk of assault by others if not prevented with a high level of staffing and/or skilled staff intervention,

d. Chronic psychiatric symptoms that cause distress to and escalate the individual and/or other residents to crisis if not monitored and redirected by staff,

activities of daily living:

The minimum level of assistance required for each ADL is:
-Eating: Self performance is supervision and support provided one-person physical assist; or
-Toileting: Self performance is extensive assistance and support provided is one-person physical assist; or
-Bathing: Self performance is limited assistance and support provided is one-person physical assist; or
-Transfer and Mobility: Self performance is extensive assistance and support provided is one person physical assist; or
-Bed Mobility: includes limited assistance in self-performance and the need for turning and repositioning; and support provided is one-person physical assist;
-Medication Management: Assistance required daily in self-performance; or
-If the need for assistance in any activities listed in this section did not occur because the individual was unable or no provider was

		3 or more	2
A7	Taking care of clothes, including laundering	2 or more	2 or more
		3 or more	1
A8	Housekeeping and cleaning	2 or more	2 or more
		3 or more	1
B6	Shopping and purchasing goods and services	2 or more	2 or more
		3 or more	1
C1	Learning and using problem-solving strategies	2 or more	3 or more
		3 or more	2
C5	Learning self-management strategies	2 or more	3 or more
		3 or more	2
E1	Taking medications	2 or more	4
		3 or more	2
E2	Ambulating and moving about	2 or more	4
		3 or more	2
E3	Avoiding health and safety hazards	2 or more	3 or more
		3 or more	2
E6	Maintaining a nutritious diet	2 or more	2 or more
		3 or more	1
E8	Maintaining emotional well-being	2 or more	3 or more
		3 or more	2
F1	Using appropriate social skills	2 or more	3 or more
		3 or more	2
G7	Managing money and personal finances	2 or more	2 or more
		3 or more	1

severe psychiatric or behavioral symptoms (including hallucinations or delusions that are very bothersome to the individual or are associated with severe pressure to respond or act, severely disorganized speech, severe mania, depression, anxiety or comorbid substance use disorder, etc.) accompanied by severe dysfunction in daily living (as evidenced by complete neglect of self-care, complete withdrawal from all social interactions, complete inability to maintain any appropriate aspect of personal responsibility in any adult roles, etc.); or

- The individual will not participate in treatment voluntarily and requires involuntary commitment, needs physical restraint, seclusion, or other involuntary control, is significantly delirious, or has

e. Sexual inappropriateness related to a behavioral health condition that requires skilled staff intervention to redirect to maintain safety of the individual and other vulnerable adults. f. A history of any of the above behaviors, which are currently only prevented by additional skilled staff intervention AND also meets #2 and/or #3 below: 2. History of being unsuccessful in community living settings, as evidenced by at least one or more of the following: a. History of multiple failed stays in residential settings within the past 2 years b. In imminent danger of losing a current community living setting due to behaviors related to behavioral health condition(s) c. Frequent caregiver turnover due to behaviors related to behavioral health condition(s) within past 2 years d. Without current Community Behavioral Health Support services would be at imminent	available to assist, that need is counted for the purpose in determining functional eligibility; or d. The individual has a cognitive impairment and requires supervision due to one or more of the following: Disorientation, memory impairment, impaired decision making, or wandering and have an unmet or partially met need with at least one or more of the following: The minimum level of assistance required for each ADL is: -Eating: Self performance is supervision and support provided one-person physical assist; or -Toileting: Self performance is extensive assistance and support provided is one-person physical assist; or -Bathing: Self performance is limited assistance and support provided is one-person physical assist; or -Transfer and Mobility: Self performance is extensive assistance and support provided is one-person physical assist; or -Bed Mobility:		a severe behavioral health disorder that requires around-the clock psychiatric care to evaluate, stabilize, and treat the individual.

risk of losing long-term care placement setting AND/OR 3. Past psychiatric history, with no significant functional improvement that can be maintained without Community Behavioral Health Support services and/or supports, as evidenced by at least one or more of the following: a. 2 or more inpatient psychiatric hospitalizations in the last 12 months b. An inpatient stay in a community hospital (acute or psychiatric) or free-standing evaluation and treatment facility for 30 days or more in the last 12 months, with barriers to discharge related to behavioral health condition(s) c. Discharge from a state psychiatric hospital and long term 90/180-day inpatient psychiatric setting in the last 12 months d. Without Community Behavioral Health Support services would likely be at imminent risk of requiring inpatient level of care	includes limited assistance in self-performance and the need for turning and repositioning; and support provided is one-person physical assist; -Medication Management: Assistance required daily in self-performance; or -If the need for assistance in any activities listed in this section did not occur because the individual was unable or no provider was available to assist, that need is counted for the purpose in determining functional eligibility.		

*Long Term Care/Chronic Care Hospital **LOC= level of care

7. ☑ **Target Group(s).** The state elects to target this 1915(i) State Plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 180 days prior to the end of this 5-year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.745(a)(2)(vi)(A). (*Specify target group(s)*):

Community Behavioral Health Support Services are available to persons 18 or over, Medicaid, and are eligible for who have a primary diagnosis of one of the following are considered behavioral health diagnoses that "serious mental illness", and/or diagnosis related to traumatic brain injury.	
ICD-10 Code	**DIAG_DESC**
F060	Psychotic disorder w hallucin due to known physiol condition
F062	Psychotic disorder w delusions due to known physiol cond
F0630	Mood disorder due to known physiological condition, unsp
F0631	Mood disorder due to known physiol cond w depressv features
F0632	Mood disord d/t physiol cond w major depressive-like epsd
F0633	Mood disorder due to known physiol cond w manic features
F0634	Mood disorder due to known physiol cond w mixed features
F064	Anxiety disorder due to known physiological condition
F070	Personality change due to known physiological condition
S062X9S	Diffuse Traumatic Brain INJ W/LOC UNS DUR SEQ
F200	Paranoid schizophrenia
F201	Disorganized schizophrenia
F202	Catatonic schizophrenia
F203	Undifferentiated schizophrenia
F205	Residual schizophrenia
F2081	Schizophreniform disorder
F2089	Other schizophrenia
F209	Schizophrenia, unspecified
F21	Schizotypal disorder
F22	Delusional disorders
F23	Brief psychotic disorder
F24	Shared psychotic disorder
F250	Schizoaffective disorder, bipolar type
F251	Schizoaffective disorder, depressive type
F258	Other schizoaffective disorders
F259	Schizoaffective disorder, unspecified
F28	Oth psych disorder not due to a sub or known physiol cond
F29	Unsp psychosis not due to a substance or known physiol cond
F3010	Manic episode without psychotic symptoms, unspecified
F3011	Manic episode without psychotic symptoms, mild
F3012	Manic episode without psychotic symptoms, moderate
F3013	Manic episode, severe, without psychotic symptoms
F302	Manic episode, severe with psychotic symptoms
F303	Manic episode in partial remission
F304	Manic episode in full remission
F308	Other manic episodes
F309	Manic episode, unspecified
F310	Bipolar disorder, current episode hypomanic
F3110	Bipolar disord, crnt episode manic w/o psych features, unsp
F3111	Bipolar disord, crnt episode manic w/o psych features, mild
F3112	Bipolar disord, crnt episode manic w/o psych features, mod
F3113	Bipolar disord, crnt epsd manic w/o psych features, severe
F312	Bipolar disord, crnt episode manic severe w psych features

