Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.3

Submitted by:

State of Washington Department of Social and Health Services Aging and Disability Services Administration Division of Developmental Disabilities

Submission Date:	November 1, 2006

CMS Receipt Date *(CMS Use)*	

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment):

Brief Description:
This is a renewal request for the State of Washington's Community Protection Waiver- 0411

Application for a §1915(c) Home and Community-Based Services Waiver

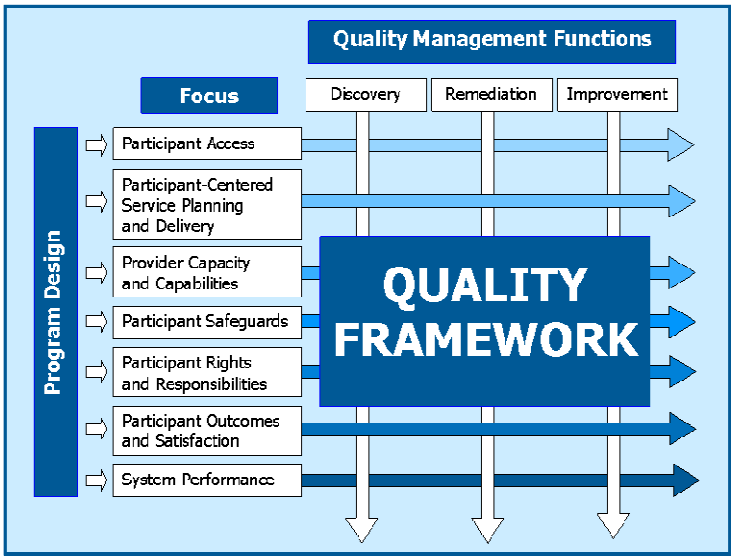
PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

The waiver application is based on the HCBS Quality Framework. The Framework focuses on seven broad, participant-centered desired outcomes for the delivery of waiver services, including assuring participant health and welfare:

- **Participant Access**: *Individuals have access to home and community-based services and supports in their communities.*
- **Participant-Centered Service Planning and Delivery**: *Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.*
- **Provider Capacity and Capabilities**: *There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
- **Participant Safeguards**: *Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
- **Participant Rights and Responsibilities**: *Participants receive support to exercise their rights and in accepting personal responsibilities.*
- **Participant Outcomes and Satisfaction**: *Participants are satisfied with their services and achieve desired outcomes.*
- **System Performance**: *The system supports participants efficiently and effectively and constantly strives to improve quality.*



The Framework also stresses the importance of respecting the preferences and autonomy of waiver participants.

The Framework embodies the essential elements for assuring and improving the quality of waiver services: design, discovery, remediation and improvement. The State has flexibility in developing and implementing a Quality Management Strategy to promote the achievement of the desired outcomes expressed in the Quality Framework.

1. Request Information

A. The **State** of **Washington** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Waiver Title (*optional*): Community Protection Waiver

C. Type of Request *(select only one)*:

○	**New Waiver (3 Years)**	CMS-Assigned Waiver Number (*CMS Use*):	
○	**New Waiver (3 Years) to Replace Waiver #** CMS-Assigned Waiver Number (*CMS Use*): *Attachment #1 contains the transition plan to the new waiver.*		
☒	**Renewal (5 Years) of Waiver #**	0411	
○	**Amendment to Waiver #**		

D. Type of Waiver *(select only one)*:

○	**Model Waiver**. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
☒	**Regular Waiver**, as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date: April 1, 2007

E.2 Approved Effective Date *(CMS Use):*

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan *(check each that applies)*:

☐	Hospital *(select applicable level of care)*	
	○	Hospital as defined in 42 CFR §440.10. If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
	○	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
☐	Nursing Facility *(select applicable level of care)*	
	○	As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
	○	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
☒	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:	

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities *(check the applicable authority or authorities)*:

☐	Services furnished under the provisions of §1915(a) of the Act and described in Appendix I			
☐	Waiver(s) authorized under §1915(b) of the Act. *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*			
	Specify the §1915(b) authorities under which this program operates (*check each that applies*):			
	☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
	☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)
☐	A program authorized under §1115 of the Act. *Specify the program:*			
☒	Not applicable			

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The **purpose** of the Community Protection Waiver is to provide an alternative to ICF/MR placement for individuals who:

- Are at least 18 years of age, and
- Meet the criteria for ICF/MR level of care, and
- Live or are moving into the community, and
- Require 24-hour, on-site, awake staff supervision to ensure the safety of others, and
- Require therapies and other habilitation, and
- Are found by DDD to meet the criteria for an "individual with community protection issues". Those criteria are as follows:

(1) The person has been convicted of or charged with a crime of sexual violence as defined in Chapters 9A.44 and 71.09 RCW, including, but not limited to, rape, rape of a child, and child molestation, and constitutes a current risk to others as determined by a qualified professional (note: excluding charges or crimes that resulted in acquittal);

(2) The person has been convicted of or charged with sexual acts directed toward strangers; individuals with whom a relationship has been established or promoted for the primary purpose of victimization; or persons of casual acquaintance with whom no substantial personal relationship exists, and constitutes a current risk to others as determined by a qualified professional (note: excluding charges or crimes that resulted in acquittal).

(3) The person has not been convicted and/or charged of a crime, but has a history of stalking, sexually violent, predatory, and/or opportunistic behavior, which demonstrates a likelihood to commit a sexually violent and/or predatory act based on current behaviors, and constitutes a current risk to others as determined by a qualified professional; or

(4) The person has committed one or more violent offenses, such as murder, attempted murder, arson, first degree assault, kidnapping, or use of a weapon to commit a crime (RCW 9.94A.030(45)).

The **goal** of the Community Protection Waiver is to provide a structured, therapeutic environment for persons with community protection issues in order for them to live safely and successfully in the community while minimizing the risk to public safety. This is accomplished by coordination of natural supports, community resources/services, Medicaid services and services available via the waiver. The Division of Developmental Disabilities wants people who receive Community Protection Waiver services to experience these benefits:

- Health and Safety
- Personal Power and Choice
- Personal Value and Positive Recognition By Self and Others
- A Range of Experiences Which Help People Participate in the Physical and Social life of Their Communities
- Good Relationships with Friends and Relatives
- Competence to Manage Daily Activities and Pursue Personal Goals

The **objective** of the Community Protection Waiver is to develop and implement supports and services to successfully maintain individuals in their homes and communities.

With regard to the **organizational structure**, the State of Washington's HCBS Community Protection Waiver is managed by the Aging and Disability Services Administration (ADSA)/Division of Developmental Disabilities (DDD), within the Department of Social and Health Services (DSHS) which is the State's Medicaid Agency (SMA). The State monitors against waiver requirements for all services delivered. The principles of Continuous Quality Improvement are used to enhance the Community Protection waiver services delivery systems.

Washington contracts with its counties for the implementation of Day Program/Supported Employment services. All other aspects of the Waiver are directly managed by the state. DDD operates this waiver within applicable federal regulations, manages the day-to-day administration and maintains operational responsibility for the waiver.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. **Appendix A** specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. **Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. **Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. **Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one)*:

○	The waiver provides for participant direction of services. *Appendix E is required.*
☒	Not applicable. The waiver does not provide for participant direction of services. *Appendix E is not completed.*

F. Participant Rights. **Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. **Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Management Strategy. **Appendix H** contains the Quality Management Strategy for this waiver.

I. Financial Accountability. **Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. **Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

○	Yes
○	No
☒	Not applicable

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

○	**Yes** *(complete remainder of item)*
☒	**No**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐	**Geographic Limitation**. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. S*pecify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area*:
☐	**Limited Implementation of Participant-Direction**. A waiver of statewideness is requested in order to make ***participant direction of services*** as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. *Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area*:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services.

Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected amount, frequency and duration and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial

participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.51, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Management. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:

The State secures public input by working closely with the following:

- The Legislature and other state agencies,
- State Quality Assurance Advisory Committee which includes family members, clients, providers and other stakeholders
- DDD State Advisory Committee made up of clients and family members,
- County Coordinators for Human Services,
- The State of Washington Developmental Disabilities Council,
- The Arc of Washington (advocacy organization),

- The Community Advocacy Coalition made up of advocates and providers,
- The Real Choices Advisory Committee made up of stakeholders and
- Regional Advisory Committees made up of stakeholders.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Linda
Last Name	Rolfe
Title:	Division Director
Agency:	Department of Social and Health Services
Address 1:	640 Woodland Square Loop
Address 2:	P.O. Box 45310
City	Olympia
State	Washington
Zip Code	98504-5310
Telephone:	(360) 725-3461
E-mail	RolfeLA@dshs.wa.gov
Fax Number	(360) 407-0955

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2	
City	
State	

Zip Code	
Telephone:	
E-mail	
Fax Number	

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: _____ **Date:**

State Medicaid Director or Designee

First Name:	Robin
Last Name	Arnold-Williams
Title:	Secretary
Agency:	Department of Social and Health Services
Address 1:	P.O. Box 45010
Address 2:	
City	Olympia
State	Washington
Zip Code	98504-5010
Telephone:	(360) 902-7800
E-mail	ArnolR@dshs.wa.gov
Fax Number	(360) 902-7848

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

N/A

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver *(select one)*:

☒	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one; do not complete Item A-2*):		
	○	The Medical Assistance Unit *(name of unit)*:	
	☒	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (name of division/unit)	Division of Developmental Disabilities
○	The waiver is operated by		
	a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *Complete item A-2.*		

2. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

DSHS (the Medicaid agency for operation and oversight of this waiver) retains ultimate authority and responsibility for the operation of the waiver by exercising oversight over the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

- DDD contracts with Counties to employee providers who provide employment and day program services to waiver clients. The Counties sign a contract which includes requirements for the provision of these and the expectations of the state. The state monitors these contracts to ensure compliance.
- Each biennium, the DDD County Program Manager works with the Regions to review all contracts between the county and state for compliance with risk management principles. If any areas are found to be at medium or high risk, the Program Manager will work with the region and county to establish corrective actions and a time line for diminishing risk.
- Each calendar year; DDD reviews county service evaluation systems. This is done by a random sampling of 15% or 30 contracted vendors across the state. The sample includes:
  - individual supported employment provider;
  - group supported employment;
  - pre-vocational services/specialized industries; and
  - person to person services.
- The Evaluation and Review focuses on compliance with the "Criteria for an Evaluation System" that is attached to the County Contract statement of work. The Criteria for an Evaluation System is available upon request. The Quality Assurance Monitoring Committee reviews the On-Site Evaluations submitted. The Committee will publish the results which may include recommendations for corrective action no later than July 1st, each year.

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the waiver operating agency (if applicable) (s*elect one)*:

☒	**Yes.** Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*
	Counties are responsible for the provision of day program and employment services. They disseminate information concerning day program and employment services to potential enrollees, monitor waiver expenditures against approved levels, recruit providers and determine day program and employment payment amounts or rates. The Medicaid agency retains ultimate authority and responsibility for the operation of the waiver by exercising oversight over the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.
○	**No**. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity *(check each that applies)*:

☒	**Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these agencies and complete items A-5 and A-6:*
	Counties
☐	**Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a **contract** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these entities and complete items A-5 and A-6*:
☐	**Not applicable** – Local/regional non-state agencies do not perform waiver operational and administrative functions.

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

Department of Social and Health Services
Aging and Disabilities Services Administration/Division of Developmental Disabilities

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Each biennium, the DDD County Program Manager works with the Regions to review all contracts between the county and state for compliance with contract risk management principles established by DSHS for auditing purposes for all agencies. The risk management principles used for county contracts are:

1. Risk Management is conducted early in the process of contract development.
2. Using the Risk Assessment worksheet prior to contract development is an effective screening/selection strategy for contract managers.
3. Risk Assessment can be repeated at any time, especially when renewing or significantly altering a contract, or when new risk factors are identified and considered significant.
4. In determining the risk value, the contract monitoring staffs judgment may be a determining factor. If there are special circumstances which may elevate the value of any factor, or new factors are identified that do not appear on the list, use the "other risk factor" space to explain.
5. Risk level ratings may be adjusted either up or down during the life of a contract.
6. Once the risk level is assigned, the monitoring plan is implemented.

7. The risk level largely determines the frequency of monitoring.
8. Each risk factor can be mitigated by some action or response by contract monitoring staff, either before or after the contract is executed. This action or response can take the form of training, technical assistance, special contract requirements/conditions/limitations.
9. Regardless of a contractors risk level, contract staff is encouraged to provide technical assistance throughout the contracting process as an effective risk management strategy.

If any areas are found to be at medium or high risk, the Program Manager works with the region and county to establish corrective actions and a time line for diminishing risk. If any waiver contracts are found to be out of compliance, corrective actions are immediately undertaken to correct the situation.

In January of each calendar year, beginning in January 2006; DDD reviews the county process for ensuring that its contractors are in compliance with all contract requirements is being followed and is in accordance with the contractual agreement with the state. This is done by a random sampling of 15% (approximately 30 contracted vendors across the state). The sample includes:

- individual supported employment providers,
- group supported employment providers,
- pre-vocational services/specialized industries providers,
- community access providers,
- person to person services providers, and
- child development services providers

Once a vendor is selected for random review, the appropriate county is asked to send copies of all documentation of the last evaluation done for that vendor to DDD Central Office within ten working days.

The Evaluation and Review focuses on compliance with the "Criteria for an Evaluation System" that is attached to the County Contract statement of work. The evaluation includes documentation that services meet individual needs; provide the correct degree of support; environments meet waiver standards; health and safety needs are met; individual rights are protected; and the organizational design is able to meet all service requirements.

The Quality Assurance Monitoring Committee reviews the On-Site Evaluations submitted. The Committee publishes the results which may include recommendations for corrective action no later than July of each year.

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	☒	☐	☐	☒
Assist individuals in waiver enrollment	☒	☐	☐	☐
Manage waiver enrollment against approved limits	☒	☐	☐	☐
Monitor waiver expenditures against approved levels	☒	☐	☐	☒
Conduct level of care evaluation activities	☒	☐	☐	☐
Review participant service plans to ensure that waiver requirements are met	☒	☐	☐	☐
Perform prior authorization of waiver services	☒	☐	☐	☐
Conduct utilization management functions	☒	☐	☐	☐
Recruit providers	☒	☐	☐	☒
Execute the Medicaid provider agreement	☒	☐	☐	☐
Determine waiver payment amounts or rates	☒	☐	☐	☒
Conduct training and technical assistance concerning waiver requirements	☒	☐	☐	☐

Appendix B: Participant Access and Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Included	Target Group/Subgroup	Minimum Age	Maximum Age	
			Maximum Age Limit: Through age –	No Maximum Age Limit
○	**Aged or Disabled, or Both**			
☐	Aged (age 65 and older)			☐
☐	Disabled (Physical) (under age 65)			
☐	Disabled (Other) (under age 65)			
	Specific Aged/Disabled Subgroup			
☐	Brain Injury			☐
☐	HIV/AIDS			☐
☐	Medically Fragile			☐
☐	Technology Dependent			☐
☒	**Mental Retardation or Developmental Disability, or Both**			
☐	Autism			☐
☒	Developmental Disability	18		☒
☐	Mental Retardation			☐
○	**Mental Illness**			
☐	Mental Illness (age 18 and older)			☐
☐	Serious Emotional Disturbance (under age 18)			

b. Additional Criteria. The State further specifies its target group(s) as follows:

Individuals must meet the Division of Developmental Disabilities' (DDD) definition of "developmental disability" as contained in state law and stipulated in state administrative code.

Washington state regulations and administrative codes stipulate that a developmental disability must meet the following minimum requirements:

(a) Be attributable to mental retardation, cerebral palsy, epilepsy, autism, or another neurological or other condition found by DDD to be closely related to mental retardation or requiring treatment similar to that required for individuals with mental retardation;

(b) Originate prior to age eighteen;

(c) Be expected to continue indefinitely; and

(d) Result in substantial limitations to an individual's adaptive functioning.

Individuals on this waiver meet the criteria for ICF/MR level of care and

- Are at least 18 years of age, and
- Live or are moving into the community, and
- Require 24-hour, on-site, awake staff supervision to ensure the safety of others, and
- Require therapies and other habilitation, and
- Are found by DDD to meet the criteria for an "individual with community protection issues". These criteria are as follows:

1. The person has been convicted of or charged with a crime of sexual violence as defined in Chapters 9A.44 and 71.09 RCW, including, but not limited to, rape, rape of a child, and child molestation, and constitutes a current risk to others as determined by a qualified professional (note: excluding charges or crimes that resulted in acquittal);

2. The person has been convicted of or charged with sexual acts directed toward strangers; individuals with whom a relationship has been established or promoted for the primary purpose of victimization; or persons of casual acquaintance with whom no substantial personal relationship exists, and constitutes a current risk to others as determined by a qualified professional (note: excluding charges or crimes that resulted in acquittal).

3. The person has not been convicted and/or charged of a crime, but has a history of stalking, sexually violent, predatory, and/or opportunistic behavior, which demonstrates a likelihood to commit a sexually violent and/or predatory act based on current behaviors, and constitutes a current risk to others as determined by a qualified professional; or

4. The person has committed one or more violent offenses, such as murder, attempted murder, arson, first degree assault, kidnapping, or use of a weapon to commit a crime (RCW 9.94A.030(45)).

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one)*:

☒	Not applicable – There is no maximum age limit
○	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit (*specify*):

Appendix B-2: Individual Cost Limit

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*:

☒ **No Cost Limit**. The State does not apply an individual cost limit. *Do not complete Item B-2-b or Item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.* The limit specified by the State is *(select one)*:

- ○ _____ %, a level higher than 100% of the institutional average
- ○ Other *(specify)*:

○ **Institutional Cost Limit**. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

○ **Cost Limit Lower Than Institutional Costs**. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. *Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*

The cost limit specified by the State is *(select one)*:

- ○ The following dollar amount: $ _____
  The dollar amount *(select one)*:
  - ○ Is adjusted each year that the waiver is in effect by applying the following formula:
  - ○ May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.
- ○ The following percentage that is less than 100% of the institutional average: _____ %
- ○ Other – *Specify:*

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

☐	The participant is referred to another waiver that can accommodate the individual's needs.
☐	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
☐	Other safeguard(s) *(specify)*:

Appendix B-3: Number of Individuals Served

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	461
Year 2	483
Year 3	484
Year 4 (renewal only)	481
Year 5 (renewal only)	483

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

○	The State does not limit the number of participants that it serves at any point in time during a waiver year.
☒	The State limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	461
Year 2	483
Year 3	484
Year 4 (renewal only)	481
Year 5 (renewal only)	483

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

☒ **Not applicable**. The state does not reserve capacity.

☒ The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:

Capacity is reserved for two groups of individuals:

1) Individuals receiving a state-funded residential program, require ICF/MR level of care, and elect to enroll on the Community Protection Waiver, as directed by the Governor. Capacity is based upon the number of individuals receiving those services and the capacity of staff to add individuals each month to the Community Protection Waiver.
2) Individuals who are at risk to themselves or the community, require ICF/MR level of care, and elect to enroll on the Community Protection Waiver, as directed by the Legislature (through 6/07) or the Governor (7/09 - 06/11). Capacity is based on funding and historical experience.

The capacity that the State reserves in each waiver year is specified in the following table:

Table B-3-c

Waiver Year	Purpose: State-funded residential clients eligible for and who elect to enroll on the Community Protection Waiver — Capacity Reserved	Purpose: Individuals who qualify for the Community Protection Waiver, for whom proviso funding is available, and who elect to enroll on the Community Protection Waiver. — Capacity Reserved
Year 1	0	0
Year 2	0	0
Year 3	9	15
Year 4 (renewal only)	9	36
Year 5 (renewal only)	9	58

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one):*

☒ The waiver is not subject to a phase-in or a phase-out schedule.

