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State/Territory Name: Washington

1915(k) State Plan Amendment (SPA): WA-22-0017

This file contains the following documents in the order listed:

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

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

Medicaid and CHIP Operations Group

August 26, 2022

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

RE: Washington State Plan Amendment (SPA) Transmittal Number WA-22-0017

Dear Ms. Birch and Dr. Fotinos:

The Centers for Medicare & Medicaid Services (CMS) is approving your request to amend Washington's 1915(k) Community First Choice, Home and Community Based Services (HCBS) State Plan Program. The CMS Control Number for the State Plan Amendment (SPA) is Transmittal Number WA-22-0017.

With this amendment, the state is amending the Community First Choice (CFC) program to allow tribal case managers to provide assessment of participants for level of care, person-centered service planning, and both initial and ongoing assessment of needs for Medicaid LTSS. This SPA is approved effective July 1, 2022, as requested by the state. Enclosed is a copy of the CMS-179 summary form, as well as the approved pages for incorporation into the Washington State Plan.

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

Sincerely,
George P. Failla Jr -S
Digitally signed by George P. Failla Jr -S
Date: 2022.08.26 11:02:57 -04'00'
George P. Failla, Jr., Director
Division of HCBS Operations and Oversight

cc: Bea Rector, DSHS
Alec Graham, ALTSA
Jamie Tong, ALTSA
Barbara Hannemann, ALTSA
Grace Brower, ALTSA
Ann Myers, HCA
Annese Abdullah-McLaughlin, CMCS

DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22 — 0017

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
July 1, 2022

5. FEDERAL STATUTE/REGULATION CITATION
Section 1915(k) of the Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 16,750
b. FFY 2023 $ 67,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-K pages 11, 12

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

9. SUBJECT OF AMENDMENT
Tribal Provision of Assessments of Need and Case Management for Long-Term Services and Supports (LTSS)

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
Taylor C Linke

12. TYPED NAME
Charissa Fotinos MD, MSc (Taylor Linke for Dr. Fotinos)

13. TITLE
Medicaid Director

14. DATE SUBMITTED
June 6, 2022

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

FOR CMS USE ONLY

16. DATE RECEIVED
June 6, 2022

17. DATE APPROVED
8/26/2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2022

19. SIGNATURE OF APPROVING OFFICIAL
George P. Failla Jr -S
Digitally signed by George P. Failla Jr -S
Date: 2022.08.26 10:54:00 -04'00'

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

21. TITLE OF APPROVING OFFICIAL
Division Director, DHCBSO

22. REMARKS

Instructions on Back

INSTRUCTIONS FOR COMPLETING FORM CMS-179

Use Form CMS-179 to transmit State plan material to the Center for Medicaid & CHIP Services for approval. Submit a separate typed transmittal form with each plan/amendment.

Block 1 - Transmittal Number - Enter the State Plan Amendment transmittal number. Assign consecutive numbers on a **calendar year** basis with the first two digits being the two-digit year (e.g., 21-0001, 21-0002, etc.). Because states have different state fiscal years, a calendar year is required for consistency.

Block 2 - State - Enter the two-letter abbreviation code of the State/District/Territory submitting the plan material.

Block 3 - Program Identification - Enter the applicable Title of the Social Security Act (Title XIX Medicaid or Title XXI CHIP).

Block 4 - Proposed Effective Date - Enter the proposed effective date of material. The effective date of a new plan may not be earlier than the first day of the calendar quarter in which an approvable plan is submitted. With respect to expenditures for assistance under such plan, the effective date may not be earlier than the first day on which the plan is in operation on a statewide basis or earlier than the day following publication of notice of changes.

Block 5 - Federal Statute/Regulation Citation - Enter the appropriate statutory/regulatory citation.

Block 6 - Federal Budget Impact - 6(a) - IN WHOLE DOLLARS, NOT IN THOUSANDS, Enter 1st **Federal Fiscal Year** (FFY) impacted by the SPA & estimated Federal share of the cost of the SPA for 1st FFY. The first FFY should be the FFY inclusive of the earliest effective date of any amended payment language; **6 (b)** - Enter 2nd FFY impacted by the SPA & estimated Federal share of the cost for 2nd FFY. In general, the estimates should include any amount not currently approved in the state's plan for assistance.

Block 7 - Page No.(s) of Plan Section or Attachment - Enter the page number(s) of plan material amended and transmitted. If additional space is needed, use bond paper. **New pages** should be included in Block 7, but not in Block 8.

Block 8 - Page No.(s) of the Superseded Plan Section or Attachment (if Applicable) - Enter the page number(s) (including the transmittal number) that is being superseded. If additional space is needed, use bond paper. **Deleted pages** should be included in Block 8, but not in Block 7.

Block 9 - Subject of Amendment - Briefly describe plan material being transmitted.

Block 10 - Governor's Review - Check the appropriate box. See SMM section 13026 A.

Block 11 - Signature of State Agency Official - Authorized State official signs this block.

Block 12 - Typed Name - Type name of State official who signed block 11.

Block 13 - Title - Type title of State official who signed block 11.

Block 14 - Date Submitted - Enter the date that the state transmits plan material to CMCS. Unless the state officially withdraws this SPA and then resubmits it, this date should not be revised. Documentation of version revisions will be maintained in the CMCS administrative record.

Block 15 - Return To - Type the name and address of State official to whom this form should be returned.

Block 16–22 (FOR CMS USE ONLY).

Block 16 - Date Received - Enter the date plan material is received by CMCS. This is the date that the submission is received by CMCS via the subscribed submission process.

Block 17 - Date Approved - Enter the date CMCS approved the plan material.

Block 18 - Effective Date of Approved Material - Enter the date the plan material becomes effective. If more than one effective date, list each provision and its effective date in Block 22 or attach a sheet.

Block 19 - Signature of Approving Official - Approving official signs this block.

Block 20 - Typed Name of Approving Official - Type approving official's name.

Block 21 - Title of Approving Official - Type approving official's title.

Block 22 - Remarks - Use this block to reference and explain agreed to changes and strike-throughs to the original CMS-179 as submitted, a partial approval, more than one effective date, etc. If additional space is needed, use bond paper.

a. Empowered to make financial or health-related decisions on behalf of the participant.
b. Someone who would benefit financially from the provision of assessed needs and services.
c. 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.

VI. Assessment and Service Plan

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

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

The Comprehensive Assessment Reporting Evaluation (CARE) tool is used by case managers 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-centered assessment system that is the basis for comprehensive person-centered care planning.

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

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

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

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

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

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

Qualifications of individuals responsible for completing assessments:

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

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

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.**