F3130	Bipolar disord, crnt epsd depress, mild or mod severt, unsp
F3131	Bipolar disorder, current episode depressed, mild
F3132	Bipolar disorder, current episode depressed, moderate
F314	Bipolar disord, crnt epsd depress, sev, w/o psych features
F315	Bipolar disord, crnt epsd depress, severe, w psych features
F3160	Bipolar disorder, current episode mixed, unspecified
F3161	Bipolar disorder, current episode mixed, mild
F3162	Bipolar disorder, current episode mixed, moderate
F3163	Bipolar disord, crnt epsd mixed, severe, w/o psych features
F3164	Bipolar disord, crnt episode mixed, severe, w psych features
F3170	Bipolar disord, currently in remis, most recent episode unsp
F3171	Bipolar disord, in partial remis, most recent epsd hypomanic
F3172	Bipolar disord, in full remis, most recent episode hypomanic
F3173	Bipolar disord, in partial remis, most recent episode manic
F3174	Bipolar disorder, in full remis, most recent episode manic
F3175	Bipolar disord, in partial remis, most recent epsd depress
F3176	Bipolar disorder, in full remis, most recent episode depress
F3177	Bipolar disord, in partial remis, most recent episode mixed
F3178	Bipolar disorder, in full remis, most recent episode mixed
F3181	Bipolar II disorder
F3189	Other bipolar disorder
F319	Bipolar disorder, unspecified
F320	Major depressive disorder, single episode, mild
F321	Major depressive disorder, single episode, moderate
F322	Major depressv disord, single epsd, sev w/o psych features
F323	Major depressv disord, single epsd, severe w psych features
F324	Major depressv disorder, single episode, in partial remis
F325	Major depressive disorder, single episode, in full remission
F328	Other depressive episodes
F3281	Premenstrual dysphoric disorder
F3289	Other specified depressive episodes
F329	Major depressive disorder, single episode, unspecified
F32A	Depression, unspecified
F330	Major depressive disorder, recurrent, mild
F331	Major depressive disorder, recurrent, moderate
F332	Major depressv disorder, recurrent severe w/o psych features
F333	Major depressv disorder, recurrent, severe w psych symptoms
F3340	Major depressive disorder, recurrent, in remission, unsp
F3341	Major depressive disorder, recurrent, in partial remission
F3342	Major depressive disorder, recurrent, in full remission
F338	Other recurrent depressive disorders
F339	Major depressive disorder, recurrent, unspecified
F340	Cyclothymic disorder
F341	Dysthymic disorder
F348	Other persistent mood [affective] disorders
F3481	Disruptive mood dysregulation disorder
F3489	Other specified persistent mood disorders
F349	Persistent mood [affective] disorder, unspecified
F39	Unspecified mood [affective] disorder
F4000	Agoraphobia, unspecified
F4001	Agoraphobia with panic disorder
F4002	Agoraphobia without panic disorder
F4010	Social phobia, unspecified
F4011	Social phobia, generalized
F40240	Claustrophobia
F408	Other phobic anxiety disorders

F410	Panic disorder [episodic paroxysmal anxiety]
F411	Generalized anxiety disorder
F42	Obsessive-compulsive disorder
F422	Mixed obsessional thoughts and acts
F423	Hoarding disorder
F424	Excoriation (skin-picking) disorder
F428	Other obsessive-compulsive disorder
F429	Obsessive-compulsive disorder, unspecified
F4310	Post-traumatic stress disorder, unspecified
F4311	Post-traumatic stress disorder, acute
F4312	Post-traumatic stress disorder, chronic
F440	Dissociative amnesia
F441	Dissociative fugue
F442	Dissociative stupor
F444	Conversion disorder with motor symptom or deficit
F445	Conversion disorder with seizures or convulsions
F446	Conversion disorder with sensory symptom or deficit
F447	Conversion disorder with mixed symptom presentation
F4481	Dissociative identity disorder
F4489	Other dissociative and conversion disorders
F449	Dissociative and conversion disorder, unspecified
F450	Somatization disorder
F451	Undifferentiated somatoform disorder
F4520	Hypochondriacal disorder, unspecified
F4521	Hypochondriasis
F4522	Body dysmorphic disorder
F4529	Other hypochondriacal disorders
F4541	Pain disorder exclusively related to psychological factors
F4542	Pain disorder with related psychological factors
F458	Other somatoform disorders
F459	Somatoform disorder, unspecified
F481	Depersonalization-derealization syndrome
F489	Nonpsychotic mental disorder, unspecified
F603	Borderline personality disorder
F633	Trichotillomania
F6381	Intermittent explosive disorder
F6389	Other impulse disorders
F639	Impulse disorder, unspecified
F6810	Factitious disorder imposed on self, unspecified
F6811	Factit disord imposed on self, with predom psych signs/symp
F6812	Factit disord impsd on self, with predom physcl signs/symp
F6813	Factit disord impsd on self,w comb psych & physcl signs/symp
F688	Other specified disorders of adult personality and behavior
F910	Conduct disorder confined to family context
F911	Conduct disorder, childhood-onset type
F912	Conduct disorder, adolescent-onset type
F918	Other conduct disorders
F919	Conduct disorder, unspecified
F930	Separation anxiety disorder of childhood
F938	Other childhood emotional disorders
F939	Childhood emotional disorder, unspecified
F940	Selective mutism
F941	Reactive attachment disorder of childhood
F942	Disinhibited attachment disorder of childhood
F948	Other childhood disorders of social functioning
F949	Childhood disorder of social functioning, unspecified

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State Plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

(By checking the following box, the State assures that):

8. ☑**Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. Reasonable Indication of Need for Services. In order for an individual to be determined to need the 1915(i) State Plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State Plan HCBS:

i.	**Minimum number of services**. The minimum number of 1915(i) State Plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*:* 1	
ii.	**Frequency of services**. The state requires (select one):	
	●	**The provision of 1915(i) services at least monthly**
	○	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

(By checking the following box, the State assures that):

1. ☑**Home and Community-Based Settings.** The State Plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.*

DESCRIPTION OF RESIDENTIAL SETTINGS:

Services will be provided in a home or community-based setting, which does not include a nursing facility, hospital providing long-term care services, institution for mental diseases, or an intermediate care facility for intellectually disabled. Settings include the participant's home and the following settings have been determined to meet the HCBS setting requirements established in 42 CFR 441.710 (a). Settings include:

a) Private homes
b) Licensed Assisted Living Facilities (ALF) that hold an:
   i. Assisted Living contract
   ii. Adult Residential Care contract
   iii. Enhanced Adult Residential Care contract
c) Adult Family Homes (AFH)
d) Enhances Services Facilities (ESF)

Services may also be provided when participants are accessing community resources or in their place of employment.

