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State/Territory Name: Washington

State Plan Amendment (SPA) #: 15-0002

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS/RX-200
Seattle, Washington 98104

Division of Medicaid & Children's Health Operations

June 30, 2015

Dorothy Frost Teeter, Director
MaryAnne Lindeblad, Medicaid Director
Health Care Authority
Post Office Box 45502
Olympia, Washington 98504-5502

RE: Washington State Plan Amendment (SPA) Transmittal Number 15-0002

Dear Ms. Teeter and Ms. Lindeblad:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Washington State Plan Amendment (SPA) Transmittal Number 15-0002. This amendment implements the addition of the 1915(k) Community First Choice Option services to the State Plan.

This SPA is approved July 1, 2015, as requested by the state.

The CMS appreciates the efforts and cooperation of Washington's leadership and staff throughout the review process. If you have any additional questions, please contact me, or have your staff contact Kendra Sippel-Theodore at (206) 615-2065 or kendra.sippel-theodore@cms.hhs.gov.

Sincerely,

[redacted]
Digitally signed by David L. Meacham -S
DN: c=US, o=U.S. Government, ou=HHS
Date: 2015.06.29 11:52:10 -07'00'

David L. Meacham
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc:
Marilee Fosbre, Department of Social and Health Services
Barbara Hanneman, Department of Social and Health Services
Tracey Rollins, Department of Social and Health Services
Bob Beckman, Department of Social and Health Services
Mandeep Kaundal, Department of Social and Health Services
Rachel Dressel, Division of Benefits and Coverage, CMS
Lindsey Wilde, Division of Benefits and Coverage, CMS
Daphne Hicks, Division of Long Term Services and Supports, CMS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **15-0002**

2. STATE: Washington

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

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
~~January 1, 2015~~ July 1, 2015 P&I

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 441.510

7. FEDERAL BUDGET IMPACT:
a. FFY 2015 $697,637,000
b. FFY 2016 $805,087,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
~~24~~ 25
Att. 3.1-K pages 1 – ~~20~~ (new)
Att. 4.19-B pages ~~31, 32, 32a (new)~~ ~~47 - 50 (new) P&I~~
46-50 (new) P&I

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
remove
Att. 4.19-B pages 31, 32 P&I

10. SUBJECT OF AMENDMENT

Community First Choice Services

11. 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

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
MARYANNE LINDEBLAD

14. TITLE:
MEDICAID DIRECTOR

15. DATE SUBMITTED:
1-30-15

16. RETURN TO:
Ann Myers
Office of Rules and Publications
Legal and Administrative Services
Health Care Authority
626 8th Ave SE MS: 42716
Olympia, WA 98504-2716

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 1.30.15

18. DATE APPROVED: 6/30/15

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
07/01/2015

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
David L. Meacham

22. TITLE: ~~Associate~~ Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

4.03.15: State authorizes P&I change to box 4,8, and 9

6.29.15: State authorizes P&I change to box 8 and 9

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of Washington
Community First Choice State Plan Option

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation.

I. Eligibility

a. The State determines eligibility for Community First Choice (CFC) services in the manner prescribed under 42 CFR 441.510. To receive CFC services and supports under this section, an individual must meet the following requirements:
   i. Be eligible for medical assistance under the State Plan:
      1. As determined every 12 months, be in an eligibility group under the State Plan that includes nursing facility services.
      2. If an eligibility group under the State Plan does not include such nursing facility services, have an income that is at or below 150 percent of the Federal poverty level (FPL). In determining whether the 150 percent of the FPL requirement is met, states must apply the same methodologies as would apply under their Medicaid State Plan, including the same income disregards in accordance with section 1902(r)(2) of the Act; and,
   ii. Receive a determination, at least every 12 months, that in the absence of the home and community-based attendant services and supports provided under this subpart, the individual would otherwise require the level of care furnished in a hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over, if the cost could be reimbursed under the State Plan. The State may permanently waive the annual recertification requirement for an individual if:
      1. It is determined that there is no reasonable expectation of improvement or significant change in the individual's condition because of the severity of a chronic condition or the degree of impairment of functional capacity; and
      2. The state agency, or designee, retains documentation of the reason for waiving the annual recertification requirement.
   iii. Individuals who are receiving medical assistance under the special home and community-based waiver eligibility group defined at section 1902(a)(10)(A)(ii)(VI) of the Act must continue to meet all 1915(c) requirements and must receive at least one home-and-community-based waiver service per month.
   iv. Individuals receiving services through CFC will not be precluded from receiving other home-and-community-based long-term care services and supports through other Medicaid State Plans, waivers, grants or demonstrations, but will not be allowed to receive duplicative services in CFC or any other available community-based service.
   v. For Individuals eligible under section 1902(a)(10)(A)(ii)(VI) of the Act who continue to meet all of the 1915(c) waiver requirements and who are receiving at least one 1915(c) waiver service a month, post-eligibility treatment of income rules apply as established under 42 CFR 435.726 and are applied, in addition to the cost of 1915(c) waiver services, to the cost of 1915(k) services. Therefore, excess income is applied to both 1915(c) waiver and 1915(k) services.

b. For the time period January 1, 2014 to December 31, 2018, the financial eligibility rules of section 1924 of the Act will be used to determine eligibility for married individuals who are eligible for 1915 (k) services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of Washington
Community First Choice State Plan Option

II. Service Delivery Models

__X__ Agency Model - The Agency Model is based on the person-centered assessment of need. The Agency Model is a delivery method in which the services and supports are provided by entities under a contract.

_____ Self-Directed Model with service budget – This Model is one in which the individual has both a service plan and service budget based on the person-centered assessment of need.

____ Direct Cash
____ Vouchers
____ Financial Management Services in accordance with 42 CFR 441.545(b)(1).

_____ Other Service Delivery Model as described below:

III. Use of Direct Cash Payments

The State elects not to disburse cash prospectively to CFC participants.

IV. Service Package

a. The following are included CFC services including service limitations:

i. Assistance with ADLs, IADLs and health-related tasks through hands-on assistance, supervision, and/or cueing:

1. **Personal Care Services:** Personal care services means hands-on assistance, supervision, and/or cueing with activities of daily living (ADL), instrumental activities of daily living (IADL), and health-related tasks due to functional limitations. ADLs include: bathing, bed mobility, body care, dressing, eating, locomotion, medication management, toilet use, transfers, and personal hygiene. IADL assistance is incidental to the provision of ADL assistance and includes: meal preparation, ordinary housework, essential shopping, ensuring wood supply when wood is the primary source of heat, and travel to medical services. Health-related tasks are tasks related to the needs of an individual which can be delegated or assigned by licensed health care professionals under state law to be performed by an attendant.