○ The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an ***intra-year*** limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity. *Select one:*

☒	Waiver capacity is allocated/managed on a statewide basis.
○	Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

State regulations stipulate: When there is capacity on a waiver and available funding for new waiver participants, DDD may enroll people from the statewide data base in a waiver based on the following priority considerations:

(1) First priority will be given to current waiver participants assessed to require a different waiver because their needs have increased and these needs cannot be met within the scope of their current waiver.

(2) DDD may also consider any of the following populations in any order:

(a) Priority populations as identified and funded by the legislature.

(b) Persons DDD has determined to be in immediate risk of ICF/MR admission due to unmet health and safety needs.

(c) Persons identified as a risk to the safety of the community.

(d) Persons currently receiving services through state-only funds.

(e) Persons on an HCBS waiver that provides services in excess of what is needed to meet their identified health and welfare needs.

(f) Persons who were previously on an HCBS waiver since April 2004 and lost waiver eligibility due to residing in an institution).

(3) For the Basic waiver only, DDD may consider persons who need the waiver services available in the Basic waiver to maintain them in their family's home or in their own home.

Attachment #1 to Appendix B-3

Waiver Phase-In/Phase Out Schedule

a. The waiver is being *(select one)*:

○	Phased-in
○	Phased-out

b. **Waiver Years Subject to Phase-In/Phase-Out Schedule** *(check each that applies)*:

Year One	Year Two	Year Three	Year Four	Your Five
☐	☐	☐	☐	☐

c. **Phase-In/Phase-Out Time Period**. *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month		
Phase-in/Phase out begins		
Phase-in/Phase out ends		

d. **Phase-In or Phase-Out Schedule**. *Complete the following table:*

Phase-In or Phase-Out Schedule			
	Waiver Year:		
Month	Base Number of Participants	Change in Number of Participants	Participant Limit

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

a. State Classification. The State is a *(select one)*:

☒	§1634 State
○	SSI Criteria State
○	209(b) State

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)				
☐	Low income families with children as provided in §1931 of the Act			
☒	SSI recipients			
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121			
☐	Optional State supplement recipients			
☐	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*			
	○	100% of the Federal poverty level (FPL)		
	○	%	of FPL, which is lower than 100% of FPL	
☐	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)			
☒	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)			
☒	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)			
☐	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)			
☐	Medically needy			
☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:			
Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*				
○	**No**. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.			
☒	**Yes**. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5.*			
	○	All individuals in the special home and community-based waiver group under 42 CFR §435.217		

☒	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:			
	☒	A special income level equal to (select one):		
		☒	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of FBR, which is lower than 300% (42 CFR §435.236)
		○	$	which is lower than 300%
	☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)		
	☐	Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)		
	☐	Medically needy without spend down in 209(b) States (42 CFR §435.330)		
	☐	Aged and disabled individuals who have income at: *(select one)*		
		○	100% of FPL	
		○	%	of FPL, which is lower than 100%
	☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:		

Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one)*:

☒	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (*select one*):
☒	Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b-2 (SSI State) or B-5-c-2 (209b State) and Item B-5-d.*
○	Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). Do not complete Item B-5-d.*
○	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. *Complete Item B-5-c-1 (SSI State) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

b-1. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):				
○	The following standard included under the State plan *(select one)*			
	○	SSI standard		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The special income level for institutionalized persons *(select one):*		
		○	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300%.
	○	%	of the Federal poverty level	
	☐	Other (specify):		
○	The following dollar amount:	$	If this amount changes, this item will be revised.	
○	The following formula is used to determine the needs allowance:			

ii. Allowance for the spouse only (*select one*):

○	SSI standard		
○	Optional State supplement standard		
○	Medically needy income standard		
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○			
○	Not applicable *(see instructions)*		

iii. Allowance for the family *(select one)*:

○	AFDC need standard		
○	Medically needy income standard		
○	The following dollar amount:	$	The amount specified cannot exceed the higher Of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○			
○	Other (specify):		
○	Not applicable (see instructions)		

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

c-1. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

○	The following standard included under the State plan *(select one)*

	○	The following standard under 42 CFR §435.121:			
	○	Optional State supplement standard			
	○	Medically needy income standard			
	○	The special income level for institutionalized persons *(select one)*			
		○	300% of the SSI Federal Benefit Rate (FBR)		
		○	%	of the FBR, which is less than 300%	
		○	$	which is less than 300% of the FBR	
	○	%	of the Federal poverty level		
	○	Other (specify):			
○	The following dollar amount:	$	If this amount changes, this item will be revised.		
○	The following formula is used to determine the needs allowance:				

ii. <u>Allowance for the spouse only</u> (*select one*):

○	The following standard under 42 CFR §435.121		
○	Optional State supplement standard		
○	Medically needy income standard		
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Not applicable *(see instructions)*		

iii. <u>Allowance for the family</u> *(select one)*

○	AFDC need standard		
○	Medically needy income standard		
○	The following dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		

○	Other (specify):
○	Not applicable (see instructions)

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

NOTE: Items B-5-c-2 and B-5-d-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.

b-2. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ The following standard included under the State plan *(select one)*
  - ○ SSI standard
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The special income level for institutionalized persons *(select one):*
    - ○ 300% of the SSI Federal Benefit Rate (FBR)
    - ○ ____ % of the FBR, which is less than 300%
    - ○ $ ____ which is less than 300%.
  - ○ ____ % of the Federal poverty level
  - ○ Other (specify):

- ○ The following dollar amount: $ ____ If this amount changes, this item will be revised.

- ☒ The following formula is used to determine the needs allowance:

The State will apply two different maintenance needs allowances:

1) For recipients who live in their own home, the State shall disregard the special income level (SIL), which is three hundred percent (300%) of the SSI Federal Benefit Rate (FBR) for an individual.

2) For recipients who live in a state-contracted or state-operated residence (i.e., group care home, group training home, adult family home, adult residential care facility), the maintenance allowance is at the Medically Needy Income Level (MNIL) (which is equal to the SSI payment standard [FBR]).

In addition to the MNIL, an allowance will be made for (when applicable):

a) Any payee and/or court-ordered guardianship fees; plus

b) Any court-ordered guardianship-related attorney fees; plus

c) An amount for employed individuals equal to the first $65 of the recipient's earned income, if any [as provided for SSI recipients at 20 C.F.R. 416.1112(c)(4)] plus one- half of any remaining earned income [as provided for SSI recipients at 20 C.F.R. 416.1112(c)(6)].

	The maximum amount for the maintenance needs allowance for individuals who live in a state-contracted or state-operated residence is three hundred percent (300%) of the SSI FBR for an individual.

ii. Allowance for the spouse only (*select one*):

○	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:			
	Specify the amount of the allowance:			
	○	SSI standard		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The following dollar amount:	$	If this amount changes, this item will be revised.
	○			
☒	Not applicable			

iii. Allowance for the family *(select one)*:

○	AFDC need standard
☒	Medically needy income standard
○	The following dollar amount: $ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	
○	Other (specify):
○	Not applicable (see instructions)

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.

☒	The State establishes the following reasonable limits *(specify)*:
	The deduction for medical and remedial care expenses that were incurred as the result of the imposition of a transfer of assets penalty is limited to zero.

c-2. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):					
○	The following standard included under the State plan *(select one)*				
	○	The following standard under 42 CFR §435.121:			
	○	Optional State supplement standard			
	○	Medically needy income standard			
	○	The special income level for institutionalized persons *(select one)*			
		○	300% of the SSI Federal Benefit Rate (FBR)		
		○	%	of the FBR, which is less than 300%	
		○	$	which is less than 300% of the FBR	
	○	%	of the Federal poverty level		
	○	Other (specify):			
○	The following dollar amount:	$	If this amount changes, this item will be revised.		
○	The following formula is used to determine the needs allowance:				

ii. Allowance for the spouse only (*select one*):				
○	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:			
	Specify the amount of the allowance:			
	○	The following standard under 42 CFR §435.121:		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The following dollar	$	If this amount changes, this item will be revised.

		amount:		
	○	The amount is determined using the following formula:		
○	Not applicable			

iii. Allowance for the family *(select one)*

○	AFDC need standard
○	Medically needy income standard
○	The following dollar amount: $ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:
○	Other (specify):
○	Not applicable (see instructions)

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care.

i. Allowance for the personal needs of the waiver participant *(select one)***:**

○	SSI Standard			
○	Optional State Supplement standard			
○	Medically Needy Income Standard			
○	The special income level for institutionalized persons			
○	%	of the Federal Poverty Level		
○	The following dollar amount:	$		If this amount changes, this item will be revised
☒	The following formula is used to determine the needs allowance:			

The State will apply two different maintenance needs allowances:

1) For recipients who live in their own home, the State shall disregard the special income level (SIL), which is three hundred percent (300%) of the SSI Federal Benefit Rate (FBR) for an individual.

2) For recipients who live in a state-contracted or state-operated residence (i.e., group care home, group training home, adult family home, adult residential care facility), the maintenance allowance is at the Medically Needy Income Level (MNIL) (which is equal to the SSI payment standard [FBR]).

In addition to the MNIL, an allowance will be made for (when applicable):

a) Any payee and/or court-ordered guardianship fees; plus

b) Any court-ordered guardianship-related attorney fees; plus

c) An amount for employed individuals equal to the first $65 of the recipient's earned income, if any [as provided for SSI recipients at 20 C.F.R. 416.1112(c)(4)] plus one- half of any remaining earned income [as provided for SSI recipients at 20 C.F.R. 416.1112(c)(6)].

The maximum amount for the maintenance needs allowance for individuals who live in a state-contracted or state-operated residence is three hundred percent (300%) of the SSI FBR for an individual.

○	Other (*specify*)**:**

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. *Select one:*

☒	Allowance is the same
○	Allowance is different. Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:

a. Health insurance premiums, deductibles and co-insurance charges.

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
☒	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

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

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

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

☒	Directly by the Medicaid agency
○	By the operating agency specified in Appendix A
○	By an entity under contract with the Medicaid agency. *Specify the entity*:
○	Other (*specify*):

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Regional DDD Case/Resource Managers are the only individuals who perform the initial evaluations of level of care prior to placement onto the waiver. In addition to meeting the following minimum qualifications, staff must pass a background check prior to being hired and receive mandatory waiver training prior to completing any evaluations.

DDD Case/Resource Manager
Minimum Qualifications:
A Bachelor's degree in social sciences, social services, human services, behavioral sciences or an allied field and two years of experience providing social services to people with developmental disabilities, graduate training in social science, social services, human services, behavioral sciences or

an allied field will substitute, year for year, for one year of the experience providing social services to people with developmental disabilities.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

DDD will implement a new assessment and planning tool June 1, 2007. The new assessment tool includes a new LOC tool. DDD will maintain current practice through May 31, 2007. Please see below for an explanation of both our current ICF/MR LOC process and the process that will be implemented June 1, 2007.

Current ICF/MR LOC Process

Support needs are assessed in the following areas:

A. Activities of Daily Living
B. Instrumental Activities of Daily Living
C. Family Supports
D. Safety & Interactions
E. Peer Relationships

Protocols for Determination of the Need for ICF/MR Level of Care

Scoring of the needs assessments enables staff to identify the variety of individuals who require an ICF/MR level of care.
This includes:
1) individuals who have low levels of cognitive functioning and require support and/or training in a variety of areas, such as activities of daily living and interpersonal relations;
2) individuals (e.g., with cerebral palsy) who have high levels of cognitive functioning and require support and/or training in areas such as medical needs, activities of daily living, and community integration;
3) individuals (e.g., with poor impulse control and/or judgment due to neurological impairment, sometimes in combination with a diagnosis of mental illness) who have varying levels of cognitive functioning, may require little support with activities of daily living, but need a high degree of support, supervision, and/or training due to behaviors that put themselves and/or others at risk; and
4) individuals who may require assistance with activities of daily living, may have varying levels of cognitive functioning, require extensive support to develop and maintain support systems, and require extensive support to work.

Assessment-Current Support Needs

The adult Current Support Needs Assessment is used to determine ICF/MR LOC for individuals on the CP Waiver. The protocol scores the need for support on 20 items. A high need for support is indicated by a score of at least 40.

Differential points are assigned to items on the adult assessment to reflect the varying support, supervision, and training needs of individuals who require an ICF/MR level of care. The items that reflect the need for support to maintain health and safety, to work, and to deal with behavior problems, as well as the availability of others to provide support are scored higher than items that reflect the need for support with activities of daily living, relating to specific individuals and participation in the community.

ICF/MR LOC Process as of June 1, 2007

The Supports Intensity Scale (SIS) is a nationally normed instrument developed by the American Association on Intellectual and Developmental Disabilities (formerly American Association on Mental Retardation) used to determine ICF/MR Level of Care for individuals aged 16 and over. The SIS is a multidimensional scale designed to determine the pattern and intensity of individuals support needs. The SIS was designed to a) assess support needs b) determine the intensity of needed supports c) monitor progress and d) evaluate outcomes of adults with mental retardation and related developmental disabilities.

The Supports Intensity Scale evaluates individuals using the following subscales:

A. Home Living
B. Community Living
C. Lifelong Learning
D. Employment
E. Health & Safety
F. Social

ICF/MR Level of Care as described in Washington Administrative Code (WAC) Chapter 388-820:

How does DDD determine if I meet the eligibility requirements for ICF/MR Level of care if I am age 16 or older? If you are age sixteen or older, DDD determines you to be eligible for ICF/MR Level of care when you meet one or more of the following:

1. You have a percentile rank over nine percent for three or more of the six subscales in the SIS Support Needs Scale; or
2. You have a percentile rank over twenty-five percent for two or more of the six subscales in the SIS Support Needs Scale; or
3. You have a percentile rank over fifty percent in at least one of the six subscales in the SIS Support Needs Scale; or
4. You have a support score of one or two for any of the questions listed in the SIS Exceptional Medical Support Needs Scale; or
5. You have a support score of one or two for at least one of the following items in the SIS Exceptional Behavior Support Needs Scale:
    a. Prevention of assaults or injuries to others; or
    b. Prevention of property destruction (e.g. fire setting, breaking furniture); or
    c. Prevention of self-injury; or
    d. Prevention of PICA (ingestion of inedible substances); or
    e. Prevention of suicide attempts; or
    f. Prevention of sexual aggression; or
    g. Prevention of wandering; or
6. You have a support score of two for any of the questions listed in the SIS Exceptional Behavior Support Needs Scale; or
7. You meet or exceed any of the qualifying scores for one or more of the following SIS questions:

Question # of SIS Support	Text of Question	Your score for "Type of Support"	And your score for "Frequency of Support"

Needs Scale		is:	is:
A1	Using the toilet	2 or more	4
		3 or more	2
A2	Taking care of clothes	2 or more	2 or more
		3 or more	1
A3	Preparing food	2 or more	4
		3 or more	2
A4	Eating food	2 or more	4
		3 or more	2
A5	Housekeeping and cleaning	2 or more	2 or more
		3 or more	1
A6	Dressing	2 or more	4
		3 or more	2
A7	Bathing and taking care of personal hygiene and grooming needs	2 or more	4
		3 or more	2
C3	Learning and using problems solving strategies	2 or more	3 or more
		3 or more	2
C9	Learning self-management strategies	2 or more	3 or more
		3 or more	2
B6	Shopping and purchasing goods and services	2 or more	2 or more
		3 or more	1
E1	Taking medication	2 or more	4
		3 or more	2
E2	Avoiding health and safety hazards	2 or more	3 or more
		3 or more	2
E4	Ambulating and moving about	2 or more	4
		3 or more	2
E6	Maintaining a nutritious diet	2 or more	2 or more
		3 or more	1
E8	Maintaining emotional well-being	2 or more	3 or more
		3 or more	2
F6	Using appropriate social skills	2 or more	3 or more
		3 or more	2
G2	Managing money and personal finances	2 or more	2 or more
		3 or more	1

How does DDD determine your percentile rank for each subscale in the SIS Support Needs Scale? DDD uses the following table to convert your total raw score for each subscale into a percentile ranking:

If your total raw score for the following SIS subscales is:	Then your

Home Living	Community Living	Lifelong Learning	Employment Support	Health and Safety	Social Activities subscale	percentile rank for the SIS subscale is:
						>99
>88	>94					>99
87-88	93-94					>99
85-86	91-92			>97		99
81-84	88-90	>96	>95	92-97	>97	98
77-80	84-87	92-96	91-95	86-91	91-97	95
73-76	70-83	86-91	85-90	79-85	84-90	91
68-72	74-78	79-85	78-84	72-78	76-83	84
62-67	69-73	72-78	70-77	65-71	68-75	75
55-61	63-68	64-71	61-69	57-64	58-67	63
48-54	56-62	55-63	52-60	49-56	48-57	50
40-47	49-55	46-54	42-51	42-48	38-47	37
32-39	41-48	36-45	32-41	34-41	28-37	25
25-31	33-40	27-35	23-31	27-33	19-27	16
18-24	25-32	18-26	15-22	20-26	10-18	9
11-17	16-24	9-17	7-14	13-19	3-9	5
3-10	6-15	<9	<7	7-12	<3	2
<3	<6			1-6		1
				<1		<1
						<1

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

☒	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
○	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation. Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The Level of Care Evaluation/Reevaluation is completed at least annually. DDD Case Resource Managers are the only individuals who perform Level of Care Evaluations/Reevaluations. Please see B-6-d for a description of the Level of Care criteria.

A qualified and trained interviewer (DDD Case Resource Manager) completes the SIS at least annually by obtaining information about the person's support needs via a face to face interview with the person and one or more respondents who know the person well.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

○	Every three months
○	Every six months
☒	Every twelve months
○	Other schedule (*specify*):

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

☒	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
○	The qualifications are different. The qualifications of individuals who perform reevaluations are *(specify)*:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify)*:

- Regional management is responsible for ensuring that Case Resource Managers complete annual evaluations.
- Assessment data is monitored monthly by regional management and HQ Program Managers and Quality Assurance staff to ensure compliance.
  - Reports are generated monthly by HQ and distributed to regional management to assist with monitoring.
- CRMs set personal tickler systems.
- Annual, monthly and quarterly file reviews track compliance. Quarterly reviews are completed by supervisors. Annual and monthly reviews are completed by the Quality Compliance Coordinators (QCC).
- The DDD assessment (on the CARE platform) tracks timeliness of reevaluations. Case Resource Managers, DDD supervisors and DDD executive management all monitor these reports.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Records of evaluations will be maintained for a minimum of three years. Paper copies are available in the client file which is maintained in the regional office. The electronic evaluation is on an electronic platform and can be viewed remotely from any DDD office in the state.

Appendix B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The DDD Case/Resource Manager (CRM) discusses the alternatives available as a part of the annual assessment process. The individual and/or their legal representative initials the Individual Support Plan at the time of the annual review to indicate the choice of community based services or ICF/MR services.

b. Maintenance of Forms. Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

A hard copy of the annual Individual Support Plan, to include all initials and signatures is maintained in the client record in the local DDD field service office.

Appendix B-8: Access to Services by Limited English Proficient Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Service access for limited English Proficient individuals is ensured by providing bilingual staff or contracted interpreter services at no cost to the participant. Program materials are translated into the participant's primary language. Outreach materials explaining the program are translated into eight different languages.

Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	☐	
Homemaker	☐	
Home Health Aide	☐	
Personal Care	☐	
Adult Day Health	☐	
Habilitation	☒	
Residential Habilitation	☒	
Day Habilitation	☒	Person to Person
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	☒	
Supported Employment	☒	Individual Supported Employment and Group Supported Employment
Education	☐	
Respite	☐	
Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	

Other Services *(select one)*	
○	Not applicable
☒	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
a.	Behavior Management and Consultation

b.	Staff/Family Consultation and Training
c.	Environmental Accessibility Adaptations
d.	Transportation
e.	Specialized Medical Equipment and Supplies
f.	Community Transition
g.	Skilled Nursing
h.	Sexual Deviancy Evaluation
i.	Specialized Psychiatric Services **(Please refer to section C-3 for details)**
.	Mental Health Stabilization Services consisting of: **(Please refer to section C-3 for details)** • Behavior management and consultation • Mental health crisis diversion bed services • Skilled nursing • Specialized psychiatric Services

Extended State Plan Services *(select one)*

○	Not applicable
☒	The following extended State plan services are provided *(list each extended State plan service by service title)*:
a.	Occupational Therapy- Occupational Therapy may be authorized as a waiver service only after an individual have accessed what is available under Medicaid and any other private health insurance plan
b.	Speech, Hearing and Language Services- Speech, Hearing and Language Services may be authorized as a waiver service only after an individual have accessed what is available under Medicaid and any other private health insurance plan
c.	Physical Therapy- Physical Therapy may be authorized as a waiver service only after an individual have accessed what is available under Medicaid and any other private health insurance plan

Supports for Participant Direction *(select one)*

○	The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
☒	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	☐	
Financial Management Services	☐	

Other Supports for Participant Direction *(list each support by service title)*:

a.	
b.	

c.	

b. Alternate Provision of Case Management Services to Waiver Participants. When case management is not a covered waiver service, indicate how case management is furnished to waiver participants *(check each that applies)*:

☐	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*
☒	As an administrative activity. *Complete item C-1-c.*
☐	Not applicable – Case management is not furnished as a distinct activity to waiver participants. *Do not complete Item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

DDD Case Resource Managers conduct case management functions on behalf of waiver participants.

Appendix C-2: General Service Specifications

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services *(select one)*:

☒	**Yes**. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):
	(a) Anyone who has unsupervised access to individuals with developmental disabilities and children. This includes volunteers, students, interns, or contracted or licensed staff and state staff. (b) Searches are through Washington State Patrol; and persons living in Washington less than three years are required to have a fingerprint check through the FBI. The DSHS Background unit also checks Adult Protective Services and Department of Health registers. (c) The entity responsible for retrieving this information is DSHS/ Background Check Centralized Unit (BCCU). It is up to the hiring authority to make a decision based on the information that they have received from BCCU. (d) Relevant state laws, regulations and policies are: RCW 43.43.380-, RCW 74.15.030, WAC 388-06 and Administrative Policy 9.04
○	**No**. Criminal history and/or background investigations are not required.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry *(select one)*:

☒	**Yes**. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
	Under state authority RCW 74.34, the Aging and Disability Services Administration (ADSA) receives reports and conducts investigations of abuse, neglect, exploitation and abandonment for clients enrolled with the Division of Developmental Disabilities. ADSA Residential Care Services (RCS) investigates abuse and neglect occurring in nursing homes, boarding homes, adult family homes, & supported living programs. ADSA Adult Protective Services (APS) investigates abuse and neglect involving adults residing in their own homes. Both APS and RCS forward final findings of abuse, neglect and exploitation to the DSHS Background Check Central Unit (BCCU). The BCCU enters the information into their database used to screen all names submitted for a background check. Prior to providing contracted waiver services, the DSHS requires screening of individuals through the BCCU which includes the abuse registry findings. Per RCW 74.39.050(8) No provider or staff, or prospective provider or staff, entered into a state registry finding him or her guilty of abuse, neglect, exploitation, or abandonment of a minor or a vulnerable adult as defined in chapter 74.34 RCW shall be employed in the care of and have unsupervised access to vulnerable adults.

○	**No**. The State does not conduct abuse registry screening.

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one*:

○	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.*
☒	**Yes**. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Complete Items C-2-c.i –c.iii.*

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit
Adult Residential Treatment Facility	Mental Health Stabilization Services-MH Crisis Diversion Bed Services	Capacity is dependent on facility size.

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

The only use of a community residential facility for individuals on this waiver is to provide mental health crisis diversion bed services. These services are temporary in nature, and any facility on which they are provided is not the permanent residence of the individual. Nevertheless, clients' rights are safeguarded through State policy and contractual requirements as well as provider policies. The Individual Support Plan developed for each waiver participant identifies goals for community living.

iii. Scope of Facility Standards. By type of facility listed in Item C-2-c-i, specify whether the State's standards address the following *(check each that applies)*:

Standard	Facility Type: Adult Residential Treatment Facility
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

b. **Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

☒	**No**. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
○	**Yes**. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians**. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○	The State does not make payment to relatives/legal guardians for furnishing waiver services.
○	The State makes payment to relatives/legal guardians under ***specific circumstances*** and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
☒	Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
	As described in Washington Administrative Code Chapter 388-845: The following limitations apply to providers for waiver services: (1) The client's spouse cannot be their paid provider for any waiver service. (2) The client's natural, step, or adoptive parent cannot be their paid provider for any waiver service with the exception of: (a) Transportation to a waiver service; or (b) Residential Habilitation services per WAC 388-845-1510 if their parent is certified

	as a residential agency per chapter 388-101 WAC. The following controls are in place to ensure payments are made only for services rendered: • Annual Individual Support Plans • CRM monitoring of plan • Annual ISP audits • Supervisory file reviews • National Core Indicator interviews • Individual Support Plan surveys To ensure the safety of waiver participants the state instructs Case Managers to locate a third party to supervise providers when the provider is a guardian.
○	Other policy. *Specify*:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The State of Washington allows for continuous open enrollment of qualified providers. Provider qualifications are available to the public on-line per Washington Administrative Code (WAC). Waiver enrollees may select qualified providers at any time during the waiver year. Providers may enroll at any time during the year.

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Residential Habilitation
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
☒	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

(1) Residential habilitation services include assistance:
  (a) With personal care and supervision; and
  (b) To learn, improve or retain social and adaptive skills necessary for living in the community.

(2) Residential habilitation services may provide instruction and support addressing one or more of the following outcomes:
  (a) Health and safety;
  (b) Personal power and choice;
  (c) Competence and self-reliance;
  (d) Positive recognition by self and others;
  (e) Positive relationships; and
  (f) Integration into the physical and social life of the community.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Rates (Please see Appendix I-2 for more detail):

- Contracted Supported Living daily rates are negotiated regionally utilizing policy and standards developed by the Central Office ADSA/DDD cost reimbursement section and the Central Office DDD residential program manager. Final rates are based on residential support levels (assigned by the DDD assessment), specific support needs listed in the assessment, support provided by others (e.g., family members), and the number of people living in the household who can share the support hours. (4/1/08)
- State-Staffed Supported Living daily rates are established on a prospective basis by the ADSA/DDD cost reimbursement section. At the close of each year, a settlement calculation is prepared to recover additional federal funds, or to pay back funds previously received.

With the exception of state-staffed supported living services, payments are made directly from the DDD to the provider. For state-staffed supported living services, a prospective (daily) rate is established each year for each location (region) based on the projected costs and number of resident days for the ensuing fiscal year. The established rates are transmitted to the Office of Financial Recovery. OFR uses the daily reimbursement rates and the number of Medicaid eligible days at each location to recalculate the federal share of cost for each facility. The OFR calculation report goes to the Office of Accounting Services and to ADSA. The fiscal unit at ADSA prepares a journal voucher to record the federal share under the federal funds appropriation in the FRS. Reported resident days and FFP claims are reconciled with the Office of

Financial Recovery each month. At the close of each year, a settlement calculation is prepared to recover additional federal funds, or to pay back funds previously received.

State regulations stipulate:

(1) An individual may only receive a residential habilitation service from one provider type at a time.
(2) None of the following can be paid for under the CORE or community protection waiver:
(a) Room and board;
(b) The cost of building maintenance, upkeep, improvement, modifications or adaptations required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code;
(c) Activities or supervision already being paid for by another source;
(d) Services provided in an individual's parents' home unless they are receiving alternative living services for a maximum of six months to transition you from their parents' home into their own home.

The following added effective 4/1/08:

(3) The following persons cannot be paid providers for residential habilitation services:
(a) The individual's spouse;
(b) the individual's natural, step, or adoptive parent unless the individual's parent is certified as a residential agency per chapter 388-101 WAC (ADSA administrative code concerning certified community residential services and support) or is employed by a certified or licensed agency qualified to provide residential habilitation services.
(4) The initial authorization of residential habilitation services requires prior approval by the DDD regional administrator or designee.

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	☒	Agency. List the types of agencies:
				Contracted Supported Living
				State Operated Living Alternative (SOLA)

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person (guardian) as per section C-2-e	☒	Relative/Legal Guardian per section C-2-e

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Contracted Supported Living		Chapter 388-101 WAC (ADSA administrative code concerning certified community residential	

		services and support)	
State Operated Living Alternatives (SOLA)		Chapter 388-101 WAC (ADSA administrative code concerning certified community residential services and support)	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Contracted Supported Living	Medicaid Agency	Every two years
State Operated Living Alternatives (SOLA)	Medicaid Agency	Every two years

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification

Service Title:	Day Habilitation-Person to Person

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
☒	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

"Person-to-person" is a day program service intended to assist participants to progress toward employment goals through individualized planning, skill instruction, information and referral, and one to one relationship building. This service may be provided in addition to community access, prevocational services, or supported employment. (effective 4/1/07 – 3/31/08)

Replace the above with the following paragraph effective 4/1/08:
"Person-to-person" is a day program service intended to assist participants to progress toward employment goals through individualized planning, technical assistance, and discovery. This service may be provided in addition to community access, prevocational services, or supported employment.

Relationship to specific services:
The focus of Person to Person services is on individual supported employment. Pre-vocational and group supported employment (one component of supported employment) services are not individualized and are provided in group settings. Someone receiving pre-vocational or group supported employment may need

planning and other assistance to transition to individualized employment.

Service Implementation:
This service is provided to help individuals make the transition from a non-employment (e.g., community access), pre-employment (e.g., pre-vocational services) or group setting (e.g., pre-vocational, group supported employment) to individual employment. The focus is on planning a path to individual employment, development of skills necessary for individual employment, and linkage to job coaches and work settings that will facilitate individual employment for individuals with developmental disabilities.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Person to person services are only available to individuals who do not have access to services available under the Rehabilitation Act of 1973, or the Individuals with Disabilities Education Improvement Act of 2004. (effective 4/1/07 +)

Add to the above the following sentence effective 4/1/08:
Person to person services are part of the pathway toward individual employment and are dependent on participants demonstrating steady progress toward gainful employment over time.

Next paragraph added 4/1/08:
These services will be provided in an integrated environment and are time limited. Service hours are determined by the level of assistance a participant needs to reach their employment outcomes.

The rates (hourly, daily, or monthly) for person-to-person services are negotiated between the counties and their providers.

ADSA/DDD contracts with the counties for day habilitation (including person to person) and expanded habilitation services. The counties in turn contract provide services directly or contract with local providers for day habilitation and expanded habilitation services. The ADSA/DDD reimburses the counties on a monthly basis for the cost of all services provided within the county. The counties in turn reimburse vendors for services provided based on the negotiated unit rates contained in their contracts with the vendors.

Provider Specifications

Provider Category(s) *(check one or both)*:	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Person to Person		Person to Person	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual Provider			Contract Standards As stipulated in DDD policy 6.13 (concerning day program provider qualifications), all providers shall meet the

			following qualifications: • Demonstrate experience or knowledge in providing services to individuals with developmental disabilities; • Have a history of working with community-based employers and/or other community entities; • Demonstrate a method for providing services/jobs based on individual choice and interest; • Demonstrate an understanding of and commitment to integration of individuals with developmental disabilities with people who are not disabled; • Have experience in working cooperatively with other organizations such as the Division of Vocational Rehabilitation (DVR),schools, and other community entities; • Shall have the administrative capabilities necessary to safe guard public funds; • Shall maintain books, records, documents and other materials relevant to the provision of goods and services; • Shall provide for systematic accumulation, filing and retention of timely reports for department and/or federal audits; • Shall be 18 years of age or older and have experience or received training in the following areas: o Positive Behavior Support o Health and Welfare • Shall have experience or training to provide training and support to clients in the program area(s) identified in the client's Individual Support Plan (ISP).
Agency Provider			Contract Standards As stipulated in DDD policy 6.13 (concerning day program provider qualifications), all providers shall meet the following qualifications: • Demonstrate experience or knowledge in providing services to

			individuals with developmental disabilities; • Have a history of working with community-based employers and/or other community entities; • Demonstrate a method for providing services/jobs based on individual choice and interest; • Demonstrate an understanding of and commitment to integration of individuals with developmental disabilities with people who are not disabled; • Have experience in working cooperatively with other organizations such as the Division of Vocational Rehabilitation (DVR),schools, and other community entities; • Shall have the administrative capabilities necessary to safe guard public funds; • Shall maintain books, records, documents and other materials relevant to the provision of goods and services; • Shall provide for systematic accumulation, filing and retention of timely reports for department and/or federal audits; • Shall be 18 years of age or older and have experience or received training in the following areas: o Positive Behavior Support o Health and Welfare • Shall have experience or training to provide training and support to clients in the program area(s) identified in the client's Individual Support Plan (ISP).

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual Provider	County	Every two years
Agency Provider	County	Every two years

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification	
Service Title:	Expanded Habilitation Services-Prevocational
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
☒	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Prevocational services prepare an adult for paid or unpaid employment through the teaching of such concepts as compliance, attendance, task completion, problem solving and safety. . (effective 4/1/07 – 3/31/08)

Replace the above with the following language effective 4/1/08):

Prevocational services occur in a segregated setting and are designed to prepare an adult for gainful employment in an integrated setting through training and skill development.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

- Prevocational services are only available to individuals who do not have access to services available under the Rehabilitation Act of 1973, or the Individuals with Disabilities Education Improvement Act of 2004.
- The individual is not expected to be competitively employed within one year (excluding supported employment programs).
- An individual cannot be authorized to receive prevocational services if they receive community access services or supported employment services. (These three bullets effective 4/1/07 – 3/31/08)

Replace the above with the following language effective 4/1/08:

- Prevocational services are only available to individuals who do not have access to services available under the Rehabilitation Act of 1973, or the Individuals with Disabilities Education Improvement Act of 2004.
- New referrals for prevocational services require prior approval by the DDD Regional Administrator and County Coordinator or their designees.
- Prevocational services are a time limited step on the pathway toward individual employment and are dependent on participants demonstrating steady progress toward gainful employment over time. A participant's annual vocational assessment will include exploration of integrated settings within the next service year. Criteria that would trigger a review of the need for these services include, but are not limited to:
  - Compensation at more than fifty percent of the prevailing wage;
  - Significant progress made toward the defined goals;
  - An expressed interest in competitive employment; and/or
  - Recommendation by the individual support plan team.
- Service hours are determined by the assistance a participant needs to reach their employment outcomes.
- An individual cannot be authorized to receive prevocational services if they receive community access services or supported employment services.

Effective 4/1/07 (no change):

ADSA/DDD contracts with the counties for day habilitation and expanded habilitation (including prevocational) services. The counties in turn contract provide services directly or contract with local providers for day

habilitation and expanded habilitation services. The ADSA/DDD reimburses the counties on a monthly basis for the cost of all services provided within the county. The counties in turn reimburse vendors for services provided based on the negotiated unit rates contained in their contracts with the vendors.

Provider Specifications

Provider Category(s) *(check one or both)*:	☒	Individual. List types:	☒	Agency. List the types of agencies:
		Prevocational (Sheltered workshop)		Prevocational (Sheltered workshop)

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual Prevocational			Contract Standards
Agency Prevocational			Contract Standards

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual Provider	County	Every two years
Agency Provider	County	Every two years

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification

Service Title:	Expanded Habilitation Services- Supported Employment-Individual Supported Employment/Group Supported Employment

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
☒	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Supported employment provides intensive ongoing individual or group support in a work setting to adults with developmental disabilities.

- Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training.
- Supported employment is conducted in a variety of community settings; in which persons without disabilities are employed.

Replace the above with the following language as of 4/1/08:

Supported employment services provide individualized assistance to gain and/or maintain employment and ongoing support. These services are tailored to individual needs, interests, abilities, and promote career development. These services are provided in individual or group settings.

(1) Individual supported employment services include activities needed to sustain minimum wage pay or higher. These services are conducted in integrated business environments and include the following:

(a) Creation of work opportunities through job development;
(b) On-the-job training;
(c) Training for the supervisor and/or peer workers;
(d) Modification of the work site tasks;
(e) Employment retention and follow along support; and
(f) Development of career and promotional opportunities.

(2) Group supported employment services are a step on the pathway toward gainful employment in an integrated setting and include:

(a) The activities outlined in individual supported employment services;
(b) Daily supervision by a qualified employment provider; and
(c) Groupings of no more than eight workers with disabilities.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

- Supported employment services are only available to individuals who do not have access to services available under the Rehabilitation Act of 1973, or the Individuals with Disabilities Education Improvement Act of 2004. (effective 4/1/07 +)

- Payment will be made only for the adaptations, supervision, training and support with the activities of daily living a person requires as a result of his/her disabilities.
- Payment is excluded for the supervisory activities rendered as a normal part of the business setting.
- An individual cannot be authorized to receive supported employment services if he/she receives prevocational services.

ADSA/DDD contracts with the counties for day habilitation and expanded habilitation (including supported employment) services. The counties in turn contract provide services directly or contract with local providers for day habilitation and expanded habilitation services. The ADSA/DDD reimburses the counties on a monthly basis for the cost of all services provided within the county. The counties in turn reimburse vendors for services provided based on the negotiated unit rates contained in their contracts with the vendors.

Provider Specifications

Provider Category(s) *(check one or both)*:	☒	Individual. List types:	☒	Agency. List the types of agencies:

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Individual Provider			Contract Standards
Agency Provider			Contract Standards

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual Provider	County	Every two years
Agency Provider	County	Every two years

Service Specification	
Service Title:	Behavior Management and Consultation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
☒	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

State regulations stipulate that:
(1)Behavior management and consultation may be provided to persons on any of the four HCBS waivers and include the development and implementation of programs designed to support waiver participants using:
(a) Strategies for effectively relating to caregivers and other people in the waiver participant's life; and
(b) Direct interventions with the person to decrease aggressive, destructive, and sexually inappropriate or other behaviors that compromise their ability to remain in the community (i.e., training, specialized cognitive counseling).
(2)Behavior management and consultation may also be provided as a Mental Health Stabilization Service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

State regulations stipulate that:
(1) DDD and the treating professional will determine the need and amount of service an individual will receive, subject to the limitations in subsection (2) below.
(2) DDD reserves the right to require a second opinion from a department-selected provider.
(3) Behavior management and consultation not provided as a mental health stabilization service requires prior approval by DDD.