Ongoing evaluation of all settings for HCBS characteristics

The state evaluates settings for HCBS characteristics during the monitoring process completed by ALTSA's Residential Care Services (RCS) Division. During this process, sites or homes receive an on-site review, interviews are completed with participants, staff, and administrators as appropriate to the setting, and a visual review of the home or facility, and participant record reviews are completed.

This information is entered into a database which creates a report that is used to track and trend issues that arise regarding these, and all, participant rights. This information is used by the RCS Management Team, HCS Management Team, and the HCA/ALTSA waiver management committee to address systemic issues through Quality Improvement projects. When systemic issues are identified, the state will develop and implement an improvement plan to address systemic issues, including training of providers, revision of laws and rules, and strengthening of licensing requirements.

Remediation

For individual settings that fail to meet any of the HCBS requirements, outcomes of the licensing/certification processes include citations and/or enforcement actions taken on non-compliant providers (such as plans of correction, shortened timelines for certification, fines, and certification/license revocation). If a setting that provides 1915(i) services receives a corrective action plan (CAP) related to 1915(i) services, that issue will be remediated as identified in the approved CAP.

If a provider is unable or unwilling to come into compliance with the HCBS rules (or other rules and regulations that pose a health or safety risk to residents), RCS revokes the license of the facility. HCS then follows a person-centered approach to assist participants to relocate to a facility of the participant's choice.

Person-Centered Planning & Service Delivery

(By checking the following boxes, the state assures that):

1. ☐☑ There is an independent assessment of individuals determined to be eligible for the State Plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☐☑ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State Plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☑ The person-centered service plan is reviewed and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

The assessment will be completed by ALTSA, the operating agency of the HCBS programs, face-to-face, through telemedicine, or other information technology medium when warranted.

Registered Nurse (RN): licensed under Chapter 18.79 RCW

Case Manager:

In addition to meeting the following minimum qualifications, staff must pass a background check prior to being hired and receive mandatory training prior to completing any evaluations/service plans.

Service plans are developed by case managers who can be a registered nurse licensed in the state, or a social service specialist. For social service specialists, minimum qualifications are as follows:

- A master's degree in social services, human services, behavioral sciences, or an allied field and two years of paid social service experience performing functions equivalent to a social service specialist 2;

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 functions equivalent to a social service specialist 2;

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.

Note: Employees must successfully complete the formal training course sponsored by their division within one year of their employment.

Note: Equivalent social service experience includes the previous classes of caseworker 3 or higher;

OR

A bachelor's degree and three years of experience as a caseworker 3, social worker 1A or B, social worker 2, casework supervisor trainee, casework supervisor, juvenile rehabilitation supervisor 1 or juvenile rehabilitation counselor 2 in state service.

5. **Responsibility for Development of Person-Centered Service Plan**. There are qualifications (that are reasonably related to developing service plans) for participants responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

Development of the person-centered service plan will be done by ALTSA, the operating agency of HCBS programs:

Registered Nurse (RN): licensed under Chapter 18.79 RCW

Case Manager:

In addition to meeting the following minimum qualifications, staff must pass a background check prior to being hired and receive mandatory training prior to completing any evaluations/service plans.

Service plans are developed by case managers who can be a Registered Nurse, licensed in the state, or a social service specialist. For social service specialists, minimum qualifications are as follows:

- A master's degree in social services, human services, behavioral sciences, or an allied field and two years of paid social service experience performing functions equivalent to a social service specialist 2;

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 functions equivalent to a social service specialist 2;

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.

Note: Employees must successfully complete the formal training course sponsored by their division within one year of their employment.

Note: Equivalent social service experience includes the previous classes of caseworker 3 or higher;

OR

A bachelor's degree and three years of experience as a caseworker 3, social worker 1A or B, social worker 2, casework supervisor trainee, casework supervisor, juvenile rehabilitation supervisor 1 or juvenile rehabilitation counselor 2 in state service.

6. **Supporting the Participant in Development of Person-Centered Service Plan**. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the*

supports and information made available, and (b) the participant's authority to determine who is included in the process):

(a) Prior to enrollment, the state provides participants an assessment, information about services and supports, including HCBS settings requirements, and assistance needed to make an informed choice about the program. Upon enrollment, appropriate information and assistance is provided by either the case manager or others selected by the individual to ensure that the individual or individual's representative is able to understand, manage, and select their service provider and supports. Information is communicated to the participant in a manner and language understandable by the participant, including needed auxiliary aids and/or translation services.

(b) In the development of the person-centered service plan, participants choose who to include in the process.

7. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

The person-centered planning process includes a review of all available qualified providers. Information and assistance are provided to ensure that the individual, or individual's representative, is able to understand and select their service provider. Information is communicated to the participant in a manner and language understandable by the participant, including needed auxiliary aids and/or translation services.

Participants select a provider from available contracted providers.

8. **Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

The person-centered service plan is developed using the CARE assessment application, with information entered in CARE by the participant and Case Manager during the assessment process.

When the assessment indicates the individual may meet the needs-based eligibility criteria and would benefit from services under this State Plan, the Case Manager will provide information and options to the participant. With agreement from the individual, the assessment, care plan recommendation, and referral will be sent to the MCO, or directly to HCA for participants in the FFS program. The MCO will review the documentation for completeness and forward information on to the Medicaid agency.

The Medicaid agency will review the submission for accuracy and completeness and determine if the participant meets the eligibility criteria. The eligibility determination is then communicated back to the Case Manager to finalize the person-centered service plan , including ensuring the plan meets all requirements of 42 CFR 441.725. The Medicaid Agency maintains oversight of person-centered care plans, in partnership with the Operating agency as described in #5 of the Quality Measures below.

The review process of the person-centered service plans is outlined under 1.a-c of the Quality Improvement Strategy section of the application. ALTSA/Home and Community Services Division (HCS) Quality Assurance Unit, with HCA oversight, will conduct annual record reviews using a representative sample using a 95% confidence interval with a 5% margin of error. Review methodology will look at the following: a) does the service plan address assessed needs of 1915(i) participants; b) are the service plans updated annually; and c) does the service plan document

choice of services and providers. Results will be jointly reviewed by ALTSA/HCS Division and HCA to identify areas of deficiency and to inform quality improvement strategies. Non-compliance will be determined by the performance measure falling below 86%. HCA and ALTSA/HCS Division are leveraging an already existing joint committee called the "Waiver Management Committee" to meet on a quarterly basis and ensure coordination is cohesive and aligned.