   The provision of assistance with ADLs, IADLs, and health-related tasks can be provided concurrently with skills acquisition training.

   Participants are offered a choice of residential-based care, in-home care provided through an individually contracted provider, or a home care agency provider. Participants receiving personal care from an Individual Provider have employer authority including hiring, dismissing, scheduling, and supervising providers. The participant determines the schedule and

how and when personal care tasks will be performed. Participants receiving personal care from an agency provider choose the agency from among all qualified agency providers. The participant and the agency work together to determine the schedule of the agency worker and how and when personal care tasks will be performed based on the needs and preferences of the individual. The participant may request a different worker from the agency, select a different home care agency, or change to an Individual Provider at any time.

Participants receiving personal care from a residential provider select the provider from all available options. Using the person-centered service plan, the participant and the residential provider develop a care agreement that details how and when care will be provided based on the needs and preferences of the individual.

For participants under age 21, services will be provided in accordance with EPSDT requirements at 1905(r), subject to determination of medical necessity and prior authorization by the Medicaid agency.

2. **Nurse Delegation:** Nurse Delegation means that a licensed registered nurse assigns specific nursing task(s) to an unlicensed person to perform under the nurse's direction and supervision. The delegating nurse has the responsibility to assess the participant to ensure that the participant's condition is stable and predictable, train the caregiver to complete the task(s), evaluate the competency of the unlicensed caregiver to perform the task(s), and provide supervision to the caregiver.

   Nurse Delegation is required for certain tasks if the provider is a paid, non-family member. A care provider must be a Certified Nursing Assistant, a Registered Nursing Assistant, or a Certified Home Care Aide and must have completed the nurse delegation training. All providers must also demonstrate to the registered nurse delegator the ability to perform the specific tasks. Nurse-delegated tasks may include medication administration, blood glucose monitoring, insulin injections, ostomy care, simple wound care, straight catheterization, or other tasks determined appropriate by the delegating nurse. The following tasks may not be delegated: administration of medications by injection other than insulin, central line maintenance, sterile procedures, and tasks that require nursing judgment.

   The delegating Nurse may only delegate tasks that are within the scope of the state's Nurse Practice Act as defined in RCW 18.79.040..

   The State will be claiming enhanced match for this service.

ii. Acquisition, maintenance, and enhancement of skills necessary for the participant to accomplish activities of daily living, instrumental activities of daily living, and health related tasks.

This service includes skills acquisition training to accomplish, maintain, or enhance ADL, IADL, and health-related skills. This service is provided concurrently with the performance of ADLs, IADLs, and/or health-related tasks. When skills acquisition training results in the provision of ADLs, IADLS, and/or health related tasks, the state will ensure that duplicate payment is not made for CFC activities that serve the same purpose.

Training is for the sole benefit of the participant and is provided directly to the participant receiving CFC services. Formal and informal care providers may participate in the training in order to continue to support the participant's goal outside of the training environment.

Skills acquisition training may be accessed through the use of personal care hours or may be purchased separately. Purchases made for Skills acquisition training are limited in combination with assistive technology to $500 during each state fiscal year. The $500 fiscal year limit for the combination of these CFC supports and services can be exceeded based on a determination of medical necessity.

Skills acquisition training does not include therapy (e.g., occupational, physical, communication therapy) or nursing services that must be performed by a licensed therapist or nurse, but may be used to complement therapy or nursing goals when coordinated through the support plan.

iii. Back-up systems or mechanisms to ensure continuity of services and supports.

1. **Personal Emergency Response Systems (PERS):** Eligible participants may access a PERS which includes a basic electronic device that enables participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is programmed to signal a response center once a "help" button is activated. The emergency response activator must be able to be activated by breath, by touch, or by some other means, and must be usable by participants who are visually impaired, hearing impaired, or physically disabled.

   Installation and maintenance of the PERS equipment is included in the service.

2. **Relief Care Services:** This service allows participants to utilize alternate service providers who are contracted with the Medicaid Agency as providers of personal care. Relief care providers may be identified in the service plan or used if the participant's primary provider becomes ill or is suddenly unavailable. Relief care providers will be identified during development of the person-centered service plan.

iv. Voluntary training on how to select, manage, and dismiss attendants (Caregiver Management).

Participants will be offered the opportunity to receive training materials on how to select, manage, and dismiss their attendants. Participants are informed of the training during service planning. This training will be available to all participants. Training will be available in booklet, DVD, and web-based formats to both participants and their chosen representatives when requested as an accommodation.

Training accessed through these formats will be claimed by the State as an administrative activity.

b. The State elects to include the following CFC permissible service(s):

i. *Expenditures relating to a need identified in a participant's person-centered plan of services that substitute for human assistance, to the extent that expenditures would otherwise be made for human assistance.*

Assistive Technology will be provided in accordance with 42 CFR 441.525. Assistive Technology purchases in combination with skills acquisition training are limited to $500.00 during each state fiscal year. This limit may be exceeded based on medical necessity.

Assistive Technology includes items that increase the individual's independence or substitutes for human assistance. These also include specialized add-ons to the basic PERS system such as fall detectors, medication reminders, and GPS locators which would have required human assistance but for the additional technology.

This service includes the training of participants and caregivers on the maintenance or up-keep of equipment purchased under this service.

ii. *Expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities required for a participant to make the transition from a nursing facility, institution for mental diseases, or intermediate care facility for individuals with intellectual disabilities to a community-based home setting where the participant resides.*

Community Transition Services are non-recurring set-up expenses for participants who are transitioning from an institutional setting to a living arrangement in a home-and-community-based setting where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

1. Security deposits that are required to obtain a lease on an apartment or home, including first month's rent;
2. Essential household furnishings required to occupy and use a community domicile, including, but not limited to, furniture, window coverings, food preparation items, and bath/linen supplies;
3. Set-up fees or deposits for utilities and/or service access, including telephone, electricity, heating, water, and garbage;
4. Services necessary for the participant's health and safety such as pest eradication and one-time cleaning prior to occupancy;
5. Moving expenses; and
6. Activities to assess need, arrange for, and procure needed resources.

Community Transition Services may not exceed $850.00 per occurrence with no limitations on number of transitions in any given time frame. This limit may be exceeded based on medical necessity.