Unit rates are negotiated by DDD regional staff and are provider-specific. All payments are made directly from the DDD to the provider of service.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Marriage and family therapist		Behavior Management Agency Provider ▫ Any agency that employees an individual with the qualifications listed under individual provider types	
	Mental health counselor			
	Psychologist			

	Sex offender treatment provider	
	Social worker	
	Registered nurse (RN) or licensed practical nurse (LPN)	
	Psychiatrist	
	Psychiatric advanced registered nurse practitioner (ARNP)	
	Physician assistant working under the supervision of a psychiatrist	
	Registered or certified counselor	
	Polygrapher	
	Behavior Management Provider with 5 years of experience serving individuals with developmental disabilities	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Marriage and family therapist	Chapter 246-809 WAC (Department of Health-DOH-administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)		Contract Standards
Mental health counselor	Chapter 246-809 WAC (DOH administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)	Chapter 246-810 WAC (DOH administrative code concerning requirements for counselors)	Contract Standards

Psychologist	Chapter 246-924 WAC (DOH administrative code concerning requirements for Psychologists)		Contract Standards
Sex offender treatment provider		Chapter 246-930 WAC (DOH administrative code concerning requirements for Sex Offender Treatment Providers)	Contract Standards
Social worker	Chapter 246-809 WAC (DOH administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)		Contract Standards
Registered nurse (RN) or licensed practical nurse (LPN)	Chapter 246-840 WAC (DOH administrative code concerning requirements for Practical and Registered Nursing)		Contract Standards
Psychiatrist	Chapter 18.71 RCW (DOH administrative code concerning requirements for Physicians)		Contract Standards
Psychiatric advanced registered nurse practitioner (ARNP)	RCW 18.79.050 (DOH administrative code concerning "Advanced registered nursing practice" and exceptions)		Contract Standards

Physician assistant working under the supervision of a psychiatrist	Chapter 18.71A RCW (DOH administrative code concerning requirements for Physician Assistants)		Contract Standards
Registered or certified counselor	Chapter 246-810 WAC (DOH administrative code concerning requirements for counselors)	Chapter 246-810 WAC (DOH administrative code concerning requirements for counselors)	Contract Standards
Polygrapher			Contract Standards
Behavior Management Provider with 5 years of experience serving individuals with developmental disabilities			Five years experience serving individuals with Developmental Disabilities. Contract Standards
Behavior Management Agency Provider			An agency could employee any of the provider types listed above and the employees must meet the qualifications listed. Contract Standards

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Marriage and family therapist	Medicaid Agency	Every 3 years
Mental health counselor	Medicaid Agency	Every 3 years
Psychologist	Medicaid Agency	Every 3 years
Sex offender treatment provider	Medicaid Agency	Every 3 years
Social worker	Medicaid Agency	Every 3 years
Registered nurse (RN) or licensed practical nurse (LPN)	Medicaid Agency	Every 3 years
Psychiatrist	Medicaid Agency	Every 3 years
Psychiatric advanced registered nurse practitioner (ARNP)	Medicaid Agency	Every 3 years
Physician assistant working under the supervision of a	Medicaid Agency	Every 3 years

psychiatrist		
Registered or certified counselor	Medicaid Agency	Every 3 years
Polygrapher	Medicaid Agency	Every 3 years
Behavior Management Provider with 5 years of experience serving individuals with developmental disabilities	Medicaid Agency	Every 3 years
Behavior Management Agency Provider	Medicaid Agency	Every 3 years

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification	
Service Title:	Staff Family Consultation and Training

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
☒	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

State regulations stipulate that:

- Staff/family consultation and training is professional assistance to families or direct service providers to help them better meet the needs of the waiver person.
- Consultation and training is provided to families, direct staff, or personal care providers to meet the specific needs of the waiver participant as outlined in the individual's plan of care, including:
  (a) Health and medication monitoring,
  (b) Positioning and transfer,
  (c) Basic and advanced instructional techniques,
  (d) Positive behavior support; and
  (e) Augmentative communication systems.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

State regulations stipulate that:

- Expenses to the family or provider for room and board or attendance, including registration, at conferences are excluded as a service under staff/family consultation and training.

Unit rates are negotiated by DDD regional staff and are provider-specific. All payments are made directly from the DDD to the provider of service.

Provider Specifications				
Provider Category(s)	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Audiologist		Staff Family Consultation Agency Provider	

(check one or both):		▫ Any agency that employees an individual with the qualifications listed under individual provider types
	Licensed Practical Nurse	
	Marriage and Family Therapist	
	Mental Health Counselor	
	Occupational Therapist	
	Physical Therapist	
	Registered Nurse	
	Sex Offender Treatment Provider	
	Speech/Language Pathologist	
	Social Worker	
	Psychologist	
	Certified American Sign Language Instructor	
	Nutritionist	
	Registered or Certified Counselor	
	Certified Dietician	
	Certified Recreation Therapist	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Audiologist		WAC 246-828-095 (DOH administrative code concerning Audiology minimum standards of practice)	Contract Standards
Licensed Practical Nurse	Chapter 246-840 WAC (Department of Health-DOH-administrative code concerning requirements for Practical and Registered Nursing)		Contract Standards
Marriage and Family Therapist	Chapter 246-809 WAC (DOH		Contract Standards

	administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)		
Mental health counselor	Chapter 246-809 WAC (DOH administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)	Chapter 246-810 WAC (DOH administrative code concerning requirements for Counselors)	Contract Standards
Occupational Therapist	Chapter 246-847 WAC (DOH administrative code concerning requirements for Occupational Therapists)		Contract Standards
Physical Therapist	Chapter 246-915 WAC (DOH administrative code concerning requirements for Physical Therapists)		Contract Standards
Registered Nurse	Chapter 246-840 WAC (DOH administrative code concerning requirements for Practical and Registered Nursing)		Contract Standards
Sex Offender Treatment Provider		Chapter 246-930 WAC (DOH administrative code concerning requirements for	Contract Standards

		Sex Offender Treatment Providers)	
Speech/Language Pathologist		WAC 246-828-105 (DOH administrative code concerning requirements for Speech-language pathology-minimum standards of practice)	Contract Standards
Social worker	Chapter 246-809 WAC (DOH administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)		Contract Standards
Psychologist	Chapter 246-924 WAC (DOH administrative code concerning requirements for Psychologist)		Contract Standards
Certified American Sign Language Instructor			Contract Standards
Nutritionist		Chapter 18.138 RCW (State law concerning requirements for Dietitians and Nutritionists) Chapter 246-822 WAC (DOH administrative code concerning requirements for Dietitians or Nutritionists)	Contract Standards
Registered or Certified Counselor	Chapter 246-810 WAC (DOH administrative	Chapter 246-810 WAC (DOH administrative code	Contract Standards

	code concerning requirements for counselors)	concerning requirements for counselors)	
Certified Dietician		Chapter 18.138 RCW (State law concerning requirements for Dietitians and Nutritionists) Chapter 246-822 WAC (DOH administrative code concerning requirements for Dietitians or Nutritionists)	Contract Standards
Certified Recreation Therapist			Contract Standards
Staff Family Consultation Agency Provider			An agency could employee any of the provider types listed above and the employees must meet the qualifications listed.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Audiologist	Medicaid Agency	Every 3 years
Licensed Practical Nurse	Medicaid Agency	Every 3 years
Marriage and Family Therapist	Medicaid Agency	Every 3 years
Mental Health Counselor	Medicaid Agency	Every 3 years
Occupational Therapist	Medicaid Agency	Every 3 years
Physical Therapist	Medicaid Agency	Every 3 years
Registered Nurse	Medicaid Agency	Every 3 years
Sex Offender Treatment Provider	Medicaid Agency	Every 3 years
Speech/Language Pathologist	Medicaid Agency	Every 3 years
Social Worker	Medicaid Agency	Every 3 years
Psychologist	Medicaid Agency	Every 3 years
Certified American Sign Language Instructor	Medicaid Agency	Every 3 years
Nutritionist	Medicaid Agency	Every 3 years
Registered or Certified	Medicaid Agency	Every 3 years

Counselor		
Certified Dietician	Medicaid Agency	Every 3 years
Certified Recreation Therapist	Medicaid Agency	Every 3 years
Staff Family Consultation Agency Provider	Medicaid Agency	Every 3 years

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification	
Service Title:	Environmental Accessibility Adaptation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
☒	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

- Environmental accessibility adaptations provide the physical adaptations to the home required by the individual's plan of care needed to:
  (a) Ensure the health, welfare and safety of the individual; or
  (b) Enable the individual who would otherwise require institutionalization to function with greater independence in the home.
- Environmental accessibility adaptations may include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or installing specialized electrical and/or plumbing systems necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The following service limitations apply to environmental accessibility adaptations:

- Prior approval by DDD is required.
- Environmental accessibility adaptations or improvements to the home are excluded if they are of general utility without direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc.
- Environmental accessibility adaptations cannot add to the total square footage of the home.
- Environmental accessibility adaptations do not include fences.

Rates are based upon bids received by potential contracts. All payments are made directly from the DDD to the provider of service.

Provider Specifications				
Provider Category(s) *(check one or*	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Registered Contractor (Individual Provider)		Registered Contractor (Agency)	

both):		

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Registered Contractor (Individual Provider)			Chapter 18.27 RCW (State law concerning the registration of contractors) Chapter 19.27 RCW (State law concerning the State Building Code)
Registered Contractor (Agency)			Chapter 18.27 RCW (State law concerning the registration of contractors) Chapter 19.27 RCW (State law concerning the State Building Code)

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Registered Contractor (Individual Provider)	Medicaid Agency	Every 3 years
Registered Contractor (Agency)	Medicaid Agency	Every 3 years

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification

Service Title:	Transportation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
☒	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Transportation services provide reimbursement to a provider when the transportation is required and specified in the waiver plan of care.

- Transportation provides the person access to waiver services specified by the plan of care.
- Whenever possible, the person will use family, neighbors, friends, or community agencies that can provide this service without charge.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The following limitations apply to transportation services:

- Transportation to/from medical or medically related appointments is a Medicaid transportation service and is to be considered and used first.
- Transportation is offered in addition to medical transportation but cannot replace Medicaid transportation services.

- Transportation is limited to travel to and from a waiver service.
- Transportation does not include the purchase of a bus pass.
- Reimbursement for provider mileage requires prior approval by DDD and is paid according to contract.
- This service does not cover the purchase or lease of vehicles.
- Reimbursement for provider travel time is not included in this service.
- Reimbursement to the provider is limited to transportation that occurs when the individual is with the provider.
- The individual is not eligible for transportation services if the cost and responsibility for transportation is already included in the waiver provider's contract and payment.

The rate per mile is based upon historical reimbursement of state staff for transportation to and from meetings. Effective 7/1/08, the rate per mile is based on the Collective Bargaining Agreement (CBA) with the State Employees International Union (SEIU). All payments are made directly from the DDD to the provider of service.

Provider Specifications

Provider Category(s) *(check one or both)*:	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Individual Provider		Agency Provider	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual Provider	Chapter 308-104 WAC (State administrative code concerning Drivers Licenses)		Chapter 308-106 WAC (State administrative code concerning mandatory insurance to operate a vehicle) Contract Standards
Agency Provider	Chapter 308-104 WAC (State administrative code concerning Drivers Licenses)		Chapter 308-106 WAC (State administrative code concerning mandatory insurance to operate a vehicle) Contract Standards

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual Provider	Medicaid Agency	Every 3 years
Agency Provider	Medicaid Agency	Every 3 years

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification	
Service Title:	Specialized Medical Equipment and Supplies

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
☒	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

- Durable and nondurable medical equipment not available through Medicaid or the state plan which enables individuals to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live.
- This service also includes items necessary for life support; ancillary supplies and equipment necessary to the proper functioning of such items.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The following limitations apply to the receipt of specialized medical equipment and supplies:

- Prior approval by the department is required for each authorization.
- The department reserves the right to require a second opinion by a department-selected provider.
- Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the Medicaid state plan.
- Items must be of direct medical or remedial benefit to the individual and necessary as a result of the individual's disability.
- Medications, prescribed or nonprescribed, and vitamins are excluded.

All rates are based upon the usual and customary charges for the specialized medical equipment/supplies. All payments are made directly from the DDD to the provider of the specialized medical equipment/supplies.

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☒	Agency. List the types of agencies:
				Medical Equipment Supplier (Agency)

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Medical Equipment Supplier (Agency)	Chapter 19.02 RCW (State law concerning business licenses)		Contract Standards

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Medical Equipment Supplier (Agency)	Medicaid Agency	Every 3 years

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification	
Service Title:	Community Transition
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
☒	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Community transition services are reasonable costs (necessary expenses in the judgment of the state for an individual to establish his or her basic living arrangement) associated with moving from an institutional setting, facility-based setting (e.g., group home), or private residence (e.g., parents' home) to a community setting (i.e., their own residence) and receiving services from a DDD certified residential habilitation services provider.

- Community transition services include:
  - Security deposits (not to exceed the equivalent of two month's rent) that are required to obtain a lease on an apartment or home;
  - Essential furnishings such as a bed, a table, chairs, window blinds, eating utensils and food preparation items;
  - Moving expenses required to occupy and use a community domicile;
  - Set-up fees or deposits for utility or service access (e.g., telephone, electricity, heating); and
  - Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Community transition services do not include:

- Diversional or recreational items such as televisions, cable TV access, VCRs, MP3, CD or DVD players
- Computers whose use is primarily diversional or recreational.
- Community transition services are available only to individuals that are moving from an institution to a community setting.

Rates for community transition are based upon local housing (e.g., rent deposit) and utility costs and the specific needs of the individual 9e.g., for furnishings). Payment for community transition costs are made to the provider of residential habilitation services, who in turn makes payment directly to the landlord, utility, furniture vendor.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☒	Agency. List the types of agencies:
				Any provider listed herein as a waiver provider of residential habilitation services.

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Any provider listed herein as a waiver provider of residential habilitation services.	~~State licensure standards as required.~~ Not Applicable	State certification standards as required.	~~Contract Standards~~ Not Applicable

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Any provider listed herein as a waiver provider of residential habilitation services.	Medicaid Agency	Every 3 years

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification

Service Title:	Skilled Nursing

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
☒	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Skilled nursing is continuous, intermittent, or part time nursing services.

- Services include nurse delegation services provided by a registered nurse, including the initial visit, follow-up instruction, and/or supervisory visits.
- Services listed in the plan of care must be within the scope of the State's Nurse Practice Act.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The following limitations apply to receipt of skilled nursing services:

- Skilled nursing services require prior approval by DDD.
- The department and the treating professional determine the need for and amount of service.

The department reserves the right to require a second opinion by a department-selected provider.

The hourly rate for skilled nursing services is negotiated by DDD regional staff on a provider-specific basis. All payments are made directly from the DDD to the provider of service.

Provider Specifications

Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
	LPN Skilled Nursing (Individual Provider)		LPN Skilled Nursing (Agency Provider)	
	RN Skilled Nursing (Individual Provider)		RN Skilled Nursing (Agency Provider)	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
LPN Skilled Nursing (Individual Provider))	Chapter 246-840 WAC (Department of Health-DOH-administrative code concerning requirements for practical and registered nursing)		Contract Standards
RN Skilled Nursing (Individual Provider)	Chapter 246-840 WAC (DOH administrative code concerning requirements for practical and registered nursing)		Contract Standards
LPN Skilled Nursing (Agency Provider)	Chapter 246-840 WAC (DOH administrative code concerning requirements for practical and registered nursing)		Contract Standards
RN Skilled Nursing (Agency Provider)	Chapter 246-840 WAC (DOH administrative code concerning requirements for practical and registered nursing)		Contract Standards

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
LPN Skilled Nursing (Individual Provider))	Medicaid Agency	Every 3 years
RN Skilled Nursing (Individual Provider)	Medicaid Agency	Every 3 years
LPN Skilled Nursing (Agency Provider)	Medicaid Agency	Every 3 years

RN Skilled Nursing (Agency Provider)	Medicaid Agency	Every 3 years

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification	
Service Title:	Sexual Deviancy Evaluation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
☒	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Sexual deviation evaluations are professional evaluations of sexual deviancy to determine the need for psychological, medical or therapeutic services. Sexual deviancy evaluations are available in all four waivers.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

State regulations stipulate that:

(1) General considerations in evaluating clients. Providers shall:

(a) Be knowledgeable of assessment procedures used;

(b) Be aware of the strengths and limitations of self-report and make reasonable efforts to verify information provided by the offender;

(c) Be knowledgeable of the client's legal status including any court orders applicable. Have a full understanding of the SSOSA and SSODA process and be knowledgeable of relevant criminal and legal considerations;

(d) Be impartial; provide an objective and accurate base of data; and

(e) Avoid addressing or responding to referral questions which exceed the present level of knowledge in the field or the expertise of the evaluator.

(2) Scope of assessment data.

Comprehensive evaluations under SSOSA and SSODA shall include a compilation of data from as many sources as reasonable, appropriate, and available. These sources may include but are not limited to:

(a) Collateral information (i.e., police reports, child protective services information, criminal correctional history and victim statements);

(b) Interviews with the offender;

(c) Interviews with significant others;

(d) Previous assessments of the offender conducted (i.e., medical, substance abuse, psychological and sexual deviancy);

(e) Psychological/physiological tests;

(f) If a report fails to include information specified in (a) through (e) of this subsection, the evaluation should indicate the information not included and cite the reason the information is not included; and

(g) Second evaluations shall state whether other evaluations were considered. The decision regarding use of other evaluations prior to conducting the second evaluation is within the professional discretion of the provider. The second evaluation need not repeat all assessment or data compilation measures if it reasonably relies on existing current information. The second evaluation must address all issues outlined in subsection (3) of this section, and include conclusions, recommendations and a treatment plan if one is recommended.

(3) Evaluation reports.

(a) Written reports shall be accurate, comprehensive and address all of the issues required for court

disposition as provided in the statutes governing SSOSA and SSODA;

(b) Written reports shall present all knowledge relevant to the matters at hand in a clear and organized manner;

(c) Written reports shall include the referral sources, the conditions surrounding the referral and the referral questions addressed; and

(d) Written reports shall state the sources of information utilized in the evaluation. The evaluation and written report shall address, at a minimum, the following issues:

(i) A description of the current offense(s) including, but not limited to, the evaluator's conclusion about the reasons for any discrepancy between the official and offender's versions of the offenses;

(ii) A sexual history, sexual offense history and patterns of sexual arousal/preference/interest;

(iii) Prior attempts to remediate and control offense behavior including prior treatment;

(iv) Perceptions of significant others, when appropriate, including their ability and/or willingness to support treatment efforts;

(v) Potentiators of offending behavior to include alcohol and drug abuse, stress, mood, sexual patterns, use of pornography, and social and environmental influences;

(vi) A personal history to include medical, marital/relationships, employment, education and military;

(vii) A family history;

(viii) History of violence and/or criminal behavior;

(ix) Mental health functioning to include coping abilities, adaptational styles, intellectual functioning and personality attributes; and

(x) The overall findings of psychological/physiological/medical assessment when such assessments have been conducted.

(e) Conclusions and recommendations shall be supported by the data presented in the body of the report and include:

(i) The evaluator's conclusions regarding the appropriateness of community treatment;

(ii) A summary of the clinician's diagnostic impressions;

(iii) A specific assessment of relative risk factors, including the extent of the offender's dangerousness in the community at large;

(iv) The client's amenability to outpatient treatment and conditions of treatment necessary to maintain a safe treatment environment.

(f) Proposed treatment plan shall be described in detail and clarity and include:

(i) Anticipated length of treatment, frequency and type of contact with providers, and supplemental or adjunctive treatment;

(ii) The specific issues to be addressed in treatment and a description of planned treatment interventions including involvement of significant others in treatment and ancillary treatment activities;

(iii) Recommendations for specific behavioral prohibitions, requirements and restrictions on living conditions, lifestyle requirements, and monitoring by family members and others that are necessary to the treatment process and community safety;

(iv) Proposed methods for monitoring and verifying compliance with the conditions and prohibitions of the treatment program; and

(v) If the evaluator will not be providing treatment, a specific certified provider should be identified to the court. The provider shall adopt the proposed treatment plan or submit an alternative treatment plan for approval by the court, including each of the elements in WAC 246-930-330 (5)(a) through (d) (DOH administrative code concerning standards and documentation of treatment).

(4) The provider shall submit to the court and the parties a statement that the provider is either adopting the proposed treatment plan or submitting an alternate plan. The plan and the statement shall be provided to the court before sentencing.

Rates for sexual deviancy evaluation services are provider-specific as negotiated by DDD regional staff. All payments are made directly from the DDD to the provider of the evaluation.

Provider Specifications

Provider Category(s) *(check one or both)*:	☒	Individual. List types:	☐	Agency. List the types of agencies:
	Certified Sex Offender Treatment Provider (Individual Provider)			
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Certified Sex Offender Treatment Provider (Individual Provider)		Chapter 246-930 WAC DOH administrative code concerning requirements for sex offender treatment providers)	Contract Standards

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Certified Sex Offender Treatment Provider (Individual Provider)	Medicaid Agency	Every 3 years

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification

Service Title:	Specialized Psychiatric Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
☒	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope):

Specialized psychiatric services are specific to the individual needs of persons with developmental disabilities who are experiencing mental health symptoms.