9. **Maintenance of Participant-Centered Service Plan Forms**. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

☐	Medicaid agency	☐	Operating agency	☐	Case manager
☑	Other (*specify):*	Partnering state agency DSHS/ALTSA			

Services

1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Community Behavioral Health Support Services - Supportive supervision and oversight
Service Definition (Scope)*:*	
Community Behavioral Health Support Services: Individually tailored services designed to assist participants in restoring or acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Community Behavioral Health Support Services may include supportive supervision/oversight, which is described as follows: Supportive supervision and oversight is in-person monitoring, redirection, diversion, and cueing of the participant to prevent at-risk behavior that may result in harm to the participant or to others. These interventions are not related to the provision of personal care. Provides individuals with assistance to build skills and resiliency to support stabilized living and community integration. These interventions are coordinated as appropriate with other support services, to include behavioral health services provided by a behavioral health agency and/or behavior support services or other community supports as appropriate. Supportive supervision should include integration of behavior support and/or crisis plans to help ensure community stability and an escalation process for collaborative care, including following CFR 441.710(a)(vi)(F)(1) through (8) when necessary.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration, and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard State Plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
	N/A
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Adult Family Home (AFH)	Licensed under Chapter 388-76 WAC		
Adult Residential Care (ARC) Facility	Assisted Living Facilities with a contract to provide ARC services and are licensed under Chapter 18.20 RCW and Chapter 388-78A WAC		
Enhanced Adult Residential Care (EARC) Facility	Assisted Living Facilities with a contract to provide EARC services and are licensed under Chapter 18.20 RCW and Chapter 388-78A WAC		
Enhanced Services Facilities	Licensed under Chapter 70.97 RCW and Chapter 388-107 WAC		
Assisted Living Facility	Licensed under Chapter 18.20 RCW and Chapters 388-78A and 388-110 WAC		

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Adult Family Home	Managed Care Organization/HCA	Every three years

Enhanced Adult Residential Care facility	MCOHCA	Every three years
Assisted Living Facility	MCO/HCA	Every three years
Enhanced Services Facilities	MCO/HCA	Every three years

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	

Service Definition (Scope)*:*

1.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

N/A

☐ Medically needy *(specify limits):*

N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☑	Provider managed

2. ☐ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box, the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State Plan HCBS, who are relatives of the individual. There are additional policies and controls if the State makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS.

(Specify (a) who may be paid to provide State Plan HCBS; (b) the specific State Plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. **Election of Participant-Direction**. (S*elect one):*

●	The state does not offer opportunity for participant-direction of State Plan HCBS.
○	Every participant in State Plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State Plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

2. **Description of Participant-Direction. (Provide an overview of the opportunities for participant-***direction under the State Plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

3. Limited Implementation of Participant-Direction. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to state wideness requirements. Select one):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State Plan HCBS are available. (*Specify the areas of the state affected by this option)*:

4. Participant-Directed Services. *(Indicate the State Plan HCBS that may be participant-directed, and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

5. Financial Management. (*Select one):*

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State Plan.

6. ☐ Participant–Directed Person-Centered Service Plan. *(By checking this box, the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State Plan HCBS that the individual will be responsible for directing.
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget.
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual.
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

7. Voluntary and Involuntary Termination of Participant-Direction. ***(****Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can select, manage, and dismiss State Plan HCBS providers). (*Select one):*

○	The state does not offer opportunity for Participant-Employer Authority.	
○	Participants may elect Participant-Employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

○	The state does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. **Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.**

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement	***1a. Service Plans address assessed needs of 1915(i) participants***
Discovery	
Discovery Evidence *(Performance Measure)*	The number and percent of service plans for 1915(i) participants that address all assessed needs by the provision of state plan services or by other means. ***N=****Number of participant service plans that address all assessed needs by the provision of state plan services or by other means* ***D=****Number of participant service plans reviewed*
Discovery Activity *(Source of Data & sample size)*	**Source:** Records review conducted off site **Sample size:** A representative sample using a 95% confidence interval with a 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	ALTSA/HCS
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(1) ALTSA/HCS, with HCA oversight, will conduct periodic reviews of performance measures to determine compliance with applicable Washington State rules and the quality improvement strategy. (2) Reviews will be conducted through an off-site records review process and data analysis. (3) Data and reports related to this performance measure will be jointly reviewed by ALTSA/HCS and HCA to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Non-compliance will be determined by the performance measure falling below 86%. Remediation activities may include targeted training and revision of administrative processes and procedures. This is in addition to individual remediation strategies.
Frequency *(Of Analysis and Aggregation)*	Annually

Requirement	*1b. Service Plans are updated annually*
Discovery	
Discovery Evidence *(Performance Measure)*	The number and percent of service plans reviewed and updated prior to annual review date. ***N** = Number of service plans reviewed and updated prior to annual review date* ***D** = Number of service plans reviewed*
Discovery Activity *(Source of Data & sample size)*	**Source:** Records review conducted off site **Sample size**: A representative sample using a 95% confidence interval with a 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	ALTSA/HCS
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(1) ALTSA/HCS with HCA oversight, will conduct periodic reviews of performance measures to determine compliance with applicable Washington State rules and the quality improvement strategy. (2) Reviews will be conducted through an off-site records review process and data analysis. (3) Data and reports related to this performance measure will be jointly reviewed by ALTSA/HCS and HCA to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Non-compliance will be determined by the performance measure falling below 86%. Remediation activities may include targeted training and revision of administrative processes and procedures.
Frequency *(Of Analysis and Aggregation)*	Annually

Requirement	*1c. Service Plans document choice of services and providers*
Discovery	
Discovery Evidence *(Performance Measure)*	The number and percent of participants who were provided an informed choice of services and providers by the Case Manager. ***N** = Number of participants with documentation that the Case Manager informed them of their choices related to state plan services and provider types* ***D** = Number of participants reviewed*
Discovery Activity *(Source of Data & sample size)*	**Source:** Records review conducted off site **Sample Size:** A representative sample using a 95% confidence interval with a 5% margin of error

	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	ALTSA/HCS
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(1) ALTSA/HCS, with HCA oversight, will conduct periodic reviews of performance measures to determine compliance with applicable Washington State rules and the quality improvement strategy. (2) Reviews will be conducted through an off-site records review process and data analysis. (3) Data and reports related to this performance measure will be jointly reviewed by ALTSA/HCS and HCA to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Non-compliance will be determined by the performance measure falling below 86%. Remediation activities may include targeted training and revision of administrative processes and procedures. This is in addition to individual remediation strategies.
	Frequency *(Of Analysis and Aggregation)*	Annually

2. Eligibility Requirements: (a) an evaluation for 1915(i) State Plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved State Plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved State Plan for 1915(i) HCBS.

Requirement		***2a. An evaluation for 1915(i) State Plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future***
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of applicants that received an evaluation for 1915(i) services. ***N=****Number of 1915(i) HCBS assessments completed.* ***D=****Total number of referrals received.*
	Discovery Activity *(Source of Data & sample size)*	**Source:** Records review conducted off site **Sample Size:** A representative sample using a 95% confidence interval with a 5% margin of error
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	HCA