V. Qualifications of Providers of CFC Services

a. All personal care providers are required to complete Basic training. The number of hours for Basic training varies depending on the current credentials of the provider, the relationship of the provider to the participant, and how many hours the provider works. Unless exempt by state rule, all personal care providers must obtain certification as a Home Care Aide. The Basic training covers basic skills and information needed to provide hands-on personal care, and may also include population-specific training if the provider is trained to meet the needs of a specific population. Once training is complete, unless exempt by state rule, the provider must take and pass a written and a skills examination through the Washington State Department of Health to become certified as a Home Care Aide.

b. Residential and non-residential settings in this program comply with federal HCB Settings requirements at 42 CFR 441.530 and associated CMS guidance. The state will provide comprehensive training on HCB setting requirements for all Assisted Living Facilities and Adult Family Home provider types by August 31, 2015. This language sunsets on December 31, 2015.

i. **Personal Care, Relief Care, and Nursing Providers:**
1. *Individual Providers:* Individual providers (IPs) must contract with the Department before being paid to provide personal care services. Prior to contracting, staff must verify that the individual provider:

a. Has a valid current photo identification and Social Security card.
b. Has completed the requirements established for state background checks.
c. Is age 18 or older.

Individual Providers are required to complete Basic training and obtain certification as a Home Care Aide, as stipulated in state law. If not exempt by state law, they must also complete continuing education credits every 12 months in order to continue to provide personal care services.

2. *Home Care Agencies, Adult Family Homes and Assisted Living programs:* Must be licensed and must contract with the Department before being paid to provide personal care services under CFC. Staff employed by these entities to provide personal care are required to complete background checks. If not exempt by state law, staff must complete Basic training and complete the process to become a State-Certified Home Care Aide within a state-specified time frame after employment. They are also expected to complete continuing education credits every 12 months in order to continue to provide personal care services.

3. *Nurses:* Registered Nurses (RNs) must be licensed in accordance with the state laws that define the scope of their practice. RNs must contract with the Department or be employed by an agency that is contracted with the Department before being paid to provide nurse delegation under CFC. Contracting and agency employment require background checks and RNs must maintain their licensure in accordance with all state laws to continue to provide services and supports under CFC.

ii. Skills Acquisition Providers:

1. *Skills Acquisition Providers:* The contractor must demonstrate by relevant successful experience, training, license, or credential that they have the skills and abilities to provide training services that are:
    a. Expected to achieve outcomes identified by the participant.
    b. Competent and relevant to the participant's culture.
    c. Delivered in a manner and format that is individually tailored to the participant's abilities, strengths, and learning styles.
    d. Designed to be outcome based and measurable.
    e. Delivered in accordance with health and safety needs related to the diagnosis and conditions identified in the participant's CARE assessment.

iii. Equipment and Technology Providers:

1. *Equipment and Technology Providers:*
    a. *A qualified Personal Emergency Response Services* (PERS): Providers must:

i. All PERS equipment vendors must provide equipment approved by the Federal Communications Commission (FCC). The equipment must also meet the Underwriters Laboratories, Incl. (UL) standard, or Emergency Locator Transmitters (ELT) listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard.

ii. The emergency response communicator must not interfere with normal telephone use. The communicator must be capable of operating without external power during a power failure at the participant's home in accordance with UL or ELT requirements for home health care signaling equipment with stand-by capability.

b. *Assistive Technology Providers:* The contractor must be a legal business entity and legitimately engaged in the business of the provision of Assistive Technology. Contractors located in the State of Washington must have a Universal Business Identifier and Master Business License, as issued by the State Department of Revenue. Out-of-state contractors must possess a Universal Business Identifier and Master Business License only when it is required by Washington State law.

The provider must be currently registered as a general or specialty contractor and in good standing with the Department of Labor and Industries as required by state statute.

VI. Home and Community-Based Settings

a. CFC 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 the intellectually disabled. Settings will include the participant's home. CFC services will be provided in the following settings that have been determined to meet the HCB setting requirements established at 42 CFR 441.530:
   i. Private homes
   ii. Licensed Assisted Living Facilities (ALF) that hold an:
      1. Assisted Living contract
      2. Adult Residential Care contract
      3. Enhanced Adult Residential Care contract
   iii. Adult Family Homes (AFH)

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

c. No CFC services will be provided in settings that meet the definition of an Institution for Mental Diseases at 42 CFR 435.1010.

VII. Support System Activities

Prior to enrolling in CFC, the State provides participants an assessment, information about CFC services and supports, including HCB setting requirements, and assistance needed to make an informed choice about the program. Upon enrollment, appropriate information and assistance is provided to ensure that the individual or the individual's representative is able to understand, manage, and select their CFC services and supports. Information about provider owned settings must include, but not be limited to, the Admissions Agreement process and the requirement of the provider to incorporate the person-centered service plan into the provider's Negotiated Care Plan or Negotiated Service Agreement. Information is communicated to the participant in a manner and language understandable by the participant, including needed auxiliary aids and/or translation services.

In accordance with 42 CFR 441.555 (b) (2), information provided includes information on:

a. Person-centered planning and how it is applied;
b. Range and scope of individual choices and options;
c. Process for changing the person-centered service plan;
d. The grievance process;
e. Information on the risks and responsibilities of self-direction;
f. The ability to freely choose from available home and community-based attendant providers and available service delivery models;
g. Individual rights (including appeal rights);
h. Reassessment and review schedules;
i. Defining goals, needs, and preferences of CFC services and supports;
j. Identifying and accessing services, supports and resources; and
k. Development of risk management agreements.
l. Development of a personalized backup plan.
m. Recognizing and reporting critical events.
n. Information about an advocate or advocacy systems available in the State and how an individual can access the advocate or advocacy systems.

Additional support activities, responsibilities for assessment of functional need, and person-centered service plan development are more fully described in the Assessment and Service Plan section of this document.

VIII. Conflict of Interest Standards

The State assures that conflict of interest standards for the functional needs assessment and development of the person-centered service plan applies to all individuals and entities, both public and private. The State will ensure that the individual conducting the functional needs assessment and person-centered service plan is not:

a. Related by blood or marriage to the participant, or to any paid caregiver of the participant.
b. Financially responsible for the participant.
c. Empowered to make financial or health-related decisions on behalf of the participant.

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

IX. Assessment and Service Plan

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

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

The Comprehensive Assessment Reporting Evaluation (CARE) tool is used by case managers during a face-to-face visit with the participant to document functional ability, determine eligibility for long-term care services and supports, and develop the person-centered service plan. The CARE tool is designed to be an automated, participant-entered assessment system that is the basis for comprehensive person-centered care planning.

