Table of Contents

State/Territory Name: Washington

1915(k) State Plan Amendment (SPA) #: WA-24-0011

This file contains the following documents in the order listed:

1) Approval Letter
2) Form CMS-179
3) Approved SPA Pages

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 14, 2026

Ryan Moran, Director
Trinity Wilson, Medicaid Director
Health Care Authority
PO Box 45502
Olympia, WA 98504-5010

Re: WA-24-0011 §1915(k) Community First Choice State Plan Amendment (SPA)

Dear Director Moran and Director Wilson,

The Centers for Medicare and Medicaid Services (CMS) is approving your request to amend the Community First Choice (CFC) state plan benefit submitted under transmittal number WA-24-0011. This amendment updates State Plan language to include tribal care facilities as a home and community-based setting for Community First Choice services. CMS conducted the review of the state's submittal according to statutory requirements in Title XIX of the Social Security Act and relevant federal regulations.

The SPA is approved with a retroactive effective date of July 1, 2024, as requested by the state. Enclosed are the following pages to be incorporated into your approved state plan:

- Attachment 3.1-K: Pages 2, 3, 6, 7, 7a (new), 9, 18, 22, 22a (new), 23
- Attachment 4.19-B: Pages 46, 47, 47a (new)

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

If you have any questions concerning this information, please contact me at (410) 786-7561. You may contact Nick Sukachevin at Nickom.Sukachevin@cms.hhs.gov or (206) 615-2416.

Sincerely,

[redacted]

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

Enclosure

cc: Bea Rector, HCLA
Jamie Tong, HCS
Rebecca Howard, HCS
Annie Moua, HCS
Ann Myers, HCA

DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24-0011

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, 2024

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

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 12,000
b. FFY 2025 $ 517,391

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-K pages 2, 3, 6, 7, 7a (new), 9, 18, 22, 22a (new), 23
Attachment 4.19-B pages 46, 47, 47a (new)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-K pages 2 (TN# 21-0011), 3 (TN# 22-0001), 6 (TN# 22-0001), 7 (TN# 20-0011), 9 (TN# 16-0031), 18 (TN# 16-0031), 22 (TN# 16-0031), 23 (TN# 16-0031).
Attachment 4.19-B pages 46 (TN# 21-0011), 47 (TN# 15-0002)

9. SUBJECT OF AMENDMENT
Add Tribal Care Facilities as Community First Choice Providers

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
[redacted]

12. TYPED NAME
Charissa Fotinos, MD, MSc

13. TITLE
Medicaid and Behavioral Health Medical Director

14. DATE SUBMITTED
July 22, 2024

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

FOR CMS USE ONLY

16. DATE RECEIVED
July 22, 2024

17. DATE APPROVED
August 14, 2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2024

19. SIGNATURE OF APPROVIN
[redacted]

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

21. TITLE OF APPROVING OFFICIAL
Director, Divisions of HCBS Operations and Oversight

22. REMARKS
On 4/1/2025, in Box 7, WA authorized pen and ink changes to add "page 22a (new)" as an additional Attachment 3.1-K SPA page.
On 4/16/2025, in Box 7, WA authorized pen and ink changes to correct the Attachment 4.19-B SPA pages from "page 47, 48" to "page 46, 47."
On 4/16/2025, in Box 8, WA authorized pen and ink changes to make the following corrections to the page numbers of the superseded plan section:
Attachment 3.1-K SPA page "3 (TN# 17-0022)" to "3 (TN# 22-0001)"
Attachment 4.19-B SPA pages "47 (TN# 21-0011), 48 (TN# 15-0002)" to "46 (TN# 21-0011), 47 (TN# 15-0002)"
On 4/21/2025, in Box 7, WA authorized pen and ink changes to add "page 47a (new)" as an additional Attachment 4.19-B SPA page.
On 4/22/2025, in Box 8, WA authorized pen and ink changes to correct the TN# that Attachment 3.1-K SPA page 6 is superseding from TN# 22-0011 to TN# 22-0001.