- Service may include any of the following:
  (a) Psychiatric evaluation,
  (b) Medication evaluation and monitoring,
  (c) Psychiatric consultation.

DDD works closely with the Mental Health Division to Prevent duplication of RSN/State Plan MH Services. DSHS's expectation is that any DDD eligible client who meets the Mental Health division's access to care and medical necessity standards will receive mental health services through Regional Support Networks (RSNs) or

Prepaid Inpatient Health Plans (PIHP). Individuals that do not meet access to care or medical necessity standards for the service type may be served under the crisis prevention and intervention contracts.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Specialized psychiatric services are excluded if they are available through other Medicaid programs.

The rates for specialized psychiatric services are negotiated by DDD regional staff on a client-specific basis. All payments are made directly from the DDD to the provider of specialized psychiatric services.

Provider Specifications

Provider Category(s) *(check one or both)*:	☒	Individual. List types:	☐	Agency. List the types of agencies:
		Advanced Registered Nurse Practitioner (Individual Provider)		Advanced Registered Nurse Practitioner (Agency Provider)
		Physician Assistant (Individual Provider)		Physician Assistant (Agency Provider)
		Psychiatrist (Individual Provider)		Psychiatrist (Agency Provider)

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Advanced Registered Nurse Practitioner (Individual Provider)	RCW 18.79.050 (State law concerning "Advanced registered nursing practice" and exceptions)		Contract Standards
Physician Assistant (Individual Provider)	Chapter 18.71A RCW (State law concerning requirements for Physician Assistants)		Contract Standards
Psychiatrist (Individual Provider)	Chapter 18.71 RCW (State law concerning requirements for Physicians)		Contract Standards
Advanced Registered Nurse Practitioner (Agency Provider)	RCW 18.79.050 (State law concerning "Advanced registered nursing practice" and exceptions)		Contract Standards

Physician Assistant (Agency Provider)	Chapter 18.71A RCW (State law concerning requirements for Physician Assistants)		Contract Standards
Psychiatrist (Agency Provider)	Chapter 18.71 RCW (State law concerning requirements for Physicians)		Contract Standards

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Advanced Registered Nurse Practitioner (Individual Provider)	Medicaid Agency	Every 3 years
Physician Assistant (Individual Provider)	Medicaid Agency	Every 3 years
Psychiatrist (Individual Provider)	Medicaid Agency	Every 3 years
Advanced Registered Nurse Practitioner (Agency Provider)	Medicaid Agency	Every 3 years
Physician Assistant (Agency Provider)	Medicaid Agency	Every 3 years
Psychiatrist (Agency Provider)	Medicaid Agency	Every 3 years

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification

Service Title:	Mental Health Stabilization

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
☒	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Mental health stabilization services assist persons who are experiencing a mental health crisis. These services are available to adults determined by mental health professionals or DDD to be at risk of institutionalization in a psychiatric hospital without one or more of the following services:

Behavior management and consultation:
(1)Includes the development and implementation of programs designed to support waiver participants using:
a) Strategies for effectively relating to caregivers and other people in the waiver participant's life; and
b) Direct interventions with the person to decrease aggressive, destructive, and sexually inappropriate or other behaviors that compromise their ability to remain in the community (i.e., training, specialized cognitive counseling).

Skilled nursing services:
(1) Are continuous, intermittent, or part time nursing services.
a) Services include nurse delegation services provided by a registered nurse, including the initial visit, follow-up instruction, and/or supervisory visits.
b) Services listed in the plan of care must be within the scope of the State's Nurse Practice Act.
(Skilled nursing removed as a Mental Health Stabilization Service effective 1/1/10.)

Specialized psychiatric services:
(1) Are specific to the individual needs of persons with developmental disabilities who are experiencing mental health symptoms.

(2) Service may be any of the following:
a) Psychiatric evaluation,
b) Medication evaluation and monitoring,
c) Psychiatric consultation.

Mental health crisis diversion bed services:
Are temporary residential and behavioral services that may be provided in a client's home or licensed or certified setting. These services are available to eligible clients who are at risk of serious decline of mental functioning and who have been determined to be at risk of psychiatric hospitalization.

DDD works closely with the Mental Health Division to Prevent duplication of RSN/State Plan MH Services. DSHS's expectation is that any DDD eligible client who meets the Mental Health division's access to care and medical necessity standards will receive mental health services through Regional Support Networks (RSNs) or Prepaid Inpatient Health Plans (PIHP). Individuals that do not meet access to care or medical necessity standards for the service type may be served under the crisis prevention and intervention contracts.

Some Crisis diversion bed services are provided in Adult Residential Treatment facilities, one of which is an IMD. The services claimed under the waiver have their own statement of work and are provided separately from services provided to IMD residents.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

- Mental health stabilization services are intermittent and temporary.
- The duration and amount of services needed to stabilize the individual in crisis is determined by a mental health professional and/or DDD.
- Mental health stabilization services require prior approval by DDD or its designee.

Rates for **behavior management and consultation** as a component of mental health stabilization services are negotiated by DDD regional staff with the Regional Support Network (RSN) and/or individual providers. Payments are made from the DDD to the RSN or individual provider of service.

Rates for **skilled nursing services** as a component of mental health stabilization services are negotiated by DDD regional staff with the Regional Support Network (RSN) and/or individual providers. Payments are made from the DDD to the RSN or individual provider of service.

(Skilled nursing removed as a Mental Health Stabilization Service effective 1/1/10.)

Rates for **specialized psychiatric services** as a component of mental health stabilization services are negotiated by DDD regional staff with the Regional Support Network (RSN) and/or individual providers. Payments are made from the DDD to the RSN or individual provider of service.

Rates for **mental health crisis diversion bed services** as a component of mental health stabilization services are negotiated by DDD regional staff with the Regional Support Network (RSN) and/or individual providers. Payments are made from the DDD to the RSN or individual provider of service.

Provider Specifications		
Provider Category(s) *(check one or both)*:	☒ Individual. List types:	☒ Agency. List the types of agencies:
	Behavior Management and Consultation (Individual Provider)	**Behavior Management** (Agency Provider)
	o Marriage and family therapist	o Any agency that employees an individual with the qualifications listed under individual provider types
	o Mental health counselor	
	o Psychologist	
	o Sex offender treatment provider	
	o Social worker	
	o Registered nurse (RN) or licensed practical nurse (LPN)	
	o Psychiatrist	
	o Psychiatric advanced registered nurse practitioner (ARNP)	
	o Physician assistant working under the supervision of a psychiatrist	
	o Registered or certified counselor	
	o Polygrapher	
	o Behavior Management Provider with 5 years of experience serving individuals with developmental disabilities	
	Skilled Nursing (Individual Provider) (removed as a Mental Health Stabilization Service effective 1/1/10.)	**Skilled Nursing** (Agency Provider)(removed as a Mental Health Stabilization Service effective 1/1/10.)
	o LPN Skilled Nursing	o LPN Skilled Nursing

	o RN Skilled Nursing	o RN Skilled Nursing
	Specialized Psychiatric Services (Individual Provider)	**Specialized Psychiatric Services (Agency Provider)**
	o Advanced Registered Nurse Practitioner	o Advanced Registered Nurse Practitioner
	o Physician Assistant	o Physician Assistant
	o Psychiatrist	o Psychiatrist
		Mental Health Crisis Diversion Bed Services (Agency Provider)
		o Mental Health Stabilization- Mental health crisis diversion bed services (Supported Living Agency)
		o Mental Health Stabilization- Mental health crisis diversion bed services (Other department-licensed or certified agencies)

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Behavior Management and Consultation Services			
Marriage and family therapist	Chapter 246-809 WAC (Department of Health-DOH-administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)		Contract Standards
Mental health counselor	Chapter 246-809 WAC (DOH administrative code concerning licensure for mental	Chapter 246-810 WAC (DOH administrative code concerning requirements for Counselors)	Contract Standards

	health counselors, marriage and family therapists, and social workers)		
Psychologist	Chapter 246-924 WAC (DOH administrative code concerning requirements for Psychologists)		Contract Standards
Sex offender treatment provider		Chapter 246-930 WAC (DOH administrative code concerning requirements for Sex Offender Treatment Providers)	Contract Standards
Social worker	Chapter 246-809 WAC (DOH administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)		Contract Standards
Registered nurse (RN) or licensed practical nurse (LPN)	Chapter 246-840 WAC (DOH administrative code concerning requirements for Practical and Registered Nursing)		Contract Standards
Psychiatrist	Chapter 18.71 RCW (DOH administrative code concerning requirements for Physicians)		Contract Standards
Psychiatric advanced registered nurse practitioner (ARNP)	RCW 18.79.050 (DOH administrative		Contract Standards

	code concerning requirements for "Advanced registered nursing practice" and exceptions)		
Physician assistant working under the supervision of a psychiatrist	Chapter 18.71A RCW (State law concerning requirements for Physician Assistants)		Contract Standards
Registered or certified counselor	Chapter 246-810 WAC (DOH administrative code concerning requirements for counselors)	Chapter 246-810 WAC (DOH administrative code concerning requirements for counselors)	Contract Standards
Polygrapher			Contract Standards
Behavior Management Provider with 5 years of experience serving individuals with developmental disabilities			Five years experience serving individuals with Developmental Disabilities. Contract Standards
Behavior Management Agency Provider			An agency could employee any of the provider types listed above and the employees must meet the qualifications listed. Contract Standards
Skilled Nursing Services (Removed as a Mental Health Stabilization Service effective 1/1/10.)			
LPN Skilled Nursing (Individual Provider))	Chapter 246-840 WAC (DOH administrative code concerning requirements for practical and registered nursing)		Contract Standards
RN Skilled Nursing (Individual Provider)	Chapter 246-840 WAC (DOH administrative code concerning		Contract Standards

	requirements for practical and registered nursing)		
LPN Skilled Nursing (Agency Provider)	Chapter 246-840 WAC (DOH administrative code concerning requirements for practical and registered nursing)		Contract Standards
RN Skilled Nursing (Agency Provider)	Chapter 246-840 WAC (DOH administrative code concerning requirements for practical and registered nursing)		Contract Standards
Specialized Psychiatric services			
Advanced Registered Nurse Practitioner (Individual Provider)	RCW 18.79.050 (State law concerning "Advanced registered nursing practice" and exceptions)		Contract Standards
Physician Assistant (Individual Provider)	Chapter 18.71A RCW (State law concerning requirements for Physician Assistants)		Contract Standards
Psychiatrist (Individual Provider)	Chapter 18.71 RCW (State law concerning requirements for Physicians)		Contract Standards
Advanced Registered Nurse Practitioner (Agency Provider)	RCW 18.79.050 (State law concerning "Advanced registered nursing practice" and exceptions)		Contract Standards
Physician Assistant (Agency Provider)	Chapter 18.71A RCW (State law		Contract Standards

	concerning requirements for Physician Assistants)		
Psychiatrist (Agency Provider)	Chapter 18.71 RCW (State law concerning requirements for Physicians)		Contract Standards
Mental Health Crisis Diversion Bed Services			
Mental Health Stabilization- Mental health crisis diversion bed services (Supported Living Agency)		Chapter 388-101 WAC (ADSA administrative code concerning requirements for certified community residential services and Support)	DDD Policy 15.04 (concerning standards for community protection residential services, applicable only if they serve CP clients). Contract Standards
Mental Health Stabilization- Mental health crisis diversion bed services (Other department-licensed or certified agencies)	Chapter 246-337 WAC (DOH administrative code concerning requirements for Adult Residential Treatment Facilities)	Chapter 388-101 WAC (ADSA administrative code concerning requirements for certified community residential services and support) Chapter 246-337 WAC (DOH administrative code concerning requirements for Adult Residential Treatment Facilities)	Contract Standards

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Behavior Management and Consultation Services		
Marriage and family	Medicaid Agency	Every 3 years

therapist		
Mental health counselor	Medicaid Agency	Every 3 years
Psychologist	Medicaid Agency	Every 3 years
Sex offender treatment provider	Medicaid Agency	Every 3 years
Social worker	Medicaid Agency	Every 3 years
Registered nurse (RN) or licensed practical nurse (LPN)	Medicaid Agency	Every 3 years
Psychiatrist	Medicaid Agency	Every 3 years
Psychiatric advanced registered nurse practitioner (ARNP)	Medicaid Agency	Every 3 years
Physician assistant working under the supervision of a psychiatrist	Medicaid Agency	Every 3 years
Registered or certified counselor	Medicaid Agency	Every 3 years
Polygrapher	Medicaid Agency	Every 3 years
Behavior Management Provider with 5 years of experience serving individuals with developmental disabilities	Medicaid Agency	Every 3 years
Behavior Management Agency Provider	Medicaid Agency	Every 3 years
Skilled Nursing Services (Removed as a Mental Health Stabilization Service effective 1/1/10.)		
LPN Skilled Nursing (Individual Provider))	Medicaid Agency	Every 3 years
RN Skilled Nursing (Individual Provider)	Medicaid Agency	Every 3 years
LPN Skilled Nursing (Agency Provider)	Medicaid Agency	Every 3 years
RN Skilled Nursing (Agency Provider)	Medicaid Agency	Every 3 years
Specialized Psychiatric Services		
Advanced Registered Nurse Practitioner	Medicaid Agency	Every 3 years

(Individual Provider)		
Physician Assistant (Individual Provider)	Medicaid Agency	Every 3 years
Psychiatrist (Individual Provider)	Medicaid Agency	Every 3 years
Advanced Registered Nurse Practitioner (Agency Provider)	Medicaid Agency	Every 3 years
Physician Assistant (Agency Provider)	Medicaid Agency	Every 3 years
Psychiatrist (Agency Provider)	Medicaid Agency	Every 3 years
Mental Health Crisis Diversion Bed Services		
Mental Health Stabilization- Mental health crisis diversion bed services (Supported Living Agency)	Medicaid Agency	Every two years
Mental Health Stabilization- Mental health crisis diversion bed services (Other department-licensed or certified agencies)	Medicaid Agency	Every year

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification	
Service Title:	Occupational Therapy
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
☒	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
State law stipulates: "Occupational therapy" is the scientifically based use of purposeful activity with individuals who are limited by physical injury or illness, psychosocial dysfunction, developmental or learning disabilities, or the aging process	

in order to maximize independence, prevent disability, and maintain health. The practice encompasses evaluation, treatment, and consultation. Specific occupational therapy services include but are not limited to: Using specifically designed activities and exercises to enhance neurodevelopmental, cognitive, perceptual motor, sensory integrative, and psychomotor functioning; administering and interpreting tests such as manual muscle and sensory integration; teaching daily living skills; developing prevocational skills and play and avocational capabilities; designing, fabricating, or applying selected orthotic and prosthetic devices or selected adaptive equipment; and adapting environments for the handicapped. These services are provided individually, in groups, or through social systems.

State law stipulates:
"Occupational Therapy" services must be provided by a person licensed to provide Occupational Therapy in the State of Washington. These requirements are comparable to the qualifications specified in 42 CFR 440.110 (concerning physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders).

Occupational therapy is covered under the waiver as an extended state plan service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

- Additional therapy may be authorized as a waiver service only after an individual has accessed what is available to her/him under Medicaid and any other private health insurance plan.
- The department does not pay for treatment determined by DSHS to be experimental;
- The department and the treating professional determine the need for and amount of service an individual can receive:
  - The department reserves the right to require a second opinion from a department-selected provider.
  - The department will require evidence that the individual has accessed their full benefits through Medicaid and private insurance before authorizing this waiver service.

Unit rates for occupational therapy are negotiated by DDD regional staff on a provider-specific basis. All payments are made directly from the DDD to the provider of service.

Provider Specifications

Provider Category(s) *(check one or both)*:	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Occupational Therapist (Individual Provider)		Occupational Therapist (Agency Provider)	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Occupational Therapist (Individual Provider)	RCW 18.59.050 (State law concerning licensure		RCW 18.59.060 (State law concerning examination requirements for occupational therapists)

	requirements for occupational therapists) Chapter 246-847 WAC (Department of Health-DOH-administrative code concerning requirements for occupational therapists)		Contract Standards.
Occupational Therapist (Agency Provider)	RCW 18.59.050 (State law concerning licensure requirements for occupational therapists) Chapter 246-847 WAC (Department of Health-DOH-administrative code concerning requirements for occupational therapists)		RCW 18.59.060 (State law concerning examination requirements for occupational therapists) Contract Standards

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Occupational Therapist (Agency Provider)	Medicaid Agency	Every three years
Occupational Therapist (Agency Provider)	Medicaid Agency	Every three years

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification

Service Title:	Speech, Hearing and Language

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
☒	Service is included in approved waiver. The service specifications have been modified.

○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Speech, hearing and language services are services provided to individuals with speech hearing and language disorders by or under the supervision of a speech pathologist or audiologist.

State law stiuplates:
"Speech-language pathology" means the application of principles, methods, and procedures related to the development and disorders, whether of organic or nonorganic origin, that impede oral, pharyngeal, or laryngeal sensorimotor competencies and the normal process of human communication including, but not limited to, disorders and related disorders of speech, articulation, fluency, voice, verbal and written language, auditory comprehension, cognition/communication, and the application of augmentative communication treatment and devices for treatment of such disorders

"Audiology" means the application of principles, methods, and procedures related to hearing and the disorders of hearing and to related language and speech disorders, whether of organic or nonorganic origin, peripheral or central, that impede the normal process of human communication including, but not limited to, disorders of auditory sensitivity, acuity, function, processing, or vestibular function, the application of aural habilitation, rehabilitation, and appropriate devices including fitting and dispensing of hearing instruments, and cerumen management to treat such disorders.

State law stipulates:
"Speech-language pathology" and "Audiology" services must be provided by a person licensed to provide these services in the State of Washington. These requirements are comparable to the qualifications specified in 42 CFR 440.110 (concerning physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders).

Speech, hearing and language services are covered under the waiver as an extended state plan service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

- Additional therapy may be authorized as a waiver service only after an individual has accessed what is available to her/him under Medicaid and any other private health insurance plan;
- The department does not pay for treatment determined by DSHS to be experimental;
- The department and the treating professional determine the need for and amount of service an individual can receive:
  - The department reserves the right to require a second opinion from a department-selected provider.
  - The department will require evidence that the individual has accessed their full benefits through Medicaid and private insurance before authorizing this waiver service.

Unit rates for speech, hearing and language services are negotiated by DDD regional staff on a provider-specific basis. All payments are made directly from the DDD to the provider of service.

Provider Specifications

Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
		Speech-Language Pathologist (Individual Provider)		Speech-Language Pathologist (Agency Provider)
		Audiologist (Individual Provider)		Audiologist (Agency Provider)

Specify whether the service may be provided by *(check each that*	☐	Legally Responsible Person	☒	Relative/Legal Guardian

applies):				

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Speech-Language Pathologist (Individual Provider)	RCW 18.35.080 (State law concerning certificates and licensure for speech-language pathologists and audiologists)	WAC 246-828-105 (Department of Health-DOH-administrative code concerning speech-language pathology—Minimum standards of practice.)	RCW 18.35.040 (State law concerning licensure and examination for speech-language pathologists and audiologists). Contract Standards
Audiologist (Individual Provider)	RCW 18.35.080 (State law concerning certificates and licensure for speech-language pathologists and audiologists)	WAC 246-828-095 (DOH administrative code concerning audiology minimum standards of practice.)	RCW 18.35.040 (State law concerning licensure and examination for speech-language pathologists and audiologists). Contract Standards
Speech-Language Pathologist (Agency Provider)	RCW 18.35.080 (State law concerning certificates and licensure for speech-language pathologists and audiologists)	WAC 246-828-105 (DOH administrative code concerning speech-language pathology—minimum standards of practice.)	RCW 18.35.040 (State law concerning licensure and examination for speech-language pathologists and audiologists). Contract Standards
Audiologist (Agency Provider)	RCW 18.35.080 (State law concerning certificates and licensure for speech-language pathologists and audiologists)	WAC 246-828-095 (DOH administrative code concerning audiology minimum standards of practice.)	RCW 18.35.040 (State law concerning licensure and examination for speech-language pathologists and audiologists). Contract Standards

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Speech-Language Pathologist (Individual Provider)	Medicaid Agency	Every three years
Audiologist (Individual Provider)	Medicaid Agency	Every three years
Speech-Language Pathologist (Agency	Medicaid Agency	Every three years

Provider)		
Audiologist (Agency Provider)	Medicaid Agency	Every three years

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification	
Service Title:	Physical Therapy
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
☒	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

State law stipulates:
"Physical Therapy" means the treatment of any bodily or mental condition of a person by the use of the physical, chemical, or other properties of heat, cold, air, light, water, electricity, sound massage, and therapeutic exercise, which includes posture and rehabilitation procedures; the performance of tests and measurements of neuromuscular function as an aid to the diagnosis or treatment of any human condition; performance of treatments on the basis of test findings after consultation with and periodic review by an authorized health care practitioner.