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

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

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

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

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

Initial assessments of all participants are completed by State Case Managers, Social Workers, or Nurses. Each participant receives the same assessment regardless of the assessor's title.

Reassessments of all Developmental Disabilities Administration (DDA) participants and Home and Community Services (HCS) participants residing in adult family homes or assisted living facilities are conducted by State Case Managers, Social Workers, and Nurses.

Reassessments for HCS participants residing in their own homes are conducted by Area Agency on Aging (AAA) Case Managers.

Participants eligible for services in an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 and over are evaluated by a Mental Health Professional for their potential for discharge. Department staff complete the level of care determination and assess participants using the CARE tool. Eligibility for CFC services and supports is determined based on functional need as outlined in 42 CFR 441.535.

Participants eligible for services in an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 and over are evaluated by a Mental Health Professional for level of care determination. Individuals who meet level of care are then assessed using the CARE tool, and eligibility for CFC services is determined based on functional need as outlined in 42 CFR 441.535.

Face-to-face assessments are conducted at least every 12 months, when the participant's circumstances or needs change significantly, and at the request of the participant. Significant changes are changes considered likely to result in an adjustment of authorized services or CARE classification level. The same assessors and assessment tool are used for conducting significant change assessments or reassessments requested by participants.

X. Person-Centered Service Plan Development Process

a. **Indicate how the service plan development process ensures that the person-centered service plan addresses the individual's goals, needs (including health care**

needs), and preferences, by offering choices regarding the services and supports they receive and from whom.

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

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

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

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

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

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

There is no lag between the person-centered planning and determination of eligibility. Initial and on-going person-centered service plans are developed in conjunction with the CARE assessment and functional eligibility determination. Access to services begins as

soon as the participant selects the services and supports they are eligible to receive and identifies their qualified provider.

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

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

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

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

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

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

reduced, suspended or terminated, which are referred to the administrative hearing process.

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

Conflict of interest safeguards. The State does not allow entities or individuals that have responsibility for service plan development to provide direct State Plan services to participants.

XI. **Quality Assurance and Improvement Plan**
Provide a description of the State's Community First Choice quality assurance system. Please include the following information:

The Health Care Authority (HCA), the State Medicaid agency, has ultimate approval authority for the design and implementation of the Community First Choice (CFC) State Plan program. HCA approves all changes to the program through the State Plan Amendment process. HCA retains the authority to discharge its responsibilities for the administration of the Medicaid program pursuant to 42 CFR 431.10(e).

For CFC, the Health Care Authority delegates the following authority to the Department:

- Submission of all necessary application, renewal, and amendment materials to CMS in order to secure and maintain approval of all proposed and existing State Plans and waivers;
- Responsibility for the operation, management, and reporting of allowable Medicaid administrative activities for approved federal State Plans and waivers; and
- Developing regulations, MMIS policy changes, and provider manuals.

The assigned operational and administrative functions are monitored as part of the Department's annual Quality Assurance (QA) review cycle. Final QA outcome reports are provided to the Medicaid agency for review and follow-up.

At the end of each QA review cycle, a final report is generated which includes detailed data on a statewide level. These results are analyzed and incorporated into a statewide proficiency improvement plan. The State Medicaid Agency receives annual QA review reports and meets with the operating agency at the conclusion of the QA cycle to review results and provide input into the proficiency improvement plan. The proficiency improvement plan is reviewed and approved for implementation by Department executive management.

a. **How the State will conduct activities of discovery, remediation, and quality improvement in order to ascertain whether the program meets assurances, corrects shortcomings, and pursues opportunities for improvement.**

The Department's quality assurance and improvement systems review and monitor the accuracy and consistency of operational and administrative functions through an ongoing process.

The CFC Quality Assurance strategy includes monitoring the following areas:

i. Level of care determination
ii. Person-centered planning
iii. Choice of services, supports, and providers
iv. Service Plan and delivery
v. Health and welfare
vi. Provider qualifications
vii. Fiscal accountability
viii. Compliance with HCB settings requirements, compliance with HCB setting requirements including but not limited to community integration. This language sunsets on December 31, 2015.

Discovery

The process of evaluation involves examination of a sample of participant cases through review of data stored in electronic databases, review of case files, and participant surveys.

Findings are recorded using program specific standardized tools. Formal findings are issued in a report identifying trends in policy and rule application and requiring correction or remediation of the finding.

Remediation

The State operates a comprehensive system to ensure that CFC meets the assurances, corrects shortcomings, and pursues opportunities for improvement. The State has established various entities, including supervisors, managers, and quality assurance teams to review how services and supports are provided and ensure corrections are made.

Quality Improvement

To maintain a consistency with proficiency requirements in 1915(c) waivers, a proficiency level of at least 86% is required. Quality improvement strategies are required for areas where this required proficiency level is not achieved. The State analyzes trends in order to prioritize, propose, or implement service system improvements. When the need for a system change has been identified, the State prioritizes quality improvement measures based on health and safety, best practices, legislative requirements, and stakeholder recommendations. Quality improvement strategies may include, but are not limited to, training, resource allocation, studies, policy or rule changes, and funding requests. The quality improvement plan is reviewed and updated on an on-going basis as various methods of evaluation, monitoring, analysis, and actions are completed.

The State also works with participants, families, advocates, and providers to identify opportunities for performance improvement and reports progress to stakeholders, State staff, and providers.

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b. **The system performance measures, outcome measures, and satisfaction measures that the State will monitor and evaluate.**

i. Level of care
   1. The participant met institutional level of care.

ii. Person-Centered Planning
   1. A service plan was completed and signed by the participant and responsible parties.
   2. Participant Rights and Responsibilities form was signed by the participant and responsible parties.
   3. Plans were reviewed and updated at least every 12 months.

iii. Independence and Choice
   1. Participants were provided with a choice of settings, including institutional and all potential community-based settings.
   2. Participants were provided with a choice of CFC services and supports they could choose to access.

iv. Service Plan and Delivery
   1. Assessed needs have been addressed in the service plan.

v. Health and Welfare
   1. Critical incident types were reported according to incident reporting policy.
   2. Critical incidents were reported in the time frame specified in reporting policy.

vi. Provider Qualifications
   1. Providers met contract requirements at initial contracting and at contract renewal.

vii. Personal Care Providers
   1. Personal Care Providers completed all required training.
   2. Personal Care Providers completed required continuing education.

viii. Fiscal Accountability
   1. Services billed did not exceed services and supports authorized in the service plan.
   2. Services and supports were authorized at the correct rate.

ix. Compliance with HCB setting requirements
   1. Participants were provided with information regarding the Federal and State regulations for CFC HCB setting, and were informed of all rights assured to participants with regard to HCB setting requirements.
   2. Participants were informed on methods to register complaints, concerns or questions regarding provider implementation of these requirements, as well as provided with the results of any complaint assessments.
   3. The state will perform an analysis of investigation and resolution of complaints and licensing investigations regarding HCB nature of settings and community integration activities to assess for systemic issues.
   4. The state will evaluate if providers are adhering to all state and federal HCB setting requirements and the CFC person-centered planning process when Negotiated Care Plans or Negotiated Service Agreements and Admissions Agreements are developed.