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.

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

I. 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:

II. Use of Direct Cash Payments

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

III. 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, tribal care facility, or in-home care provided through a home care agency provider or by an individual provider, employed by the Consumer Directed Employer (CDE). Participants receiving personal care from an Individual Provider employed by the CDE 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. Individual providers may not work more than the provider's assigned work week limit. The limitation does not affect the participant's total hours of service and may necessitate the use of more than one provider.

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 or tribal care facility 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.

Washington complies with the Electronic Visit Verification System (EVV) requirements for personal care services.

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.

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 $2,500.00 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, non-residential, and tribal care facility settings in this program comply with federal HCB settings requirements at 42 CFR 441.530 and associated CMS guidance. The State will provide comprehensive initial and ongoing training for all ALF, AFH, and Tribal Care Facility providers on HCB setting rules and regulations. Tribal care facilities will complete initial and ongoing HCB setting rules and regulations trainings. Additional HCB setting training will be provided periodically to individual ALF, AFH, and tribal care facility providers when needed.

i. **Personal Care, Relief Care, and Nursing Providers:**

1. *Individual Providers:* Individual providers (IP) must contract with the Department before being paid to provide personal care services. Prior to contracting, the Department must verify that the individual provider:
    a. Has a valid current photo identification and Social Security card.
    b. Has completed the state background check.
    c. Is age 18 or older.

   Individual Providers must complete Basic training and obtain certification as a Home Care Aide, as stipulated in state law. If not exempt under state law, they must also complete a federal background check within 120 days of being hired, and complete continuing education credits as stipulated in state law 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. These entities must ensure that staff employed to provide personal care:
    a. Have completed background checks as required by state law: and,
    b. If not exempt under state law, Basic training and the process to become a State-Certified Home Care Aide within a state-specified time frame after employment and,
    c. Continuing education credits as stipulated in state law in order to continue to provide personal care services.

3. *Tribal Care Facilities:* Must meet all HCB setting rules and regulations, including resident rights and be contracted with the Department before being paid to provide personal care services under CFC. These facilities must ensure that staff employed to provide personal care have:
    a. Completed background checks as required by state law: and,
    b. Completed Basic Training and the process to become a State-Certified Home Care Aide within a state-specified time frame after employment, unless exempt under state law and,
    c. Agreed to participate in continuing education credits as stipulated in state law in order to continue to provide personal care services.

4. *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. **Voluntary training on how to select, manage, and dismiss attendants (Caregiver Management) Providers.**
    1. *Peer Support Specialist:*
        a. Peer Support Specialist must contract with the Department before being paid to provide peer support services for caregiver management training. Prior to contracting, the Department must verify that the Peer Support Specialist:
            i. Has a valid current photo identification and Social Security card;
            ii. Has completed the state background check; and
            iii. Is age 18 or older.
        b. Peer Support Specialist must also demonstrate by relevant successful experience, training, license, or credential that they have the skills and abilities to provide training services that are:
            i. Expected to achieve outcomes identified by the participant;
            ii. Competent and relevant to the participant's culture; and
            iii. Delivered in a manner and format that is individually tailored to the participant's abilities, strengths, and learning styles.

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

2. *Community Choice Guides I:*
    a. Community Choice Guides must contract with the Department before being paid to provide services and must meet any licensing or certification required by State statutes or regulations. Prior to contracting, the Department must verify that the Community Choice Guide:
        i. Has a valid current photo identification and Social Security card;
        ii. Has completed the state background check; and
        iii. Is age 18 or older.

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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.

b. Community Choice Guides II:

In addition to the qualifications listed in V.ii.2., Community Choice Guides who also function as Assistive Technology and Equipment providers and Community Transition Providers must additionally have:

1. A current Washington State Business License or a valid explanation of why the person is exempt from registering the business with the state of Washington;
2. A financial business account that is separate from the personal account; and
3. Insurance as specified in the contract.

iii. Community Transition Providers:

a. Community Choice Guides II:

In addition to the qualifications listed in V.ii.2., Community Choice Guides who also function as Assistive Technology and Equipment providers and Community Transition Providers must additionally have:

1. A current Washington State Business License or a valid explanation of why the person is exempt from registering the business with the state of Washington;
2. A financial business account that is separate from the personal account; and
3. Insurance as specified in the contract.