State law stipulates:
"Physical Therapy" services must be provided by a person licensed to provide this service in the State of Washington. These requirements are comparable to the qualifications specified in 42 CFR 440.110 (concerning physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders).

Physical therapy is covered under the waiver as an extended state plan service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

- Additional therapy may be authorized as a waiver service only after an individual has accessed what is available to her/him under Medicaid and any other private health insurance plan;
- The department does not pay for treatment determined by DSHS to be experimental;
- The department and the treating professional determine the need for and amount of service an individual can receive:
    - The department reserves the right to require a second opinion from a department-selected provider.
    - The department will require evidence that the individual has accessed their full benefits through Medicaid and private insurance before authorizing this waiver service.

Unit rates for physical therapy are negotiated by DDD regional staff on a provider-specific basis. All payments are made directly from the DDD to the provider of service.

Provider Specifications				
Provider	☒	Individual. List types:	☒	Agency. List the types of agencies:

Category(s) *(check one or both)*:	Physical Therapist (Individual Provider)	Physical Therapist (Agency Provider)

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Physical Therapist (Individual Provider)	**RCW 18.74.035** (State law concerning examination for a physical therapy license) RCW 18.74.040 (State law concerning licensure of physical therapists) Chapter 246-915 WAC (DOH administrative code concerning requirements for Physical Therapists)		**RCW 18.74.030** (State law concerning minimum qualification to apply for licensure as a physical therapist). Contract Standards
Physical Therapist (Agency Provider)	**RCW 18.74.035** (State law concerning examination for a physical therapy license) RCW 18.74.040 (State law concerning licensure of physical therapists) Chapter 246-915 WAC (DOH administrative		**RCW 18.74.030** (State law concerning minimum qualification to apply for licensure as a physical therapist). Contract Standards

	code concerning requirements for Physical Therapists)		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Physical Therapist (Individual Provider)	Medicaid Agency	Every three years
Physical Therapist (Agency Provider)	Medicaid Agency	Every three years

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☒	Provider managed

Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies).*

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; and, (f) how participants are notified of the amount of the limit.

☐	**Limit(s) on Set(s) of Services**. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. *Furnish the information specified above.*
☐	**Prospective Individual Budget Amount**. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above.*
☐	**Budget Limits by Level of Support**. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above.*
☐	**Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.*
☒	**Not applicable.** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Individual Support Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(check each that applies)*:

☐	Registered nurse, licensed to practice in the State
☐	Licensed practical or vocational nurse, acting within the scope of practice under State law
☐	Licensed physician (M.D. or D.O)
☒	Case Manager (qualifications specified in Appendix B-6-c)
☐	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
☐	Social Worker. *Specify qualifications:*
☐	Other (*specify the individuals and their qualifications):*

b. Service Plan Development Safeguards. *Select one:*

☒	Entities and/or individuals that have responsibility for service plan development *may not provide* other direct waiver services to the participant.
○	Entities and/or individuals that have responsibility for service plan development *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Approximately 60 days prior to the Individual Support Plan the CRM contacts the individual and his/her representative by phone and letter.

During the phone conversation the CRM describes the Individual Support Plan process and confirms per policy 5.02 (Necessary Supplemental Accommodation) the individual has an identified representative. In addition, the individual is asked who else they would like to have participate and/or contribute.

The letter the CRM sends confirms the date and time of the meeting and includes the DDD HCBS Waiver Brochure. The DDD HCBS Waiver Brochure includes information about services, eligibility criteria and fair hearing rights. The CRM also extends invitations by phone and/or letter to individuals who are asked to participate in the ISP process.

Everyone involved in services and supports identified on the ISP is involved in the development of the plan. In those cases where a waiver participant does not want a particular family member or provider at a planning meeting the CRM explores why. A participant's refusal to have a provider involved in the planning meeting is always considered a red flag for investigation.

d. Service Plan Development Process In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

DDD will implement a new assessment and planning tool June 1, 2007. DDD will maintain current practice through May 31, 2007. The current service plan is referred to as the Plan of Care (POC). When DDD implements the new DDD Assessment the service plan will be referred to as the Individual Service Plan (ISP). Please see below for an explanation of both our current process and the process that will be implement June 1, 2007.

Current Plan of Care process
April 1, 2006-May 31, 2007

(a) Who develops the plan, who participates in the process, and the timing of the plan

- The Plan of Care (POC) is developed by the DDD CRM/ Social Worker.
- Participants or contributors to this plan consist of:
  - The individual,
  - Their legal representative (if applicable),
  - Providers, and
  - Anyone else the individual would like to have participate or contribute (family, friends, etc…)
- The POC is completed at least once every 12 months. Planning for the POC begins 60 days in advance of the due date.

(b) The types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status

- The current POC is a paper tool administered by the DDD CRM/Social Worker. The POC includes a "Current Support Needs Assessment". The "Current Support Needs Assessment" identifies client health and welfare needs and determines the need for ICF/MR LOC. The POC tool documents client preferences, goals and health status.
- DDD also uses external assessments as a part of the POC process. Examples of external assessments include; nursing evaluations, PT/OT reports, psychological evaluations etc.

(c) How the participant is informed of the services that are available under the waiver

Participants are informed of services available under the Waiver by:

1. The DDD HCBS Waiver Brochure is enclosed with the letter confirming the POC meeting. The letter and brochure are sent approximately 60 days prior to the POC

meeting. The DDD HCBS Waiver Brochure identifies waiver services.

2. During the course of the POC meeting service options are discussed and described.
3. The CRM/Social Worker provides a Waiver "Facts" sheet at the POC meeting which lists services available in the Waiver.
4. Washington Administrative Code (WAC) fully defines services available under the waiver and is made available upon request and via the DDD internet Website

(d) The plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences.

- Participant goals:
  - Section one of the POC "Personal Snapshots" provides participants the opportunity to express their personal goal.

- Participant needs (including health care needs):
  - Section four of the current POC tool provides participants with the opportunity to identify for themselves their health and welfare needs

- Preferences:
  - Sections four and five of the POC reflect participants preferences and requests for services.

(e) How Waiver and other services are coordinated:

Waiver and other services are coordinated by the CRM/Social Worker

- Services identified to meet health and welfare needs are documented in the POC.
- Providers receive a copy of the POC. This assists them to not only understand their role in the individual's life but also the supports others are giving.
- The CRM/ Social Worker monitors the POC to ensure health and welfare needs are being addressed as planned.

(f) How the plan development process provides for the assignment of responsibilities to implement and monitor the plan

- The assessment identifies health and welfare needs.
  - The identified needs are documented in section five of the POC.
    - CRM/Social Worker is required to address each identified health and welfare need.
  - When an identified need requires a Waiver funded service the CRM/Social Worker is required to identify the specific provider and the service type that will address this need.
    - The CRM/Social Worker is required to provide sufficient documentation to allow the provider and the participant to know what the provider responsibilities are.
  - When a provider or service has not been identified the plan reflects the steps in place to identify either the service or the provider.
    - When the service or provider is identified the POC is amended to reflect the updated plan.
- The CRM/Social Worker provides oversight and monitoring of the POC.

(g) How and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable)

- Per WAC 388-845-3075:
    - An individual may request a review of his/her plan of care at any time by calling his/her case manager. If there is a significant change in conditions or circumstances, DDD must reassess the plan and amend the plan to reflect any significant changes. This reassessment does not affect the end date of the annual POC.
- Updates or amendments to the POC are maintained in the client file.
    - Amendments do not change the Plan Effective date.

Individual Service Plan process to be implemented June 1, 2007

This new assessment and planning tool will be used to assess all DDD clients. The Individual Support Plan (ISP) is the planning document produced for all clients receiving paid services, including waiver clients.

The DDD Assessment provides:

- An integrated, comprehensive tool to measure support needs for adults and children.
- An improved work process to support case management services because the system:
    - Identifies the level of support needed by a client;
    - Indicates whether a service level assessment is needed; and
    - Identifies a level of service to support the client's assessed need.
- Detailed information is gathered regarding client needs in many life domains. This allows CRM's to make more effective service referrals.
- An improved planning process because health and welfare needs identified in the assessment automatically populate the ISP as needs that must be addressed.
- Clearer information for executive management and legislators on the overall needs of people with developmental disabilities.
- A nationally normed assessment for adults developed by the AAMR.

(a) Who develops the plan, who participates in the process, and the timing of the plan

- The Individual Support Plan (ISP) is developed by the DDD CRM/ Social Worker.
- Participants or contributors to this plan consist of:
    - The individual,
    - Their legal representative (if applicable),
    - Providers, and
    - Anyone else the individual would like to have participate or contribute (family, friends, etc…)
- The ISP is completed at least once every 12 months. Planning for the ISP begins 60 days in advance of the due date.

(b) The types of assessments that are conducted to support the service plan

development process, including securing information about participant needs, preferences and goals, and health status

- The DDD Assessment which is administered by the DDD CRM/Social Worker provides the internal assessment and contains the following modules which assess for participant needs preferences, goals and health status:
    1. The Support Assessment module contains:
        a. The Supports Intensity Scale Assessment (which includes the ICF/MR Level of Care for individuals age 16 and above);
        b. ICF/MR Level of Care Assessment for individual age 15 and under;
        c. Protective Supervision Scale;
        d. Caregiver Status Scale;
        e. Current Services Scale;
        f. SIS Behavior Scale; and
        g. SIS Medical Scale.

    2. The Service Level Assessment module contains:
        a. Personal Care assessment tool;
        b. Employment Support Assessment tool;
        c. Sleep Assessment tool; and
        d. Mental Health Assessment tool;
        e. Equipment tool;
        f. Medication Management tool;
        g. Medication tool;
        h. Seizure & allergies tool.

    3. The Individual Support Plan module contains:
        a. Service Summary tool;
        b. Support Needs tool;
        c. Finalize Plan tool;
        d. Environmental Plan tool;
        e. Equipment tool;
        f. DDD Referral tool;
        g. Plan review tool;
        h. Supported Living Rate Calculator;
        i. Foster Care Rate Assessment Calculator.

- DDD also uses external assessments as a part of the ISP process. Examples of external assessments include; nursing evaluations, PT/OT reports, psychological evaluations etc.

(c) How the participant is informed of the services that are available under the waiver

Participants are informed of services available under the Waiver by:

5. The DDD HCBS Waiver Brochure is enclosed with the letter confirming the ISP meeting. The letter and brochure are sent approximately 60 days prior to the ISP meeting. The DDD HCBS Waiver Brochure identifies waiver services.
6. During the course of the ISP meeting service options are discussed and described.
7. The CRM/Social Worker provides a Waiver "Facts" sheet at the ISP meeting which lists services available in the Waiver.
8. Washington Administrative Code (WAC) fully defines services available under the waiver and is made available upon request and via the DDD internet Website

(d) The plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences.

- Participant goals:
  - There is a screen in the DDD assessment that allows for the documentation of participant goals.
- Participant needs (including health care needs):
  - Health and welfare needs are identified throughout the course of the assessment on multiple screens (please see section b above). Health and welfare needs are also identified by additional documentation submitted as part of the ISP process (i.e. medical reports).
- Preferences:
  - Participant preferences are identified as requests for service. This is documented in the body of the assessment as well as in the ISP.

(e) How Waiver and other services are coordinated:

Waiver and other services are coordinated by the CRM/Social Worker

- Services identified to meet health and welfare needs are documented in the ISP.
- Providers receive a copy of the ISP. This assists them to not only understand their role in the individual's life but also the supports others are giving.
- The CRM/ Social Worker monitors the ISP to ensure health and welfare needs are being addressed as planned.

(f) How the plan development process provides for the assignment of responsibilities to implement and monitor the plan

- The assessment identifies health and welfare needs.
  - The identified needs populate the ISP.
    - Business rules require each identified need is addressed.
  - When an identified need requires a Waiver funded service the CRM/Social Worker is required to identify the specific provider and the service type that will address this need.
    - The CRM/Social Worker is required to provide sufficient documentation to allow the provider and the participant to know what the provider responsibilities are.
  - When a provider or service has not been identified the plan reflects the steps in place to identify either the service or the provider.
    - When the service or provider is identified the ISP is amended to reflect the updated plan.
- The CRM/Social Worker provides oversight and monitoring of the ISP.

(g) How and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable)

- Per WAC 388-845-3075:
  - An individual may request a review of his/her plan of care at any time by calling

his/her case manager. If there is a significant change in conditions or circumstances, DDD must reassess the plan and amend the plan to reflect any significant changes. This reassessment does not affect the end date of the annual ISP.

- Updates or amendments to the currently effective version of the Individual Support Plan (ISP) are tracked in the system.
  - When a Service Level Assessment is moved from Pending to Current status, the ISP version attached to that assessment will lock (so a record is kept of the version that the client/representative has signed off on).
  - Amendments do not change the Plan Effective date.

- Each subsequent change to the ISP is saved. There are two types of amendments—those that require a new Service Level Assessment and those that do not. Examples would be:

ISP Amendment With New Assessment

- Change in status of client in key domain (behavior, medical, caregiver, ADL, etc.)
- Change of provider for residential service (the client physically moves)
- Change in a paid service

ISP Amendment Without New Assessment

- Change in demographic information only
- No change in status of client in key domain
- Change of provider for non-residential service

Rate change only (e.g. roommate leaves so now only 3 clients vs. 4 clients in home)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Risk Assessment and Mitigation occurs via the DDD Assessment and ISP. The DDD assessment takes a comprehensive approach to assessing for risk and provides a mechanism for allowing the case manager and the individual to identify risks and develop a strategy to mitigate identified risk.

Health, welfare and safety needs are evaluated throughout the Support Assessment and Service Level Assessment modules in the DDD Assessment. They are then addressed in planning via formal referrals, authorized paid DDD Services and other documented support activities in the ISP.

The DDD Assessment evaluates risk by assessing for the following:

- Unstable/potentially unstable diagnosis
- Caregiver training required
- Medication regimen affecting plan
- Immobility issues affecting plan
- Nutritional status affecting plan
- Current or potential skin problems
- Skin Observation Protocol
- Alcohol/Substance Abuse

- Depression
- Suicide
- Pain
- Mental Health
- Legal
- Environmental
- Financial
- Community Protection
    - Community Protection criteria have been developed to identify clients not already on the CP waiver, but who are exhibiting some extreme behaviors that could pose a public safety threat.

When risk areas are identified they populate a "referral" screen in the ISP. The CRM documents the plan/response to each item that populates the referral screen.

Back-up plans are an expected component of the ISP. Back up plans and emergency plans are required in WAC for all residential providers. Arrangements for back-up plans vary from individual to individual. In some situations a back-up plan may be a family member. In others, a back up plan may include a paid provider stepping in to assure health and welfare needs are addressed during times of crisis. The client always has the choice of an ICF/MR if he/she feels needs are not being met in the community.

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Participants will be given free choice of all qualified/approved providers of each service approved in his/her plan. During the course of the ISP process the participant is advised they have a choice of providers. A part of the ISP document includes a checklist that the client and/or their representative sign. One of the items on the checklist is a statement verifying that a choice of qualified providers was given.

CRMs facilitate access to provider lists and assist with the contracting process.
In addition the following resources are available:

- Lists of provider of specific services can be generated out of the Agency Contracts Data Base (ACD) maintained by DSHS.

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

DSHS/DDD is the Waiver operating agency and the Medicaid Agency. The CRMs are employees of DDD. These workers prepare and approve each ISP.

DDD has a comprehensive **audit process**. In addition, DDD participates in the **National Core Indicators Survey** and initiates an **ISP survey.** Data is gathered and analyzed and necessary steps are taken to correct areas of concern.

DDD audit process:
There are three opportunities throughout the course of a year for files to be reviewed. The same standard protocol is used for each review. All files reviewed are selected by random sampling. Supervisors review one file per quarter per CRM. Quality Compliance Coordinators (QCC) review one file per month for each region. The QCC team completes an annual audit of randomly selected

files. The list for the annual QCC team audit is generated to produce a random sample with a 95% confidence level and a +/- 4 confidence interval.

The findings from these reviews are collected in a database. All findings are expected to be corrected within 90 days. Corrections are monitored by QCC. Findings are analyzed by management. Based on the analysis necessary steps are taken.
For example:

- Annual Waiver Training curriculum is developed in part to address audit findings
- Policy clarifications occur as a result of audit findings.
- Analyses of findings assist regions to recognize personnel issues.
- Analysis of audit finding may impact format and instructions on forms
- Analysis of findings has led to revision in Waiver WAC to clarify rule.
- Analysis of findings has led regions to revise regional processes.

The National Core Indicators Survey:
Washington State's Division of Developmental Disabilities (DDD) participates in a national study that assesses performance and outcome indicators for state developmental disabilities service systems. This study allows the division to compare its performance to service systems in other states and within our state from year to year.

There are currently 60 performance and outcome indicators to be assessed covering the following domains:

- Consumer Outcomes
- System Performance
- Health, Welfare, & Rights
- Service Delivery System Strength & Stability

In addition, DDD has added some waiver specific questions to assist with assuring ISPs are implemented as written and that health and welfare needs are being addressed. Findings are analyzed by management and shared with stakeholders. The Washington State Developmental Disabilities Council (DDC) participates in the survey process- both in visiting clients and analyzing results.

ISP Survey:
An ISP survey is given to each waiver participant at the conclusion of the ISP planning meeting. This survey gives participants an opportunity to respond to a series of questions about the ISP process. The survey is left behind at the end of the ISP meeting to allow for an anonymous submission to Central Office.

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. *Specify the minimum schedule for the review and update of the service plan:*

○	Every three months or more frequently when necessary
○	Every six months or more frequently when necessary
☒	Every twelve months or more frequently when necessary
○	Other schedule (*specify*):

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

☒	Medicaid agency
☒	Operating agency
☒	Case manager
☐	Other (*specify):*
	Copies of the signed ISP are kept in the client files which are maintained in the DDD regional offices. Electronic copies of the ISP are maintained on the CARE platform.

Appendix D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The regional DDD Case Resource Manager provides the primary oversight and monitoring of the ISP. The DDD Case Resource Manager authorizes the Waiver Services identified as necessary to meet health and welfare needs in the ISP. The DDD Case Resource Manager monitors service provision no less than two times per year. Service provision is monitored by one or more of the following: face to face client visits; telephone contact to the individual and their representative; contacting providers; reviewing progress reports submitted by providers and reviewing additional assessments (e.g. IEP's, psychological evaluations, Occupational Therapy evaluations etc..). If the DDD Case Resource Manager finds that the ISP is not meeting the individual's needs the ISP will be revised/amended. All monitoring is documented in the Service Episode Record section of the electronic DDD Assessment.

At the time of the annual review, the CRM is required to review the effectiveness of last year's plan with the individual and/or their legal representative. This review is a required step before the DDD Assessment will allow the CRM to create a new assessment. All plans are expected to address emergency preparedness such as: back-up caregivers, evacuation plans, what to do in case of natural disaster etc. The plan review process provides an opportunity to review the effectiveness of these plans.