This language sunsets on December 31, 2015

5. State licensure and survey process will include state and federal requirements for settings and where appropriate, CFC requirements such as the CFC person-centered planning process in relationship to Negotiated Care Plans or Negotiated Service Agreements and Admissions Agreements.

This language sunsets on December 31, 2015.

c. **Describe how the State's quality assurance system will measure participant outcomes associated with the receipt of community-based attendant services and supports.**
In addition to the other components of the State's quality assurance system previously described in the application, the State will survey participants both by telephone and by mail to achieve a statistically significant sample of participant responses in order to determine satisfaction and outcomes associated with the receipt of CFC services and supports.

The participant experience survey is designed to measure satisfaction with services and supports as well as the achievement of desired service outcomes. Questions focus on health and welfare, service delivery, service outcomes, and person-centered planning. and HCB settings nature of services. A positive response rate of at least 86% is expected.

d. **Describe the system(s) for mandatory reporting, investigation and resolution of allegations of neglect, abuse, and exploitation in connection with the provision of CFC services and supports.**

All participants receiving CFC services and supports have access to all of the protections in the State's abuse, neglect, and exploitation system including mandated reporting and investigation and resolution of allegations of neglect, abuse, and exploitation.

Participants receive information from their Case Manager and on a rights and responsibilities document at the time of their assessment, which informs them of their right to be free of abuse and who to call should abuse, neglect, or exploitation occur. The State has established a toll-free statewide number that may be used to report abuse or neglect of any adult or child residing in the State.

Reports of abuse, neglect, abandonment, financial exploitation, and self-neglect of a vulnerable adult are received by one of two entities - Adult Protective Services (APS) or the Complaint Resolution Unit (CRU). Each entity receives reports by phone, fax, letter, email or in-person.

1. The primary function of Adult Protective Services (APS) is to receive and investigate allegations of abuse, neglect, abandonment, financial exploitation, and self-neglect of vulnerable adults in any setting. Reports to law enforcement are made as required under state statute.

2. The primary function of the Complaint Resolution Unit (CRU) is to receive and process allegations of facility non-compliance with federal and state regulations. As part of their process, CRU determines whether to assign received complaints to Residential Care Services (RCS) Provider Practice, or Adult Protective Services (APS), or to both. In some circumstances and if applicable, CRU may also send referrals to other State agencies, such as the Department of Health or the Medicaid Fraud Unit.

Reports of abuse or neglect of a child, which includes sexual abuse, sexual exploitation, or injury of a child by any person under circumstances which cause harm to the child's health, welfare, or safety, or the negligent treatment or maltreatment of a child by a person responsible for providing care to the child, are received by Child Protective Services (CPS). Upon receiving a report of an incident of alleged abuse or neglect involving a child who has died or has had physical injury inflicted upon him or her other than by accidental means, or who has been subjected to alleged sexual abuse, CPS reports this to law enforcement. CPS takes each report and screens, assesses, and evaluates it for CPS authority, and then assigns it to the proper Children's Administration program

i. *Mandatory Reporting:* Washington law defines mandatory reporters (examples of mandatory reporters include, but are not limited to: All Department of Social and Health Services (DSHS) employees, teachers, medical professionals, and others who work with children and/or vulnerable adults), types of abuse, and timelines for investigation. The Department follows these statutes and the corresponding administrative rules. All staff must report abuse as required by statute for children and vulnerable adults as described in statute. All adult CFC participants are considered vulnerable adults under state statute.

Mandatory reporting requirements for vulnerable adults are as follows:

1. When there is a reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report this to the Department.

   When there is reasonable cause to suspect that sexual assault has occurred, mandated reporters shall immediately report this to law enforcement and to the Department.

   When there is reasonable cause to suspect that physical assault has occurred or there is reasonable cause to believe that an act has caused imminent harm, mandated reporters shall immediately report this to the Department and to law enforcement, except a mandated reporter is not required to report to law enforcement, unless requested by the injured vulnerable adult or his or her legal representative or family member, an incident of physical assault between vulnerable adults that causes minor bodily injury and does not require more than basic first aid, unless:
   a. the injury appears on the back, face, neck, head, chest, breasts, groin, inner thigh, buttock, genital, or anal area;

b. there is a fracture;
c. there is a pattern of physical assault between the same vulnerable adults; or
d. there is an attempt to choke a vulnerable adult.

When there is reason to suspect that the death of a vulnerable adult was caused by abuse, neglect, or abandonment by another person, mandated reporters must, pursuant to RCW 68.50.020, report the death to the medical examiner or coroner having jurisdiction, as well as the Department and local law enforcement, in the most expeditious manner possible. A mandated reporter is not relieved from the reporting requirement provisions of this subsection by the existence of a previously signed death certificate. If abuse, neglect, or abandonment caused or contributed to the death of a vulnerable adult, the death is a death caused by unnatural or unlawful means, and the body shall be the jurisdiction of the coroner or medical examiner pursuant to RCW 68.50.010.

Mandatory reporting requirements for children are as follows:

1. When a mandated reporter has reasonable cause to believe that a child has suffered abuse or neglect, he or she shall report such incident, or cause a report to be made, to the proper law enforcement agency or to the Department. The report must be made at the first opportunity, but in no case longer than forty-eight hours after there is reasonable cause to believe the child has suffered abuse or neglect.

ii. *Permissive reporting:* Anyone may report to the Department or a law enforcement agency when there is reasonable cause to believe that a vulnerable adult is being or has been abandoned, abused, financially exploited, or neglected.

iii. *Investigation:*
1. Adult Protective Service (APS) workers conduct investigations related to reported allegations of abandonment, neglect, abuse, and exploitation that meet the requirements defined in statute. Based on the facts and circumstances known at intake, reports are prioritized and assigned for investigation based on the severity and immediacy of actual or potential physical, mental, or financial harm to the alleged victim as follows:
   a. High priority when serious or life-threatening harm is occurring or appears to be imminent. APS will conduct an unannounced private interview with the alleged victim within 24 hours of receipt of the report.
   b. Medium priority when harm that is more than minor, but does not appear to be life-threatening at this time, has occurred, is on-going, or may occur. APS will conduct an unannounced private interview with the alleged victim within 5 working days of receipt of the report.

c. Low priority when harm that poses a minor risk at this time to health or safety has occurred, is ongoing, or may occur. APS will conduct an unannounced private interview with the alleged victim with 10 working days of receipt of the report.