	Frequency	Annually, with additional analysis as needed
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(1) HCA will conduct periodic reviews of performance measures to determine compliance with applicable Washington State rules and the quality improvement strategy. (2) Reviews will be conducted through an off-site records review process and data analysis. (3) Data and reports related to this performance measure will be reviewed by HCA to identify areas of deficiency, required improvement, and to assure completion of remediation efforts. Non-compliance will be determined by the performance measure falling below 86%. Remediation activities may include targeted training and revision of administrative processes and procedures. This is in addition to individual remediation strategies.
	Frequency *(Of Analysis and Aggregation)*	Annually, with additional analysis as needed
Requirement		***2b. The processes and instruments described in the approved State Plan for determining 1915(i) eligibility are applied appropriately.***
Discovery		
	Discovery Evidence ***(Performance Measure)***	The number and percent of participants whose eligibility was determined using the appropriate processes and instruments. ***N =*** *All participants reviewed who were found eligible, using the appropriate processes and instruments* ***D =*** *All participants records reviewed who had an eligibility determination*
	Discovery Activity *(Source of Data & sample size)*	**Source:** Records review conducted off site **Sample Size:** A representative sample using a 95% confidence interval with a 5% margin of error
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The Health Care Authority (HCA) in partnership with the Managed Care Organizations MCOs)
	Frequency	Annually, with additional analysis as needed
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(1) HCA in partnership with the MCOs will conduct periodic reviews of performance measures to determine compliance with applicable Washington State rules and the quality improvement strategy. Contract requirements with the MCOs will also be considered. (2) Reviews will be conducted through an off-site records review process and data analysis. (3) Data and reports related to this performance measure will be jointly reviewed by HCA to identify areas of deficiency, required improvement and to assure

		completion of remediation efforts. Non-compliance will be determined by the performance measure falling below 86%. Remediation activities may include targeted training and revision of administrative processes and procedures. Remediation activities may also include HCA's revision of contract requirements with the MCOs, as well as corrective action for not adhering to contract requirements or expectations. This is in addition to individual remediation strategies.
	Frequency *(Of Analysis and Aggregation)*	Annually, with additional analysis as needed

Requirement		***2c. The 1915(i)-benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.***
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of individuals re-evaluated for 1915(i) eligibility annually. ***N:*** *Number and percent of updated ongoing referrals, documenting an annual re-evaluation of eligibility.* ***D:*** *Number of Care re-assessments due for re-evaluation.*
	Discovery Activity *(Source of Data & sample size)*	**Source:** Records review conducted off site **Sample size:** A representative sample using a 95% confidence interval with a 5% margin of error
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	ALTSA/HCS
	Frequency	Annually, with additional analysis as needed
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(1) ALTSA/HCS, with HCA oversight, will conduct periodic reviews of performance measures to determine compliance with applicable Washington State rules and the quality improvement strategy. (2) Reviews will be conducted through an off-site records review process and data analysis. (3) Data and reports related to this performance measure will be jointly reviewed by ALTSA/HCS and HCA to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Non-compliance will be determined by the performance measure falling below 86%. Remediation activities may include targeted training and revision of administrative processes and procedures. This is in addition to individual remediation strategies.
	Frequency *(Of Analysis and Aggregation)*	Annually

3. Providers meet required qualifications.

Requirement		***3. Providers meet required qualifications.***
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of service providers who require licensure &/or certification that meet contract standards at time of initial contract or renewal. ***N =*** *All contracted providers reviewed that require licensure &/or certification that meet contract standards.* ***D =*** *All contracted providers reviewed that require licensure &/or certification*
	Discovery Activity *(Source of Data & sample size)*	**Source:** Records review off site of reports from MCOs (for managed care participants) and report from HCA's provider enrollment system (for FFS participants) **Sample Size:** A representative sample using a 95% confidence interval with a 5% margin of error
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	HCA
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(1) HCA will conduct periodic reviews of performance measures to determine compliance with applicable Washington State rules and the quality improvement strategy. Contract requirements with the MCOs will also be considered. (2) Reviews will be conducted through an off-site process and data analysis. (3) Data and reports related to this performance measure will be reviewed by HCA to identify areas of deficiency, required improvement and to assure completion of remediation efforts. If any provider is not in compliance with minimum requirements, HCA will issue corrective action. Non-compliance with approved corrected action will lead HCA/MCOs to seek alternative services for participants served by that provider, and HCA will inform the state's appropriate licensing authority for possible action.
	Frequency *(Of Analysis and Aggregation)*	Annually

4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).

Requirement		***Settings meet the home and community-based setting requirements as specified in this state plan and in accordance with 42 CFR 441.710(a)(1) and (2).***
Discovery		
	Discovery Evidence *(Performance Measure)*	The total number of participants whose setting, prior to authorization and ongoing, meets the home and community-based settings requirements in accordance with 42 CFR 441.710(a)(1) and (2).

		N=*Total number of participant records reviewed whose settings, prior to authorization and ongoing, meets the home and community-based settings requirement.* ***D=****Total number of participant records reviewed.*
	Discovery Activity *(Source of Data & sample size)*	**Source:** ALTSA/RCS survey data **Sample Size:** A representative sample using a 95% confidence interval with a 5% margin of error
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	ALTSA/HCS
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	ALTSA/RCS has direct oversight of residential facilities and licensing. If a provider does not meet requirements, RCS engages progressive corrective actions, which could lead to revoking of the license. In such situations, ALTSA/RCS will coordinate with HCA to ensure compliance with state plan requirements. Data and reports related to this performance measure will be reviewed by HCA to identify areas of deficiency. Refusal to comply with this performance measure will lead HCA/MCOs to seek alternative services for participants served by that provider.
	Frequency *(of Analysis and Aggregation)*	Annually

5. The SMA retains authority and responsibility for program operations and oversight.

Requirement		***5. The State Medicaid Agency retains authority and responsibility for program operations and oversight.***
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of aggregated performance measure reports, trends, and remediation efforts reviewed by HCA. ***N:*** *Number of aggregated performance measure reports, trends, and remediation efforts reviewed by HCA.* ***D:*** *Number of all performance measure reports, trends, and remediation efforts required by this state plan.*
	Discovery Activity *(Source of Data & sample size)*	**Source:** Records review off site of reports from ALTSA, MCOs (for managed care participants), and HCA systems **Sample Size:** 100% of all reports/performance measure findings data sources
	Monitoring Responsibilities	HCA

	(Agency or entity that conducts discovery activities)	
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(1) A quality review team within HCA and ALTSA/HCS will conduct a comprehensive review of performance measure reports, trends, and remediation efforts. (2) Remediation activities may include targeted training/technical assistance, revision of policies/processes, review of contract language with MCOs and potential changes to contract requirements, etc. This is in addition to individual remediation strategies. (3) An annual Quality Improvement Plan will be developed and will be updated/revised annually.
	Frequency *(of Analysis and Aggregation)*	Annually

6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

Requirement		***6. The State Medicaid Agency maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.***
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of clean claims paid within 90 days. ***N:*** *Number of clean claims paid or denied within 90 days for services, broken out by MCO claims and FFS claims.* ***D:*** *Total number clean claims received for services furnished by qualified providers, broken out by MCO claims and FFS claims.*
	Discovery Activity *(Source of Data & sample size)*	**Source:** Records review off site of reports from MCOs (for managed care participants) and report from HCA's ProviderOne system (for FFS participants) **Sample Size:** 100% of all reports required for the reporting period
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	HCA
	Frequency	Annually, with additional analysis as needed
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required*	(1) HCA will conduct periodic reviews of performance measures to determine compliance with applicable Washington State rules and the quality improvement strategy. Contract requirements with the Managed Care Organizations (MCOs) will also be considered. (2) Reviews will be conducted through an off-site process and data analysis.