In addition to DDD Case Resource Manager monitoring activities the following activities occur:

- Sampling of waiver case files are reviewed by Quality Control Coordinators and DDD supervisors.
    - Quality Control Coordinators review one file per month per region and complete an annual statewide audit of a random sample of 5% of all waiver files.
    - DDD Supervisor complete one waiver file review per DDD Case Resource Manager/Social Worker per quarter.

Specifically, waiver case files are reviewed for the following evidence:

- The ISP was completed within 12 months.
- The individual was given a choice between waiver services and institutional care.
- The client meets ICF/MR level of care.
- The client meets disability criteria.
- The client is financially eligible.
- All of the identified health and welfare needs have been addressed in the ISP.
- Services have been authorized in accordance with the service plan.
- Waiver services or appropriate monitoring activities are occurring every month.
- All authorized services are reflected in the plan.
- All providers are qualified to provide the services for which they are authorized.
- The client was given a choice of qualified providers.
- Appeal rights and procedures have been explained.

The National Core Indicators Survey (NCI) face to face interviews **:**
Washington State's Division of Developmental Disabilities (DDD) participates in a national study that

assesses performance and outcome indicators for state developmental disabilities service systems. This study allows the division to compare its performance to service systems in other states and within our state from year to year.

There are currently 60 performance and outcome indicators to be assessed covering the following domains:

- Consumer Outcomes
- System Performance
- Health, Welfare, & Rights
- Service Delivery System Strength & Stability

In addition, DDD has added some waiver specific questions to assist with assuring ISPs are implemented as written and that health and welfare needs are being addressed.

Examples of waiver specific questions:

- If you need to change your child's services, do you know what to do?
- Do the services and supports offered on your Plan of Care meet your child's and family's needs?
- Did you (did this person) receive information at your (his/her) plan of care meeting about the services and supports that are available under your (his/her) waiver?

Findings are analyzed by management and shared with stakeholders. The Washington State Developmental Disabilities Council (DDC) participates in the survey process- both in visiting clients and analyzing results.

ISP Survey:
An ISP survey is given to each waiver participant at the conclusion of the ISP planning meeting. This survey gives participants an opportunity to respond to a series of questions about the ISP process. The survey is left behind at the end of the ISP meeting to allow for an anonymous submission to Central Office.

Questions on ISP survey:

- Did your CRM ask you if you had any concerns about your current services?
- Were your concerns discussed and included in the planning process?
- Did you receive information about what services are available in your waiver to meet your assessed needs?
- Were you given a choice of services that are available in your waiver to meet your assessed needs?
- Were you given a choice of service providers?
- Did you plan to meet your needs and goals for both waiver and non-waiver services?
- Were your health and safety needs discussed?
- Were plans made to meet your health and safety needs?
- Did you plan for emergencies, such as an earthquake or if your regular provider is unavailable?
- Did you receive information on how to make a complaint or ask for a fair hearing?

Residential Care Services (RCS) certifies DDD residential providers.

- These providers are evaluated at a minimum of every two years.
- A component of the RCS evaluation process is a review of the ISP to ensure the agency is implementing the plan as written.

b. Monitoring Safeguards. *Select one:*

☒	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant.
○	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:

Appendix E: Participant Direction of Services

[NOTE: *Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.*]

Applicability *(select one)*:

○	**Yes.** This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
☒	**No.** This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction. Indicate whether Independence Plus designation is requested (select one):

○	**Yes.** The State requests that this waiver be considered for Independence Plus designation.
○	**No.** Independence Plus designation is not requested.

Appendix E-1: Overview

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

○	**Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
○	**Participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
○	**Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

☐	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
☐	Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
☐	The participant direction opportunities are available to persons in the following other living arrangements *(specify)*:

d. Election of Participant Direction. Election of participant direction is subject to the following policy (s*elect one):*

○	Waiver is designed to support only individuals who want to direct their services.
○	The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. *Specify the criteria*:

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one)*:

○		The State does not provide for the direction of waiver services by a representative.
○		The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: *(check each that applies)*:
	☐	Waiver services may be directed by a legal representative of the participant.
	☐	Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-3. *(Check the opportunity or opportunities available for each service)*:

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

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

○	**Yes**. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i)*. Specify whether governmental and/or private entities furnish these services. *Check each that applies:*
	☐ Governmental entities
	☐ Private entities
○	**No**. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i*.

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. S*elect one*:

○	FMS are covered as the waiver service entitled as specified in Appendix C-3.	
○	FMS are provided as an administrative activity. *Provide the following information:*	
	i.	**Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:
	ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:
	iii.	**Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*
		Supports furnished when the participant is the employer of direct support workers:
		☐ Assist participant in verifying support worker citizenship status
		☐ Collect and process timesheets of support workers
		☐ Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
		☐ Other *(specify):*

	Supports furnished when the participant exercises budget authority:	
	☐	Maintain a separate account for each participant's participant-directed budget
	☐	Track and report participant funds, disbursements and the balance of participant funds
	☐	Process and pay invoices for goods and services approved in the service plan
	☐	Provide participant with periodic reports of expenditures and the status of the participant-directed budget
	☐	Other services and supports *(specify)*:
	Additional functions/activities:	
	☐	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
	☐	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
	☐	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
	☐	Other *(specify):*
iv.	**Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.	

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐	**Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*
☐	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled:
☐	**Administrative Activity**. Information and assistance in support of participant direction are furnished as an administrative activity. *Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

k. Independent Advocacy *(select one).*

○	**Yes.** Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*:
○	**No.** Arrangements have not been made for independent advocacy.

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n		
	Employer Authority Only	**Budget Authority Only or Budget Authority in Combination with Employer Authority**
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

Appendix E-2: Opportunities for Participant-Direction

a. Participant – Employer Authority *(Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b)*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Check each that applies:*

☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. *Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff:*
☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Check the decision making authorities that participants exercise*:

☐	Recruit staff
☐	Refer staff to agency for hiring (co-employer)
☐	Select staff from worker registry
☐	Hire staff (common law employer)
☐	Verify staff qualifications
☐	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
☐	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
☐	Determine staff duties consistent with the service specifications in Appendix C-3.
☐	Determine staff wages and benefits subject to applicable State limits
☐	Schedule staff
☐	Orient and instruct-staff in duties
☐	Supervise staff
☐	Evaluate staff performance
☐	Verify time worked by staff and approve time sheets
☐	Discharge staff (common law employer)
☐	Discharge staff from providing services (co-employer)
☐	Other *(specify)*:

b. Participant – Budget Authority *(Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b)*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply***:**

☐	Reallocate funds among services included in the budget
☐	Determine the amount paid for services within the State's established limits
☐	Substitute service providers
☐	Schedule the provision of services
☐	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3
☐	Specify how services are provided, consistent with the service specifications contained in Appendix C-3
☐	Identify service providers and refer for provider enrollment
☐	Authorize payment for waiver goods and services
☐	Review and approve provider invoices for services rendered
☐	Other *(specify):*

ii. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

iv. Participant Exercise of Budget Flexibility. *Select one:*

○	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
○	Modifications to the participant-directed budget must be preceded by a change in the service plan.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Waiver clients have rights under Medicaid law, state law (RCW) and state rules (WAC) to appeal any decision of DDD affecting eligibility, service, or choice of provider. In addition, Per RCW 71A.12.240, individuals receiving services via the community protection waiver have the right to appeal the following decisions:

- Termination of community protection waiver eligibility;
- Assignment of the applicant to the community protection waiver; and
- Denial of a request for less restrictive community residential placement.

During entrance to a waiver an individual is given appeal rights via the DDD HCBS Waiver Brochure (DSHS #22-605). The CRM discusses fair hearing and appeal rights at the time of the initial and annual ISP meeting and appeal rights are attached to the ISP when it sent to the individual and their designee (the individual who has been designated to assist the client with understanding and exercising their appeal rights) for signature.

When the department makes a decision affecting eligibility, level of service or denial or termination of provider, a Planned Action Notices (PANs) must be sent within 5 working days of the decision. The notice is sent to the client and their designee. The PAN provides the effective date of the action, the reason and applicable WAC, appeal rights, and time lines for filing appeals. Individuals have up to 90 days to appeal a department decision. If an individual wishes to maintain services during the appeal process they must ask for a fair hearing within the ten-day notice period. If the tenth day falls on a weekend or holiday, they have until the next business day to ask for a fair hearing. If the tenth day happens before the end of the month, they have until the end of the month to ask for a fair hearing and still be able to get continued benefits.

A client or their designee may request an administrative hearing orally or in writing. Client appeals are heard and decided by Administrative Law Judges (ALJ) through an administrative or “fair” hearing. Attorney representation is not required but is allowed. The client or their representative may present the client’s case or have an attorney present the case. DSHS employees may not represent the client at an administrative hearing.

Copies of PANs are maintained in client files. Service Episode Records (SERs) document when a PAN was sent. SERs are contained electronically in the DDD Assessment on the CARE platform.

DDD uses a variety of PANs to communicate decisions. All PANs include relevant fair hearing and appeal rights and comply with Medicaid requirements.

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one*:

○	**Yes**. The State operates an additional dispute resolution process *(complete Item b)*
☒	**No**. This Appendix does not apply (*do not complete Item b)*

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

☒	**Yes.** The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver *(complete the remaining items).*
○	**No.** This Appendix does not apply (*do not complete the remaining items*)

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

ADSA/DDD operates the grievance/complaint system.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DDD provides participants with fair hearing and appeal rights and a complaints/grievance process. The Complaints/Grievance process is not a pre-requisite to a fair hearing, rather this policy provides participants with an opportunity to address those issues that are not dealt with through the fair hearing and appeal process. DDD policy 5.03 Client Complaint/Grievances clearly delineates those issues that may be addressed in this manner and those issues that should be addressed through processes such as the fair hearing process. Participants are informed of both processes via brochures, DVDs, WAC, policy and their Case Resource Manager.

DDD policy 5.03 Client Complaint/Grievances provides waiver participants an opportunity to address problems outside the scope of the fair hearing process. DDD has also worked with the Developmental Disabilities Council to produce a video to assist individuals and their representatives with understanding how to work with the department to resolve complaints/grievances.

This policy applies to all DDD Field Services offices, State Operated Living Alternatives (SOLA), and Residential Habilitation Centers (RHC).

POLICY

A. DDD staff will strive to address grievances/complaints at the lowest level possible. Complaints can be received and addressed at any level of the organization. However, the complaint will be referred back to the Case Resource Manager (CRM) for action unless the complainant specifically requests it not be.

B. Legal authorization from the client or a personal representative is required to share information with persons outside of DSHS unless otherwise authorized by law. Authorization from the client is not required when responding to correspondence assignments or inquiries from the Governor's Office as part of administration of DSHS programs.

C. Communication to complainants will be made in their primary language if needed.

D. DDD will maintain an automated complaint tracking database to log and track complaints as specified in the Procedures section of this policy.

PROCEDURES

A. The following procedures describe the handling of client complaints at four levels:

1. Case Resource Manager Level;
2. Supervisor Level;
3. Regional Administrator (RA) Level; and
4. Central Office Level

B. Complaints concerning services in the DDD Residential Habilitation Centers (RHCs) and State Operated Living Alternatives (SOLA) will be directed to the Regional Administrator in the respective region.

C. Case Resource Manager Level

1. Case Resource Managers (CRM) solve problems and resolve complaints as a daily part of their regular case management activities. This activity will be documented in the client record as appropriate.

2. If the complainant does not feel that the complaint or problem has been resolved, and he/she wants to have the complaint reviewed by a supervisor, the CRM will give his/her supervisor's name and telephone number to the complainant.

D. Supervisor Level

1. Upon receipt of an unresolved complaint at the CRM level, the supervisor has ten (10) working days to attempt to resolve the issue. If the response will take longer than 10 days, the supervisor will make an interim contact with the complainant and give a reasonable estimated date of response.

2. If resolution is reached, the supervisor will document the outcome in the client record.

3. If the complainant still does not feel that the complaint/problem has been resolved, and he/she wants to have the complaint reviewed by the RA, the supervisor will give the RA's name and telephone number to the complainant. The supervisor will also enter the complaint information in the automated DDD Complaint Tracking (CT) database.

E. Regional Administrator Level

1. Upon receipt of an unresolved complaint, the RA will assign a staff to investigate and resolve the issue within 10 working days. If the response will take longer than working10 days, the RA or designee will make an interim contact with the complainant and give a reasonable estimated date of response.

2. If resolution is achieved, the assigned Regional staff will:

a. Document the outcome in the CT database and the client record; and

b. Notify the complainant and all parties involved and document the notification in the client record.

3. If the matter is not resolved, and the complainant wants a review by DDD Central Office, the RA or designee will document the outcome in the CT database and give the name and telephone number of the Chief, Office of Quality Programs and Services (OQPS) to the complainant. The RA should also notify the OPQS Chief by phone or email of the potential contact.

F. Central Office Level

1. Upon receipt of an unresolved complaint, the OQPS Chief or designee will ensure the complaint has been entered in the database and has ten (10) working days to investigate and resolve the issue. If the response will take longer than ten (10) days, the OQPS Chief will make an interim contact with the complainant and give a reasonable estimated date of response.

2. The OQPS Chief will document the outcome in the CT database and notify the complainant and all parties involved. The OQPS Chief will send a written summary to the Region for inclusion in the client record.

G. Complaint Tracking Database

1. Entries in the CT database must include:

a. Date the complaint was received;

b. Name and phone number of person receiving the complaint;

c. Complainant name, contact number, and relationship to client;

d. Client name and identification number;

e. The specific complaint;

f. Who the complaint was assigned to;

g. Due date; and

h. Outcome.

2. The OQPS will review complaints entered in the CT database during its monitoring review cycle. Regional Quality Assurance Managers will conduct periodic regional reviews of complaints and status.

Please note, the following types of complaints are outside the scope of this policy as they are addressed through separate processes:

1. Allegations of abuse, neglect, exploitation, abandonment, financial exploitation of a child or vulnerable adult. These must be directed immediately to Adult Protective Services (APS) or the Complaint Resolution Unit (CRU) as appropriate.

2. Client disputes about services that have been denied, reduced, suspended, or terminated. These are resolved through the Fair Hearing procedure.

3. Client disputes about services that have been requested or authorized through an exception to rule (ETR) that have been denied, reduced, or terminated.

4. Complaints received from DSHS Constituent Services. These will be handled according to the requirements of DSHS Administrative Policy 8.11, *Complaint Resolution and Response Standards.*

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Alleged or suspected abuse, neglect, exploitation or abandonment is required by law to be reported to DSHS immediately. State law also requires any sexual or physical abuse to be reported to law enforcement. All DSHS employees and their contracted providers are mandated reporters per RCW 74.34. Residential Care Services (RCS) is the designated DSHS authority for abuse and neglect investigations involving client's in residential programs. Adult Protective Services (APS) investigates incidents involving vulnerable adults residing in their own homes. Abuse and neglect incidents are reported to the Department via state-wide and regional abuse reporting lines.

The Division of Developmental Disabilities requires all contracted residential providers to report a broader scope of serious and emergent incidents to the Division per DDD Policy 6.12 "Residential Reporting Requirements". Serious and emergent incidents are reported to DDD via fax, telephone and e-mail.

Division staff are required to input Serious and Emergent incidents defined in Policy 12.01, "Incident Management", into an Electronic Incident Reporting System.
Incident types reported and tracked by DDD per Policy 12.01 include:

- Abuse
- Neglect
- Exploitation
- Abandonment
- Death

Medication Errors

- Emergency Use of Restrictive Procedures
- Serious Injuries
- Criminal Activity
- Hospitalizations
- Missing clients
- Mental Health Crisis
- Serious Property Destruction

DDD Policy 12.01 Reporting Timelines

Phone call to Central Office within **1 Hour** followed by Electronic IR within **1 Working Day** (A)	Electronic IR Database within **1 Working Day** (B)	Electronic IR Database within **5 Working Days** (C)
1. **Known media Interest or litigation** must be reported to Regional Administrator & CO within 1 hour. If issue also meets other incident reporting criteria, follow with Electronic IR within 1 working day.	1. Alleged or suspected **criminal activity** (including abuse, neglect and exploitation) by a DSHS employee, volunteer, licensee or contractor	1. Serious injuries of known origin requiring medical treatment **beyond First Aid** but not hospital admission. RHCs may use discretion (see Definitions)
2. **Death of an RHC or SOLA client.**	2. **Criminal activity by clients** resulting in a case number being assigned by law enforcement	2. **Life-threatening medically emergent conditions:** medical conditions that cannot be classified as injuries
3. **Suspicious deaths** (suspicious or unusual).	3. **Sexual abuse** of a client not reported under column A	3. **Mental health inpatient admission** to a psychiatric facility other than Easter/Western State Hospitals.
4. **Natural disaster** or conditions threatening the operations of the program or facility	4. **Injuries** resulting from **client to client** abuse requiring medical treatment beyond First Aid	4. Non-accidental property **destruction by a client over $200**
5. **Alleged sexual abuse of a client by DSHS employee**, volunteer, licensee or contractor	5. **Injuries of known cause** (other than abuse) resulting in hospital admission	5. **Emergency use of restrictive procedures and physical intervention techniques**
6. Alleged **sexual assault of a child** by DDD client	6. **Missing Person:** (see Definitions)	6. **Neglect** (see Definitions)
7. **Clients missing from SOLA** or **RHC** in cases where a missing person report is being filed with law enforcement	7. **Death of client** (not suspicious or unusual)	7. **Substantiated findings reported by** APS, CPS, or RCS
8. **Injuries resulting from abuse/neglect** or unknown origin requiring hospital admission	8. Eastern or Western State Hospital admissions	8. Patterns of **client to client abuse**
9. **Client arrested with** charges or pending charges for a violent crime	*Erratum*	9. **Medication error** (see Definitions)
	9. Alleged or suspected abuse, neglect, exploitation and abandonment by other, non-client screened in by APS or CPS for investigation	10. **Sexual exploitation** not otherwise reported under B.1 or B.3
	10. Criminal activity against clients by others resulting in a case number being assigned by law enforcement	11. **Serious Community Protection treatment violations** not otherwise defined
		12. **Suicide threat/attempt/gesture** (see Definitions)

b. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The Division of Developmental Disabilities works jointly with Aging and the DSHS

Communications Division on education efforts for clients, families and providers associated with DSHS. Approximately 3,000 abuse awareness cards are handed out every year by DDD. DSHS also started an "End Harm" campaign several years ago. DDD participates in this campaign which is aimed at shedding light on abuse and educating the general public as well as DSHS staff and consumers. A statewide number 1-866-EndHarm was implemented several years ago. Anyone can call this number to report any type of abuse or neglect against a vulnerable person 24 hours per day and 7 days per week. The End Harm toll free number is promoted via news releases, the internet, DDD's Director's Corner. Thousands of "End Harm" refrigerator magnets are given out every year. Most residential programs have abuse and neglect reporting numbers posted in the participant's homes. Each year Residential Care Services receives 18,000-20,000 calls of alleged or suspected abuse for all vulnerable adults. Adult Protective Services conducts more than 2,500 intakes involving Division clients each year and the Division of Developmental Disabilities, logs, tracks and follows up on 4,000-5,000 incidents every year. Washington State has designated November as "Vulnerable Adult Awareness Month".

Every DDD CRM receives mandatory reporter/incident management training as a component of DDD Core Training.

All providers receive mandatory reporter training. Individual and AFH/ARC providers receive training via the Fundamentals of Caregiver training. DDD residential program employees receive training from their employer.

c. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Under state authority, Aging and Disability Services Administration/Residential Care Services (RCS) is the designated DSHS authority to investigate incidents of abuse (physical, mental, sexual and exploitation of person), abandonment, neglect, self-neglect and financial exploitation in residential programs. If a named alleged perpetrator is found to have committed abuse (physical, mental, sexual and exploitation of person), abandonment, neglect, self-neglect and financial exploitation, their name and the nature of the finding is submitted to any known employer and the Background Check Central Unit (BCCU).