On a case-by-case basis, the supervisor or designee may specify a specific response time shorter than the maximum response time designated for the priority level.

2. Upon receipt of a report of alleged abuse or neglect of a child, Child Protective Services (CPS) screens a case and does an investigation or a family assessment. CPS assigns cases to investigation or family assessment based on an array of factors that include: imminent danger; level of risk; number of previous child abuse or neglect reports; and other characteristics such as the type of alleged maltreatment and the age of the alleged victim. If a family does not allow a family assessment, CPS does a full investigation. CPS also does a full investigation in response to an allegation that CPS determines, based on the intake assessment:
   a. Poses a risk of "imminent harm"
   b. Poses a serious threat of substantial harm to a child
   c. Constitutes conduct involving a criminal offense that has, or is about to occur, in which the child is the victim
   d. The child is an abandoned child
   e. The child is an adjudicated dependent child, or is in a facility that is licensed, operated, or certified for the care of children by the Department or by the Department of Early Learning

   CPS provides services and refers family to services to keep the child safe. A law enforcement officer may take, or cause to be taken, a child into custody if there is probable cause to believe that the child is abused or neglected and that child would be injured.

iv. *Resolution of allegations:*

1. **APS:** During an investigation and once an investigation is completed, protective services may be offered to the participant. If the allegations are substantiated, a findings letter is sent to the alleged perpetrator within 10 days of the determination that the allegations are substantiated. Once received, the alleged perpetrator has thirty calendar days to respond to the findings and request an administrative hearing to appeal the decision.

2. **CPS:** At the completion of an investigation of child abuse or neglect, CPS makes a finding that the report of abuse or neglect is founded or unfounded. If a report is founded, the alleged perpetrator is notified.

   Within thirty calendar days after receiving the notice, the alleged perpetrator may request the Department review the findings, and has a right to challenge the founded allegation. If a request for a review is not

made in thirty days, the alleged perpetrator may not further challenge the finding and have no right to an agency review or to an adjudicative hearing or judicial review of the finding.

The Department maintains web-based tracking systems of reports and responses to reports of allegations of abuse, neglect, or exploitation among children and vulnerable adults. These systems are called Tracking Incidents among Vulnerable Adults (TIVA) in Adult Protective Services, and FamLink in the Child Welfare system.

e. **Describe the State's standards for all service delivery models for training, appeals for denials, and reconsideration procedures for a participant's person-centered service plan.**

i. *Training:* (1) Case Managers receive initial and ongoing training related to person-centered planning and conducting a functional needs assessment using the Department's CARE tool. Training includes working with participants, eligibility, care planning, ensuring free choice of providers and service settings, service options and delivery systems, the process for modification of any HCB settings conditions in provider owned or controlled settings within a person's individual plan,and protective services. (2) Long-Term Ombudsman Program staff will receive training on the CFC HCB setting requirements defined in 42 CFR 441.530.

ii. *Denials and Reconsiderations:* Participant service recipients and applicants, and their representatives, are provided timely written notice of any planned change in services or benefits, including denial, or reduction. For reduction of services, the time frame is a minimum of 10 working days prior to the effective date of the proposed action. The notice includes the reason for the Department's decision, administrative rules that support the decision and the participant's or their representative's right to due process through an administrative hearing process.

iii. *Appeals:* The Case Manager notifies the participant about the administrative hearing process during the initial and subsequent assessment/service planning. Notice is sent to the participant informing them of the service decision and their appeal rights. The notice includes a statement that the benefits automatically continue if the appeal is filed in a timely manner, unless specified otherwise by the participant, pending the outcome of the initial administrative hearing.

iv. The Department promotes policies, procedures, and practices that foster equal access to services for applicants and participants. Under Department rules, applicants and participants are eligible for Necessary Supplemental Accommodation services designed to afford them equal access to Department services. Participants who have a mental, neurological, physical or sensory impairment are entitled to have a representative who is willing to receive copies of Department correspondence in order to help participants understand Department actions and exercise their rights.

f. **Describe the quality assurance system's methods that maximize consumer independence and control and provide information about the provisions of quality improvement and assurance to each participant receiving such services and supports.**

Case Managers fully inform participants of all available choices and service options included in the CFC program. Documentation requirements and automated systems support quality assurance efforts. The quality assurance processes defined above include ensuring that participants were fully informed of their options and their ability to direct their own service plan. Quality assurance teams review a statistically significant sample of participants receiving services statewide to ensure eligible participant choice was offered.

As part of the inspection and complaint investigation processes for residential settings, the Residential Care Services Division conducts comprehensive resident interviews, reviews resident records, interviews providers/resident managers, and interviews staff to determine compliance with HCBS regulations. The review includes, but is not limited to, and examination of participant independence and control, the setting's admission agreement, the incorporation of the resident's person-centered plan into the Negotiated Care Plan or Negotiated Service Agreement, and adherence to HCB settings and community integration requirements.

Case Managers (CMs) complete face-to-face assessments every 12 months and when there is a significant change in the participant's condition. CMs ensure that participant rights are protected and make referrals to Adult Protective Services (APS) as required.

The quality assurance units conduct annual reviews of a statistically significant sample of participant files to determine if participants were offered choice between plan services and providers, agreed to their care plan, that it addressed their assessed needs and personal goals, and had an active role in the development of their service plan.

The quality assurance units conduct consumer satisfaction activities, and reviews files to determine accuracy of program eligibility, file documents, adherence to policy, procedures, and state and federal statutes including waiver requirements. The QA units are responsible for monitoring three state regional areas and 13 Area Agencies on Aging (AAA) each review cycle, verifying that corrections have been made to all items within 30 days of the issuance of the final report, and that health and safety concerns are corrected immediately. The QA units review and approve local improvement plans to ensure all required issues have been addressed. They also perform other quality improvement activities each review cycle (i.e., participant surveys, conducting or reviewing participant services verification surveys, etc.), in addition to participant record reviews.