	timeframes for remediation)	(3) Data and reports related to this performance measure will be reviewed by HCA to identify areas of deficiency, required improvement, and to assure completion of remediation efforts. If an MCO is not in compliance with minimum requirements, HCA will issue corrective action. If there are deficiencies within the Fee-for-service program, remediation activities may include targeted training/technical assistance or revision of policies/processes for system and fiscal staff.
	Frequency *(of Analysis and Aggregation)*	Annually, with additional analysis as needed

7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

Requirement		***7a. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of participants informed of where to report abuse, neglect, and exploitation. ***N*** **=** *Number of participants who received information on where to report abuse, neglect, and exploitation* ***D*** **=** *Number of records reviewed*
	Discovery Activity *(Source of Data & sample size)*	**Source:** Records review conducted off site **Sample Size:** Less than 100% (representative sample) Confidence Interval = 5%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	ALTSA/HCS
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(1) ALTSA/HCS, with HCA oversight, will conduct periodic reviews of performance measures to determine compliance with applicable Washington State rules and the quality improvement strategy. (2) Reviews will be conducted through an off-site records review process and data analysis. (3) Data and reports related to this performance measure will be jointly reviewed by ALTSA/HCS and HCA to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Remediation activities must be completed within 60 days, including informing the participant of where to report abuse, neglect, and abuse.
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement		***7b. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of identified critical incidents that were properly reported to Adult Protective Services (APS) **N =** *Number of APS referrals completed* **D =** *Number of records reviewed where a referral to APS was needed.*
	Discovery Activity *(Source of Data & sample size)*	**Source:** Records review conducted off site **Sample Size:** Less than 100% (representative sample) Confidence Interval = 5%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	ALTSA/HCS
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(3) ALTSA/HCS, with HCA oversight, will conduct periodic reviews of performance measures to determine compliance with applicable Washington State rules and the quality improvement strategy. (4) Reviews will be conducted through an off-site records review process and data analysis. (3) Data and reports related to this performance measure will be jointly reviewed by ALTSA/HCS and HCA to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Remediation activities must be completed within 60 days. The Quality Assurance team also reports all incidents that were identified and not reported.
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement		***7c.: The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of deaths investigated where appropriate follow-up action was taken. **N =** *Number of deaths investigated where appropriate follow-up action was taken* **D =** *Number of deaths investigated*
	Discovery Activity	Source: Records review conducted off site Sample Size:100%

	(Source of Data & sample size)	
	Monitoring Responsibilities ***(Agency or entity that conducts discovery activities)***	ALTSA/HCS
	Frequency	Annually
Remediation		
	Remediation Responsibilities ***(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)***	(1) ALTSA/HCS Division, with HCA oversight, will conduct periodic reviews of performance measures to determine compliance with applicable Washington State rules and the quality improvement strategy. (2) Reviews will be conducted through a review process and data analysis of Adult Protective Services Fatality Review data. (3) Data and reports related to this performance measure will be jointly reviewed by ALTSA/HCS and HCA to identify areas of deficiency and methods for making improvements.
	Frequency ***(of Analysis and Aggregation)***	Annually

Requirement		***7d. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery		
	Discovery Evidence *(Performance Measure)*	Percent of participant's records reviewed with no instances of the use of seclusion or restraints ***N=****Number of participant's records with no instances of the use of seclusion or restraints* ***D=****Number of participant's records reviewed*
	Discovery Activity *(Source of Data & sample size)*	**Source:** Records review conducted off site **Sample Size:** Less than 100% (representative sample) Confidence Interval = 5%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	ALTSA/HCS
	Frequency	Annually
Remediation		

	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(1) ALTSA, with HCA oversight, will conduct periodic reviews of performance measures to determine compliance with applicable Washington State rules and the quality improvement strategy. (2) Data analysis will be conducted using administrative data. (3) Data and reports related to this performance measure will be jointly reviewed by ALTSA/HCS and HCA to identify areas for improvement. Remediation activities must be completed within 60 days and may include unreported instances of seclusion or restraints will be reported to APS/RCS and (4) Identified instances of seclusion or restraints will be addressed by APS.
	Frequency *(of Analysis and Aggregation)*	Annually
Requirement		***7e. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of APS investigations completed within mandatory timeframe ***N =*** *Number of APS investigations completed within mandatory timeframes* **D =** *Number of APS investigations*
	Discovery Activity *(Source of Data & sample size)*	**Source:** Administrative data **Sample Size:** Less than 100% (representative sample) Confidence Interval = 5%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	APS
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(1) ALTSA, with HCA oversight, will conduct periodic reviews of performance measures to determine compliance with applicable Washington State rules and the quality improvement strategy. (2) Data analysis will be conducted using administrative data. (3) Data and reports related to this performance measure will be jointly reviewed by ALTSA/HCS and HCA to identify trends and areas for improvement. Remediation activities may include targeted training and revision of administrative processes and procedures.
	Frequency *(of Analysis and Aggregation)*	Annually

System Improvement

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

The quality management approach:

a. The state draws and monitors a representative sample of the participant's records.
b. All Quality Assurance (QA) issues are remediated at an individual level. Remediation actions and timelines are recorded and tracked by HCA. For all issues in which the state does not meet the 86% compliance, the state conducts a quality improvement project initiated at HCA or ALTSA depending on the performance measure.
c. QA monitoring reports allow patterns/trends to be tracked at both the regional and statewide level. The state analyzes these trends/patterns annually and develop a Quality Assurance annual report.
d. Ongoing discovery and remediation are facilitated by regular reporting and communications among HCA, MCO), ALTSA, and other stakeholders including service providers and agencies.
e. An annual QA Quality Review Report is prepared at the close of each audit cycle. This report is reviewed in detail with the Medicaid Agency Waiver Oversight Committee, HCA management, and the ALTSA/HCS Management Team of all QA audit activities and the status and recommendations for system improvements.
f. Data is analyzed for trends and the formulation of recommendations for system improvements. Partners included in this process are HCA, MCOs, ALTSA HCS and RCS, service providers, APS, ProviderOne, the Department of Health (DOH), and participants.
g. HCA/ALTSA and partners' proficiency improvement plans are prioritized, and changes are implemented, based on HCA/ALTSA strategic goals, stakeholder input, and available resources. System improvements may include training, process revision, and policy clarification.
h. The improvement process includes a re-evaluation component to see if improvements have been made after system changes have been implemented. Adjustments to the system are made based on the re-evaluation findings.

2. Roles and Responsibilities

HCA, as the Medicaid State Agency, will maintain oversight, coordination, and accountability for overall quality assurance of the HCBS benefit. However, roles and responsibilities often entail a close partnership between HCA and ALTSA, leveraging many existing pathways that ALTSA already has in place due to their role in delivering Long Term Services and Supports (LTSS).

HCA measures items 2a, 2b, 3, 5, and 6 from the performance measures above.

ALTSA monitors performance measures 1a, 1b, 1c, 2c, 4, 7a, 7b, and 7c as well as the oversight and functions outlined below:

- The HCS Quality Assurance unit is responsible for monitoring the three state regional areas for each review cycle. This unit uses a standardized monitoring process which includes:
  - Verifying that remediation has occurred, and
  - Providing final reports for analysis and action.