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)
iv. Tribal Care Facilities (TCF)

b. **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.
3. Federally recognized tribes receive reports and conduct complaint investigations for their tribal care facility.

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

administrative rules that support the decision and the participant's or their representative's right to due process through an administrative hearing process.

i. *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.

ii. 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.

c. **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.

Federally recognized tribes, as part of the inspection and complaint investigation processes for tribal care facilities, may complete inspections and complaint investigations to determine compliance with HCB settings regulations or elect to have the Department complete these. Federally recognized tribes with a licensed tribal care facility are also supported by APS and CRU for complaints and investigations. The review includes, but is not limited to, an 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. Tribes will sign a contract with the Department adhering to HCB settings rules and regulations. The Department will assess each tribal care facility's contract compliance at least every two years, for the life of the contract. The Department will monitor to the tribal care facility's adherence to policies and procedures, HCB setting rules, and contract requirements, which will include systemic oversight and individual outcomes.

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

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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 (e.g., 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 onanalysis 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.

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

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:

1. Individual providers employed by the Consumer Directed Employer (CDE)
2. State-licensed home-care agencies
3. Residential service providers which include:
   a. Assisted living providers
   b. Adult family homes
4. Tribal care facility providers (Indian Health Service Tribal 638 Facilities)

Personal care service provider rates:

1. Individual providers employed by the CDE
   The rate paid to the CDE for providing personal care by individual providers is an hourly rate which covers the individual provider service hours and employer functions performed by the CDE, which include hiring and qualification verification, payroll activities, call center support, employee visit verification system, and other legally required employer functions. The hourly rate is determined by a rate setting board and is subject to approval by the State legislature. The rate for personal care services provided by individual providers through the CDE consists of wages, industrial insurance, paid time off, mileage reimbursement, comprehensive medical, training, seniority pay, training-based differentials, and a retirement plan.

2. State-licensed home-care agencies
   The rate paid to home care agencies for providing personal care is an hourly rate that consists of home care worker compensation, benefits, and taxes, as defined in state parity law, and an additional amount for employer functions performed by the agency.

3. Residential service providers
   The rate paid to adult family homes and assisted living facilities for providing personal care is paid 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 and benefits.

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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)

4. Tribal care facility providers (Indian Health Service Tribal 638 Facilities)
The rate paid to tribal care facilities for providing personal care services is paid at a facility rate. Each participant is assigned to a classification group based on the CARE assessment of their personal care needs. The daily rate varies depending on the individual's classification group. Rates are based on wages and benefits.

The rate for personal care provided in tribal care facilities is based on a per day unit. Each participant is assigned to a classification group based on the State's CARE assessment of their personal care needs. The daily rate varies depending on the individual's classification group. The rates are informed by residential service rates such as adult family homes and assisted living facilities, including the average number of direct care hours provided to clients based on their CARE classification in AFHs or ALFs. This groundwork, based on care needs, wages, and benefits, was then fine-tuned to account for additional factors such as support hours and wage adjustments to reflect the unique needs of a tribal care facility.

Room and Board is not federally matched and is the SSI standard minus the state's personal needs allowance and a flat amount for each client. The rate paid to tribal care facility providers does not include room and board.

Tribal care facility providers located within the geographic boundaries of a federally recognized Indian reservation receive a facility rate for providing personal care services.

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, assisted living providers, and tribal care facility 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.

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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.

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services. The rates were set as of July 1, 2024, and are effective for dates of services provided on and after that date. See the Tribal Care Facilities tab at All_HCS_Rates.xlsx, where the fee schedules are published.

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.