Upon completion of the 12-month review cycle, statewide systemic data is analyzed for trends and patterns by managers and executive staff. Methods of improvement and training are also incorporated into quality improvement activities. Decisions for action are made based on analysis and prioritization and an improvement plan is developed. These

activities may include statewide training initiatives, policy and/or procedural changes, and identification of quality improvement activities or projects.

g. **Describe how the State will elicit feedback from key stakeholders to improve the quality of the community-based attendant services and supports benefit.**

An annual QA audit report is prepared at the close of each audit cycle to discuss the findings of all QA audit activities and the status of system improvements. This report is reviewed in detail with the Medicaid Agency Oversight Committee (discussed below), the Management Teams at the Department, AAA Directors, and all of the Regional Administrators, and is available through Department intranet sites for staff review and discussion.

The annual QA audit report and Headquarters proficiency improvement plans developed as a result of this process are reviewed, discussed with, the State Medicaid Agency through the Medicaid Agency Oversight Committee. This committee meets, at a minimum, on a quarterly basis and discusses administration and oversight issues. All performance measure activities and findings are discussed and addressed in detail with the oversight committee. The State Medicaid agency provides feedback and recommendations regarding plan activities. Improvement plans are available to stakeholders for review and recommendations.

The State will elicit feedback from the State's CFC Development and Implementation Council which includes individuals with disabilities, representatives and family of individuals with disabilities, elderly individuals, organizations for the elderly and/or individuals with disabilities, and members of the community to improve the quality of CFC services and supports.

h. **The methods used to continuously monitor the health and welfare of Community First Choice participants.**

Individual concerns about health and welfare are addressed at the time an issue is discovered or reported.

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

Assessments include identifying the participant's ability to self-direct and supervise their service providers. Participants are expected to choose a representative should they need

one. When there are no available representatives, the participant is encouraged to use an agency care provider or hire a second individual provider in order to increase opportunities for oversight. When there is no representative the method of oversight is identified in the participant's assessment.

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

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

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

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

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

XII. Assurances

a. The State assures that any individual requesting the CFC program and meeting the eligibility criteria for CFC will be offered CFC services.
b. The State assures there are necessary safeguards in place to protect the health and welfare of individuals provided services under this State Plan option, and to assure financial accountability for funds expended for CFC services. In accordance with section 1903(i), payment will not be made to individuals or entities excluded from participation in the Medicaid program per 42 CFR 441.570(a).
c. The State assures the provision of CFC home-and-community-based attendant services and supports to individuals on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and

without regard to the individual's age, type or nature of disability, severity of disability, or the form of home-and-community-based attendant services and supports that the individual requires in order to lead an independent life.

d. In accordance with 42 CFR 441.570(b), with respect to expenditures during the first full 12-month period in which the State Plan Amendment is implemented, the State will maintain or exceed the level of State expenditures for home-and-community-based attendant services and supports provided under section 1905(a), section 1915, section 1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding fiscal year.
e. The State assures the establishment and maintenance of a comprehensive, continuous quality assurance system with respect to community-based attendant services and supports.
f. The State assures the collection and reporting of information, including data regarding how the State provides home-and-community-based attendant services and supports and other home and community-based services, the cost of such services and supports, and how the State provides individuals with disabilities who otherwise qualify for institutional care under the State Plan or under a waiver, the choice to instead receive home and community-based services in lieu of institutional care.
g. The State will provide the Secretary with the following information regarding the provision of home-and-community-based attendant services and supports under this subsection for each fiscal year for which such services and supports are provided:
    i. The number of individuals who are estimated to receive home-and community-based attendant services and supports under this option during the fiscal year.
    ii. The number of individuals that received such services and supports during the preceding fiscal year.
    iii. The specific number of individuals served by type of disability, age, gender, education level, and employment status.
    iv. Whether the specific individuals have been previously served under any other home-and-community-based services program under the State Plan or waiver.
    v. Data regarding the impact of CFC services and supports on the physical and emotional health of the individuals being serviced.
    vi. The collection and reporting of information, including data regarding how the State provides home-and-community-based attendant services and supports and other home-and-community-based services, the cost of such services and supports, and how the State provides individuals with disabilities who otherwise qualify for institutional care under the State Plan or under a waiver the choice to instead receive home-and-community-based services in lieu of institutional level of care.

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State WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN

XXI. First Choice State Plan Option

State-developed fee schedule rates are the same for both governmental and private providers of the same service. The fee schedule is published at https://www.dshs.wa.gov/sites/default/files/ALTSA/msd/documents/All_HCS_Rates.xls. Rates for Personal Care and Nurse Delegation provided under 1915(k) are the same as the payment rates for Personal Care and Nurse Delegation services listed in Attachment 4.19-B, XV Personal Care Services. Rates for Nurse Delegators provided under 1915(k) are the same as the payment rates for Nurse Delegators under Attachment 4.19-B, XV Personal Care Services. Payment rates for 1915(k) services will be updated whenever the fee schedule is updated on the corresponding State Plan page under the existing Personal Care Services benefit.

A. PERSONAL CARE

Personal care service providers:
Services are provided by these provider types:

1. Individual providers of personal care
2. State-licensed home-care agencies
3. Residential service providers which include:
   a. Assisted living providers
   b. Adult family homes

Personal care service provider rates:

1. Individual providers of personal care
   Individual Providers are reimbursed on an hourly rate. The standard hourly rate for individual-provided personal care is determined by the State legislature, based on negotiations between the Governor's Office and the union representing the workers. The rate for personal care services provided by individual providers consists of wages, industrial insurance, vacation pay, mileage reimbursement, comprehensive medical, training, seniority pay and training based differentials. The agreed-upon negotiated rates schedule is used for all bargaining members.

2. State-licensed home-care agencies
   Home care agencies are reimbursed on an hourly rate. The rate for personal care services provided by home care agencies is based on an hourly unit. The agency rate determination corresponds to the rate for individual providers with an additional amount for employer functions performed by the agency.

3. Residential service providers
   The cost for personal care provided in adult family homes and assisted living facilities is reimbursed at a daily rate. Each participant is assigned to a classification group based on the State's assessment of their personal care needs. The daily rate varies depending on the individual's classification group. Rates are based on wages, benefits, and administrative expenses.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of Washington
Community First Choice State Plan Option

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN

XXI. First Choice State Plan Option (cont)

The rate for personal care provided in an adult family home is determined by the State legislature, based on negotiations between the Governor's Office and the union representing Adult Family Homes. The agreed upon negotiated rates schedule is used for all bargaining members.