- RCS provides licensing, certification, regulatory oversight, and conducts inspections of adult family homes, assisted living facilities, and

enhanced services facilities at least every 18 months to ensure they meet licensing requirements and are in compliance with federal and state laws and rules. In addition to licensing inspections, RCS investigates complaints received from residents or the public and takes action to ensure that resident rights are not being violated. If a setting violates an individual's personal rights of privacy, dignity, choice, and respect, the provider is cited and must develop a corrective action plan to address the issues.

- The Complaint Resolution Unit (CRU) in RCS investigates licensed residential providers. The CRU receives reports of abuse, abandonment, neglect, or financial exploitation by phone, fax, letter, or in-person. RCS may take enforcement actions based on the findings from licensing inspections and complaint investigations. Enforcement actions range from civil fines to license revocation to referral of criminal allegations to law enforcement.

- The Adult Protective Services (APS) Unit investigates and makes official findings on any accusations of abuse, neglect, or exploitation of vulnerable adults. APS investigations may include guardianships, protection orders, and placement on the registry when substantiated findings of abuse, neglect, or exploitation are made against an individual participant.

ALTSA and HCA also partner to ensure strong oversight and coordination of the HCBS Committee (also called the Waiver Management Committee). This committee ensures regular opportunities for discussion and oversight between the state Medicaid agency and the operating agency regarding Home and Community Based Services. The committee meets at least quarterly to review all functions delegated to the operating agency, current quality assurance activities and performance, pending waiver or State Plan activity (e.g., amendments, renewals, etc.), potential waiver/state plan and rule changes and quality improvement activities.

3. Frequency

Annually

4. Method for Evaluating Effectiveness of System Changes

The Quality Improvement Strategy is evaluated and adjusted prior to the beginning of each yearly review cycle, at the time of a state plan amendment, and at renewal. Workgroups consisting of HCA program managers, ALTSA program managers, MCOs, and fair hearing coordinators evaluate the quality assurance strategy/program.

Modifications/expectations are developed based on changes in federal or state rules and regulations, HCA's and ALTSA's policy and procedures, CMS assurances and sub assurances, input from technical consultants, participants, providers, and data from various reports including recommendations from the previous review cycle. The quality improvement strategy is reviewed and approved by the HCA and ALTSA executive management team and the Medicaid Agency Waiver Management Committee.

Methods and Standards for Establishing Payment Rates

1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates)*:

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☐	HCBS Habilitation
☐	HCBS Respite Care
For Individuals with Chronic Mental Illness, the following services:	
☐	HCBS Day Treatment or Other Partial Hospitalization Services
☑	HCBS Psychosocial Rehabilitation
	Community Behavioral Health Support Services **Supportive Supervision and Oversight** -a tiered FFS model will be utilized, as described below. When these services are provided in an Adult Family Home, these rates will be collectively bargained through HCA with the Adult Family Home Council. The rates are set based on a bargaining agreement at 2-year intervals. The rate setting process will follow an actuarily sound process and will utilize an approved methodology for services under the 1915 (i) state plan.
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☐	Other Services (specify below)

HCBS Psychosocial Rate Setting
Rates will be developed for a twelve-month period, which will be the calendar year.

Rates for 1915(i)waiver services rates will be developed by the state Medicaid agency and certified by the State's contracted actuary. After the base year, rates will be determined upon previous years cost and encounter data using such methods as a time study".

The Medicaid Agency has developed a standardized rate schedule based upon actuarially sound principles and intends to pay rates that are no less than the State Plan-approved FFS rates.

The rates are set based on the total cost of the services provided to the individual based upon the diagnosis, risk, and needs. Historical data utilization of state offered service levels were analyzed to ensure consistency of estimated levels of services to ensure sufficient rates. HCA fiscal staff projected rates based on information provided through data compiled for similar services. After the base year, rates will be determined upon previous years cost and encounter data using such methods as a time study.

The HCA-contracted actuaries projected rates utilizing an independent rate framework, which includes a determination of the costs, inclusive of all costs related to provision of services.

Rates were then set based upon those data points.

The contracted Medicaid Agency actuaries will review rates yearly to ensure the appropriateness of the rates.

Facilities will be appropriately licensed depending upon the facility license required by Washington State Department of Health for the services provided.

The fee schedule is effective for services provided on and after July 1, 2024. Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services. See 4.19-B, I, General, #G for the Agency's website where the fee schedules are published.

Community Behavioral Health Support Services – Supportive Supervision and Oversight FFS Provider Reimbursement Rate Setting Process
Services are expected to be provided in the following licensed settings: Adult Family Home, Assisted Living Facilities, Enhanced Adult Residential Care Facilities and Enhanced Services Facilities. Rates will be developed and set at the same level regardless of the setting, with the understanding that the rates for the Adult Family Home are collectively bargained with the Adult Family Home Council as described below.

Rates are paid as a daily rate. The amount paid will be the same for all providers based on tiers established.

Rates are set pursuant to a cost-based methodology with assistance from the state actuaries. Historical costs for the services provided were evaluated based on eleven consecutive months of actual costs divided by the average total consumer utilization (days or hours) for the same period. This was compared with rates projected by the actuaries and the rates were determined to be in the reasonable range.

After the base year, rates will be determined upon previous years cost and encounter data using such methods as a time study.

Actuarial rates for all six tiers are evaluated by the actuaries in utilizing the following data:

- The time required for the services to be provided for each tier is established on an average basis
- The average salary levels of the individuals providing the services are determined utilizing Bureau of Labor and Statistics (BLS) wage data at the median level

- Determination for potential shift differentials are then applied
- The training hours required for the services are applied
- PTO hours are applied
- The amount of holiday hours paid are averaged and added to the hours

This allows a calculation for total hours of service for each rate, which is multiplied by the BLS wage data. The average employee related expenses are then applied to each tier. An average provider administrative cost is calculated as part of each rate tier. This provides an average cost of the services for each tier on a cost basis.

Tiered rates are established based on needs-based criteria and risk criteria as indicated in Attachment 3.1-i pages 10 through 15. Levels of service are determined based on needs and risk criteria with a total of 6 payment levels to be implemented, which are based upon the following:

- the complexity of the individual's needs,
- the number of service hours needed, and
- the person-centered service plan.

An individual's needs determine the rate paid for the service provided.

Payment for services provided will be based on the individual's acuity needs as follows:

Tier 1 – At a minimum, all individuals deemed eligible for Supportive Supervision qualify for Tier 1, an average of up to two hours a day.

- The individual demonstrates a qualifying behavior(s) that require daily, intermittent monitoring, redirection, and cueing to promote community stability and to ensure the safety of the individual and other residents; or
- The individual has a significant history of behaviors that are well-managed in a highly structured setting but are at risk of recurring in a community setting if not met with the appropriate level of Supportive Supervision; or
- For renewal or re-assessment, the individual has a history of behavior(s) meeting the guidelines above, which are currently only prevented by additional skilled staff intervention.