The rate paid to residential providers does not include room and board.

No payment is made for services beyond the scope of the program or hours of service exceeding the Medicaid Agency's authorization. The State uses the following classification levels as the basis for daily rates paid to adult family homes and assisted living providers and to allocate the number of personal care hours for which a home care agency or individual provider may be reimbursed.

E-Group
Individuals meet criteria for exceptional care due to very high ADLs need, turning & repositioning; Bowel Program, Catheter Care or Total assist in Toileting; and assistance with Range of Motion exercises. There are two subgroups within E; E-Med and E-High.

D-Group
Individual meets criteria for Clinical Complexity and have significant or severe cognitive impairment. There are four sub-groups within D; D, D-Med, D-Med-High and, D-High.

C-Group
Individuals meet criteria for Clinical Complexity, having a qualifying condition, diagnosis, or indicator coupled with a minimum ADL. There are four sub-groups within C; C-Low, C-Med, C-Med-High and, C-High.

B-Group
Individuals meet criteria for moods and behaviors that have an impact on the time it takes to assist with personal care needs. There are four sub-groups within B; B-Low, B-Med, B-Med-High, and B-High.

A-Group
Individuals meet criteria for unmet need for personal care. That need is not significantly impacted by cognitive impairment, behaviors or clinically complex conditions. There are three sub-groups within A; A-Low, A-Med, and A-High.

Registered Nurse Delegators
Registered Nurse Delegators are paid in 15 minute units based on a standard hourly rate. The hourly rate is determined by legislative appropriation and is published on the fee schedule referenced above.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN

XXI. First Choice State Plan Option (cont)

B. SKILLS ACQUISITION TRAINING

Skills acquisition training service providers:

1. Individual providers of personal care
   Individual Providers are reimbursed on an hourly rate. The standard hourly rate for individual-provided personal care is determined by the State legislature, based on negotiations between the Governor's Office and the union representing the workers. The rate for personal care services provided by individual providers consists of wages, industrial insurance, vacation pay, mileage reimbursement, comprehensive medical, training, seniority pay, and training-based differentials.

   The agreed upon negotiated rates schedule is used for all bargaining members.

2. State-licensed home-care agencies
   Home care agencies are reimbursed on an hourly rate. The rate for personal care services provided by home care agencies is based on an hourly unit. The agency rate determination corresponds to the rate for individual providers with an additional amount for employer functions performed by the agency.

3. State–certified supported living agencies who are recruited and at the local level by Area Agencies on Aging, and Department field offices. Agencies are paid an hourly rate that must be within the range published by the Department where applicable, and shall not be higher than 1) the prevailing charges in the locality for comparable services under comparable circumstances, or 2) the rates charged by the contractor for comparable services funded under other sources.

4. Home Health Agencies
   Home Health Agencies are reimbursed per-visit for services provided by acute nursing staff, physical therapy, occupational therapy, speech, hearing and language disorders therapy staff, and home health aides.

   Reimbursement rates are determined using a historical base for the per-visit rates by profession, using the Medicare Metropolitan Statistical Area fees. Each year the State updates those per-visit rates using the state's annually published vendor rate adjustment factor.

   The Medicaid agency pays the lesser of the usual and customary charge or a fee based on a Medicaid agency fee schedule for these services.

   Rates for Home Health Agencies paid to provide skill acquisition services will be the same as those paid under attachment 4.19 B page 19 of the plan. Except as otherwise noted in the plan, payment for these services is based on state-developed fee schedule rates, which are the same for both governmental and private providers of Home Health.

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POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN

XXI. First Choice State Plan Option (cont)

All rates, including current and prior rates, are published and maintained on the agency's website. The fee schedule can be found at http://www.hca.wa.gov/medicaid/rbrvs/Pages/index.aspx. Payment rates for 1915(k) services will be updated whenever the fee schedule is updated on the corresponding State Plan page under the Home Health benefit.

The State will reimburse up to $500 per fiscal year in costs for Skills Acquisition training alone or in combination with Assistive Technology.

3. BACK-UP SYSTEMS

Backup System service providers include:

1. Individual providers of personal care are reimbursed on an hourly rate. The standard hourly rate for individual-provided personal care is determined by the State legislature, based on negotiations between the Governor's Office and the union representing the workers. The rate for personal care services provided by individual providers consists of wages, industrial insurance, vacation pay, mileage reimbursement, comprehensive medical, training, seniority pay and training based differentials. The agreed upon negotiated rates schedule is used for all bargaining members.

2. State-licensed home-care agencies are reimbursed on an hourly rate. The rate for personal care services provided by home care agencies is based on an hourly unit. The agency rate determination corresponds to the rate for individual providers with an additional amount for employer functions performed by the agency.

3. Personal Emergency Response vendors are paid a one- time rate for initial equipment and set up and are then paid a monthly service charge. Rates must be within the ranges published by the Department where applicable, and shall not be higher than 1) the prevailing charges in the locality for comparable services under comparable circumstances, or 2) the rates charged by the contractor for comparable services funded under other sources.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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XXI. First Choice State Plan Option (cont)

4. ASSISTIVE TECHNOLOGY

Assistive technology vendors are Qualified providers are paid for assistive technology (AT) equipment, and repairs of equipment purchased through this service and provided to eligible clients. The Department pays a rate negotiated with the vendors. Payment cannot exceed 1) the prevailing charges in the locality for comparable equipment under comparable circumstances, or 2) the rates charged by the contractor for comparable equipment funded by other sources.

The Department does not pay AT providers separately for services in this category that are included as part of the payment for another treatment program. For example, all items required during in inpatient stay are paid through the inpatient payment.

The Department's reimbursement for covered AT includes any adjustments or modifications to the equipment that are required within three months of the date of delivery (not to include adjustments related to a change in the client's medical condition), fitting and set-up, and instruction to the client or client's caregiver in the appropriate use of the equipment and/or supplies.

5. COMMUNITY TRANSITION SERVICES

Community transition services may include the costs for goods or services. The Department pays a rate negotiated with the vendors. Payment cannot exceed 1) the prevailing charges in the locality for comparable goods or services under comparable circumstances, or 2) the rates charged by the contractor for comparable goods or services funded by other sources. The Department will reimburse up to $850 per transition when a participant moves from a qualified setting to an eligible community based setting.