Tier 2 –

- The individual demonstrates current, qualifying behavior(s) at a frequency that requires an average of 2.1-6 hours per day of dedicated staff to redirect, deescalate, and cue to promote community stability and to ensure the safety of the individual and other residents; or
- The individual has demonstrated multiple qualifying behaviors requiring an average of 2.1-6 hours per day of 1:1 staffing within the past month. Behaviors may be well-managed in a highly structured setting but are at risk of recurring in a community setting if not met with the appropriate level of Supportive Supervision; or
- For renewal or re-assessment, the individual has a history of behavior(s) meeting the guidelines above, which are currently only prevented by additional skilled staff intervention at this tier level.

Tier 3 –

- The individual demonstrates multiple qualifying behaviors at a frequency and intensity that requires an average of 6.1-10 hours per day of 1:1 staffing to redirect, engage, deescalate, and cue to promote community stability and to ensure the safety of the individual and other residents; or
- The individual has demonstrated multiple qualifying behaviors requiring an average of 6.1-10 hours per day of 1:1 staffing within the past month. Behaviors may be well-managed in a highly

structured setting but are at risk of recurring and/or increasing in frequency/severity in a community setting if not met with the appropriate level of Supportive Supervision; or

- For renewal or re-assessment, the individual has a history of behavior(s) meeting the guidelines above, which are currently only prevented by additional skilled staff intervention at this tier level.

Tier 4 –

- The individual demonstrates multiple qualifying behaviors at a frequency and intensity that requires an average of 10.1-16 hours per day of 1:1 staffing to redirect, engage, deescalate, and cue to promote community stability and to ensure the safety of the individual and other residents; or
- The individual demonstrates multiple qualifying behaviors requiring an average of 10.1-16 hours per day of 1:1 staffing within the past month. Behaviors require at least 1:1 intervention even in a structured setting but may be at risk of increasing in frequency and/or severity in a community setting if not met with the appropriate level of Supportive Supervision; or
- For renewal or re-assessment, the individual has a history of behavior(s) meeting the guidelines above, which are currently only prevented by additional skilled staff intervention at this tier level.

Tier 5 –

- The individual demonstrates multiple behaviors at a frequency and intensity that requires an average of 16.1-20 hours per day of 1:1 staffing to redirect, engage, deescalate, and cue to promote community stability and to ensure the safety of the individual and other residents; or
- Behaviors require daily 1:1 intervention even in the context of a structured setting and there would be an imminent risk of harm should be the individual not receive an average of 16.1-20 hours per day of at least 1:1 staffing in a community setting; or
- For renewal or re-assessment, the individual has a history of behavior(s) meeting the guidelines above, which are currently only prevented by additional skilled staff intervention at this tier level.

Tier 6

- The individual demonstrates multiple qualifying behaviors at a frequency and intensity that requires an average of 20.1-24 hours per day of 1:1 staffing and/or regular episodes, that require multiple staff to redirect, engage, deescalate, and cue to promote community stability and to ensure the safety of the individual and other residents; or
- Behaviors require constant 1:1 monitoring and intervention even in the context of a structured setting and there would be an imminent risk of harm should the individual not receive an average of 20.1-24 hours per day of at least 1:1 staffing in a community setting; or
- For renewal or re-assessment, the individual has a history of behavior(s) meeting the guidelines above, which are currently only prevented by additional skilled staff intervention at this tier level.

Adult Family Homes (AFH): Medicaid reimbursement rates for providers are collectively bargained through the State of Washington on behalf of Washington State Health Care Authority with the Adult Family Home Council. These rates are set based on a bargaining agreement at two-year intervals. The collective bargaining process is a public process.

For Assisted Living Facilities, Enhanced Adult Residential Care Facility and Enhanced Service Facilities: The Medicaid Agency has developed standardized rates based upon actuarily sound principles for supportive supervision services tiered for the participant's needs. Rates for services provided in Assisted Living Facilities (ALFs), Enhanced Adult Residential Care Facility (EARC) and Enhanced Service Facilities (ESFs) will be no less than those provided in AFHs.

DEPARTMENT OF HEALTH AND HUMAN 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: 24 — 0002

2. STATE: WA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT

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

4. PROPOSED EFFECTIVE DATE
July 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
Sections 1902a & 1915i of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 0
b. FFY 2026 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 3.1-F Part 2 page 2~~0~~2

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Attachment 3.1-F Part 2 page 2~~0~~2 (TN# 23-0051 ~~20-0001~~)

9. SUBJECT OF AMENDMENT

Add 1915i State Plan Home & Community-Based Services to Managed Care

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

Susan E Birch

12. TYPED NAME
Susan E Birch, MBA, BSN, RN

13. TITLE
Director and Acting Medicaid Director

14. DATE SUBMITTED
January 8, 2024

15. RETURN TO

State Plan Coordinator
POB 42716
Olympia, WA 98504-2716

FOR CMS USE ONLY

16. DATE RECEIVED
January 8, 2024

17. DATE APPROVED
April 3, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2024

19. SIGNATURE OF APPROVING OFFICIAL

Bill Brooks

20. TYPED NAME OF APPROVING OFFICIAL
Bill Brooks

21. TITLE OF APPROVING OFFICIAL
Director, Division of Managed Care Operations

22. REMARKS

On March 15, 2024, Washington State staff authorized CMS to make the following "pen and ink" changes to this form 179:

- Box 7: replace page "20" with "22"
- Box 8: replace page "20" with "22." Replace the superseded TN# "20-0001" with "23-0051"

APPLE HEALTH MANAGED CARE

Rehabilitative services			
Behavioral health care coordination and community integration	*3.1-A*	*43*	*13.d.1(b)ix*
Crisis intervention	*3.1-A*	*39*	*13.d.1(b)i*
Crisis stabilization	*3.1-A*	*39, 40*	*13.d.1(b)ii*
Intake evaluation, assessment, and screening for mental health	*3.1-A*	*40*	*13.d.1(b)iii*
Intake evaluation, assessment, and screening for substance use or problem gambling disorder	*3.1-A*	*40, 41*	*13.d.1(b)iv*
Medication for Opioid Use Disorder (formerly Medication Assisted Treatment (MAT)- the medication component of the treatment plan for treating an SUD, including prescribing or administering medication, except for methadone, in the SUD clinic setting	*3.1-A* *Supplement 4 to 3.1-A*	*18.b*	*5.a.(12)*
Medication management	*3.1-A*	*41*	*13.d. 1(b)v*
Medication monitoring	*3.1-A*	*41*	*13.d. 1(b)vi*
Mental health treatment interventions	*3.1-A*	*42*	*13.d.1(b)vii*
Peer support	*3.1-A*	*43*	*13.d. 1(b)viii*
Substance use disorder brief intervention	*3.1-A*	*44*	*13.d.1(b)x*
Substance use or problem gambling disorder treatment interventions	*3.1-A*	*45*	*13.d.1(b)xi*
Substance use disorder withdrawal management	*3.1-A*	*46*	*13.d.1(b)xii*
1915i Community Behavioral Health Support Services – Supportive Supervision & Oversight	*3.1-i*	*1, 28, 30, 54*	*1, 1, - , 1*