In addition to investigating alleged named perpetrators, RCS reviews provider systems to see if a failed practice contributed to any finding of abuse, neglect, abandonment, self-neglect, and financial exploitation. If failed provider practice contributed to a finding RCS will issue a citation to the provider under the appropriate section of 388-101 WAC. The provider must submit and implement a corrective action plan, which is subject to on-site verification by RCS.

RCS is centrally located in Olympia. Abuse and neglect referrals must be responded to within 24 hours. RCS prioritizes reports for investigation based upon on the severity and immediacy of actual or potential harm. Reports are assigned to be investigated within 2, 10, 20 days or quality review. Any situation that involves imminent danger is reported to law enforcement immediately. Referrals are also made to any state agency which has regulatory authority over the named alleged perpetrator.

Under state authority, Aging and Disability Administration/Home and Community Services Division, Adult Protective Services (APS) receives reports and conducts investigations of abuse (physical, mental, sexual and exploitation of person), abandonment, neglect, self-neglect and

financial exploitation.

APS administration is located in Olympia and APS investigators are located in regional offices throughout the state. Investigations are prioritized based on the severity and immediacy of actual or potential harm. Emergent issues are referred to 911. The APS investigator meets face to face with the alleged victim within 24 hours for all reports categorized as "high"; within five working days for a "medium" priority report; and within ten working days for a "low" priority report. A shorter response time may be assigned on a case by case basis.

DDD requires all contracted residential providers to report a broader scope of serious and emergent incidents to the Division per DDD policy 6.12 Residential Reporting Requirement including Abuse/Neglect Reporting. Division staff are required to input serious and emergent incidents defined in policy 12.01, Incident Management into an electronic incident reporting system. Please see section G-1 for detail.

d. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Residential Care Services is responsible for overseeing the certification of all certified residential programs. Incident management, mandatory reporting, and mandatory reporter training are among the standards they evaluate per Washington Administrative Code and contract. Certification occurs a minimum of every two years, but the certification length can be reduced depending on the regulatory concerns.

The Division of Developmental Disabilities requires serious and emergent incidents to be entered into a statewide electronic incident reporting system per DDD Policy. Incidents are entered into the system by DDD CRMs with notification sent to appropriate staff.

Regional Quality Assurance staff in all six regions provides ongoing monitoring of the Incident Reporting system. The Central Office Incident Program Manager is responsible for the monitoring and oversight of all significant incidents. A Central Office Incident Report team meets monthly to review aggregate data, trends and patterns and staff incidents of particular concern.

Aggregate data analyzed by the DDD Central Office is also sent out to the regions for follow up. Regional analysis is tracked in G-Map format and discussed at the Regional Quarterly Quality Assurance Meeting. Best practices and significant issues are presented to Full Management Team quarterly.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

This Appendix must be completed when the use of restraints and/or restrictive interventions is permitted during the course of the provision of waiver services regardless of setting. When a state prohibits the use of restraints and/or restrictive interventions during the provision of waiver services, this Appendix does not need to be completed except for Item G-2-c-ii.

a. Applicability. *Select one:*

○	This Appendix is not applicable. The State does not permit or prohibits the use of restraints or restrictive interventions *(complete only Item G-2-c-ii)*
☒	This Appendix applies. Check each that applies:
☒	The use of personal restraints, drugs used as restraints, mechanical restraints and/or seclusion is permitted subject to State safeguards concerning their use. *Complete item G-2-b.*
☒	Services furnished to waiver participants may include the use of restrictive interventions subject to State safeguards concerning their use. *Complete item G-2-c.*

b. Safeguards Concerning Use of Restraints or Seclusion

i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The following information is excerpted from Division of Developmental Disabilities Policy 5.15 Use of Restrictive Procedures and 5.16 Use of Psychoactive Medications:

When a client's behavior presents a threat of injury to self or others, or threatens significant damage to the property of others, steps must be taken to protect the client, others, or property from harm. It is expected that supports as described in the Division of Developmental Disabilities (DDD) Policy 5.14, *Positive Behavior Support,* will be used to lessen the behaviors and to eliminate the need for restrictive practices. When positive behavior support alone is insufficient, procedures that involve temporary restrictions to the client may be necessary.

This policy applies to all clients who receive services in:

1. DDD contracted residential programs serving people in their own homes, including the State Operated Living Alternatives (SOLA); and
2. Services provided by counties that are funded by DDD.

A. Restrictive procedures must be used only as provided for in this policy.

B. Restrictive procedures may only be used for the purpose of protection, and may not be used for the purpose of changing behavior in situations where no need for protection is present.

C. Only the least restrictive procedures needed to adequately protect the client, others or property shall be used, and restrictive procedures must be terminated as soon as the need for protection is over.

D. When a client has restrictive procedures that may impact his/her housemate(s), efforts shall be made to minimize the effect on the housemate(s). How the client's housemate(s) will manage these restrictions must be included in their service plans (e.g., using a key or getting a staff to unlock cabinets, etc.). Consent to the plan by the housemate(s) and his/her legal representative must be documented in the client record.

PROCEDURES

A. Before implementing restrictive procedures, the client and his/her legal representative must be involved in discussions regarding the perceived need for restrictive procedures including:

- The specific restrictive procedures to be used;
- The perceived risks of both the client's challenging behavior and the restrictive procedures;
- The reasons which justify the use of the restrictive procedures; and
- The reasons why less restrictive procedures are not sufficient.

Necessary Documentation for Use of Restrictive Procedures

1. A written Functional Assessment (FA) of the challenging behavior(s) that the restrictive procedures address. Refer to DDD Policy 5.14, *Positive Behavior Support,* for more information and requirements regarding FAs.

2. Based on the FA, a written PBSP that will be implemented to reduce or eliminate the client's need to engage in the challenging behavior(s). Refer to DDD Policy 5.14, *Positive Behavior Support,* for more information and requirements regarding PBSPs. At RHCs, the psychologists are responsible for conducting the FA and developing the PBSP.

3. Program staff responsible for PBSPs must review the plan at least every thirty (30) days. If the data indicates progress is not occurring after a reasonable period, but no longer than six (6) months, the PBSP must be reviewed and revisions implemented as needed.

4. As describe in policy 5.15 Use of Restrictive Procedures, at least annually, the approving authorities must re-approve restrictive procedures that require Exceptions to Policy (ETP) or involve physical or mechanical restraint.

Policy 5.16 Use of Psychoactive Medications:

Psychoactive medications are prescribed to enable a person to function better, reduce challenging behavior, or treat a mental illness. Persons with developmental disabilities and mental illness, and/or persistent challenging behavior shall have appropriate access to information and treatment with psychoactive medications, and reasonable protection from

serious side effects or the inappropriate use of these medications.

If a psychoactive medication is used to treat a physical condition (e.g., sleep or seizure disorder) and is not also used for behavioral purposes, the requirements of this policy do not apply. Positive behavior support strategies, if warranted, should be integrated in the person's overall support plan.

Monitoring Psychoactive Medications:

1. The agency must monitor the client to help determine if the medication is being effective based on criteria identified in the PMTP. If the medication does not appear to have the desired effects, the agency must communicate this to the prescribing professional.

2. The agency must observe the client for any changes in behavior or health that might be side effects of the medication and inform the prescribing professional of any concerns.

3. The agency should request that the prescribing professional see the client at least every three (3) months unless the prescribing professional recommends a different schedule. Document the visitation schedule in the client's treatment plan.

4. Continued need for the medication and possible reduction should be assessed at least annually by the prescribing professional. See Attachment D for sample form, *Psychoactive Medication Treatment Plan: Annual Continuation of Medication.*

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The Medicaid Agency through the Aging and Disability Services Administration is responsible for detecting the unauthorized use of restrictive interventions.

Under state authority RCW 74.34, the Aging and Disability Services Administration (ADSA) receives reports and conducts investigations of abuse, neglect, exploitation and abandonment for clients enrolled with the Division of Developmental Disabilities. ADSA Residential Care Services (RCS) investigates abuse and neglect occurring in nursing homes, boarding homes, adult family homes, & supported living programs. ADSA Adult Protective Services (APS) investigates abuse and neglect involving adults residing in their own homes.

The DDD detects use of unauthorized restrictive intervention through:

- Reports submitted to Adult Protective Services,
- Reports submitted to Residential Care Services,
- Reports submitted to Child Protective Services,
- Reports received in the DDD Incident Reporting system,
- The face to face DDD Assessment process conducted yearly and at times of significant change,
- The DDD grievance process, and
- DDD Quality Assurance activities that include face to face interviews of clients and review of complaints.

Division Policies 5.15 and 5.17 (see G-2, b, i) specify the requirements for using and documenting use of any type of restraint (mechanical or pharmacological). Only the least restrictive intervention needed to adequately protect the client, others, or property may be used, and terminated as soon as the need for protection is over. Approved restraint use must be fully documented and reviewed at least monthly by the residential provider and at least quarterly by the client's interdisciplinary team. Any emergency use of a restraint requires an incident report to division headquarters where it is reviewed by the Incident Management Program Manager.

Residential Care Services Division has contracted evaluators who evaluate the residential agencies/programs at least once every two years. Their review always includes any use of restraints, restrictive procedures, or use of psychoactive medications.

c. Safeguards Concerning the Use of Restrictive Interventions

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

DDD Policy 5.15 (see G-2- b- i), Use of Restrictive Procedures, describes required protocols for the use of any restrictive procedures. Restrictive procedures include use of mechanical and physical restraints (physical intervention techniques are further described in DDD Policy 5.17). At a minimum, any agency using restrictive procedures is required to have a Positive Behavior Support Plan (PBSP) in place. Some restrictive procedures have additional requirements, depending upon the level of intrusiveness of the procedure. Emergency use of restrictive procedures without a PBSP is limited and may only be used if there is an immediate risk to the health and safety of others or a threat to property. Each emergency use of a restrictive procedure must be reported to the Division. If the same restrictive procedure is used more than 3 times in a 6- month period, a Functional Assessment is required to be conducted and, if indicated, a PBSP must be written.

The Medicaid Agency through the Aging and Disability Services Administration is responsible for detecting the unauthorized use of restrictive interventions.

Under state authority RCW 74.34, the Aging and Disability Services Administration (ADSA) receives reports and conducts investigations of abuse, neglect, exploitation and abandonment for clients enrolled with the Division of Developmental Disabilities. ADSA Residential Care Services (RCS) investigates abuse and neglect occurring in nursing homes, boarding homes, adult family homes, & supported living programs. ADSA Adult Protective Services (APS) investigates abuse and neglect involving adults residing in their own homes.

The DDD detects use of unauthorized restrictive intervention through:

- Reports submitted to Adult Protective Services,
- Reports submitted to Residential Care Services,
- Reports submitted to Child Protective Services,
- Reports received in the DDD Incident Reporting system,
- The face to face DDD Assessment process conducted yearly and at times of

significant change,
- The DDD grievance process, and
- DDD Quality Assurance activities that include face to face interviews of clients and review of complaints.

Division Policies 5.15 and 5.17 (see G-2, b, i) specify the requirements for using and documenting use of any type of restraint (mechanical or pharmacological). Only the least restrictive intervention needed to adequately protect the client, others, or property may be used, and terminated as soon as the need for protection is over. Approved restraint use must be fully documented and reviewed at least monthly by the residential provider and at least quarterly by the client's interdisciplinary team. Any emergency use of a restraint requires an incident report to division headquarters where it is reviewed by the Incident Management Program Manager.

Residential Care Services Division has contracted evaluators who evaluate the residential agencies/programs at least once every two years. Their review always includes any use of restraints, restrictive procedures, or use of psychoactive medications.

DDD Policy 5.15 (see G-2- b- i), Use of Restrictive Procedures, describes required protocols for the use of any restrictive procedures. Restrictive procedures include use of mechanical and physical restraints (physical intervention techniques are further described in DDD Policy 5.17). At a minimum, any agency using restrictive procedures is required to have a Positive Behavior Support Plan (PBSP) in place. Some restrictive procedures have additional requirements, depending upon the level of intrusiveness of the procedure. Emergency use of restrictive procedures without a PBSP is limited and may only be used if there is an immediate risk to the health and safety of others or a threat to property. Each emergency use of a restrictive procedure must be reported to the Division. If the same restrictive procedure is used more than 3 times in a 6- month period, a Functional Assessment is required to be conducted and, if indicated, a PBSP must be written.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The Department of Social and Health Services, Aging and Disability Services Administration:

- Division of Developmental Disabilities
- Residential Care Services Division

Division Policies 5.15 and 5.17(see G-2-b-i) specify the requirements for using and documenting use of restraints. Restraint use must be fully documented and reviewed at least monthly by the residential provider and at least quarterly by the client's interdisciplinary team. Additionally, emergency use of a restraint results in an incident report to division headquarters where it is reviewed by a program manager. Residential Care Services Division has contracted evaluators who evaluate the residential agencies/programs at least once every two years. Their review always includes any use of restraints, restrictive procedures, or use of psychoactive medications.

Appendix G-3: Medication Management and Administration

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

☒	**Yes**. This Appendix applies *(complete the remaining items)*.
○	**No**. This Appendix is not applicable *(do not complete the remaining items)*.

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Medication management is a component of the DDD assessment. The DDD assessment will trigger a referral requirement if medication risk factors are identified. Once this requirement is triggered the CRM must address the risk identified in the ISP. How the risk is addressed depends on the concern identified. It could result in a medication evaluation referral, additional provider training, nurse oversight visits, consultation with the healthcare provider or any of a number of measures.

Additionally, Policy 6.19 Residential Medication Management applies to individuals who receive services from a DDD certified residential program.

Policy 6.19 Residential Medication Management:

When providing instruction and support services to persons with developmental disabilities, the provider must ensure that individuals who use medications are supported in a manner that safeguards the person's health and safety.

For licensed boarding homes only, medication management requirements as described in WAC 388-78A-300 take precedence over this policy.

PROCEDURES

A. **Self-Administration of Medications**

1. Residential service providers must have a written policy, approved by DDD, regarding supervision of self-medication.

2. The provider, unless he or she is a licensed health professional or has been authorized and trained to perform a specifically delegated nursing task, may only assist the person to take medications.

3. The provider may administer the person's medication if he/she is a licensed health care professional. Medications may only be administered under the order of a physician or a health care professional with prescriptive authority.

4. If a person requires assistance with the use of medication beyond that

described in A.2. above, the assistance must be provided either by a licensed health care professional or a registered nurse (RN) who delegates the administration of the medication according to Chapters 388-101 and 246-840 WAC.

B. **Nurse Delegation (Chapter 246-840 WAC)**

1. Nursing assistants who have been delegated a nursing care task must perform the task as follows:

   a. In compliance with all requirements and protocols of Chapter 246-840 WAC and WAC 246-841-405;
   b. Only for the specific person who was the subject of the delegation; and
   c. Only with the consent of the individual or another person authorized to provide consent for health care on behalf of the individual under RCW 7.70.065.

2. Before performing any delegated nursing task, the provider must:

   a. Complete the in-service staff training as required in WAC 388-101-1680;
   b. Be a "nursing assistant - registered" or a "nursing assistant – certified";
   c. Complete nurse delegation core training as approved by the Department of Social and Health Services (DSHS) and be issued a certificate of completion. The provider must maintain documentation of this training activity.
   d. Receive task-specific training from a delegating RN.

3. Any person may call the Nurse Delegation Hotline at (800) 422-3263 to file a complaint.

C. Documentation

The provider must maintain a written record of all medications administered to, monitored, or refused by the person.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

The Department of Social and Health Services, Aging and Disability Services Administration:

- Division of Developmental Disabilities
- Residential Care Services Division

Division Policy 6.19 (see G-3-b-i) specifies the requirements for residential medication management. Residential Care Services Division has contracted evaluators who evaluate the residential agencies/programs at least once every two years.

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one*:

☒	Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*
○	Not applicable (*do not complete the remaining items*)

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Division Policy 6.19 (see G-3-b-i) specifies the requirements for residential medication management. Residential Care Services Division has contracted evaluators who evaluate the residential agencies/programs at least once every two years.

iii. Medication Error Reporting. *Select one of the following:*

☒	Providers that are responsible for medication administration are required to *both* record and report medication errors to a State agency (or agencies). *Complete the following three items:*
	(a) Specify State agency (or agencies) to which errors are reported:
	DDD
	(b) Specify the types of medication errors that providers are required to *record:*
	Providers are required to record all medication errors.
	(c) Specify the types of medication errors that providers must *report* to the State:
	Providers are required to report medication errors causing injury/harm, or a pattern of errors.
○	Providers responsible for medication administration are required to *record* medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record:

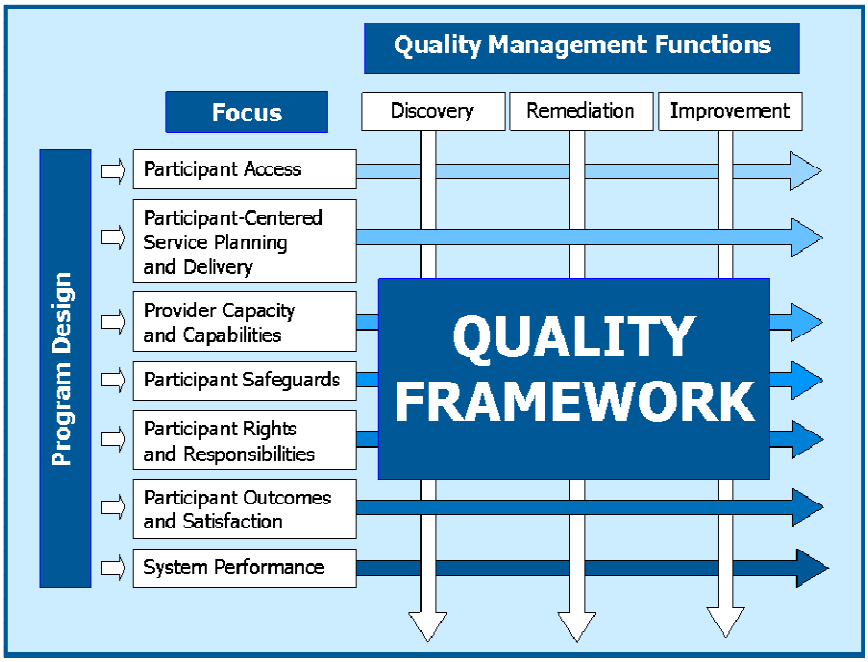
iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Department of Social and Health Services, Aging and Disability Services Administration:

- Division of Developmental Disabilities
- Residential Care Services Division

Division Policy 6.19 (see G-3-b-i) specifies the requirements for residential medication management. Residential Care Services Division has contracted evaluators who evaluate the residential agencies/programs at least once every two years.

Appendix H: Quality Management Strategy



Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

Quality Management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement. A Quality Management Strategy is explicitly describes the processes of discovery, remediation and improvement; the frequency of those processes; the source and types of information gathered, analyzed and utilized to measure performance; and key roles and responsibilities for managing quality.

CMS recognizes that a state's waiver Quality Management Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Management Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

1. **The Quality Management Strategy must describe how the state will determine that each waiver assurance and requirement is met.** The applicable assurances and requirements are: (a) level of care determination; (b) service plan; (c) qualified providers; (d) health and welfare; (e) administrative authority; and, (f) financial accountability. For each waiver assurance, this description must include:
   - Activities or processes related to discovery, i.e. monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery are provided in the application in Appendices A, B, C, D, G, and I. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance. The description of the Quality Management Strategy should not repeat the descriptions that are addressed in other parts of the waiver application;
   - The entities or individuals responsible for conducting the discovery/monitoring processes;
   - The types of information used to measure performance; and,
   - The frequency with which performance is measured.
2. **The Quality Management Strategy must describe roles and responsibilities of the parties involved in measuring performance and making improvements. Such parties include (but are not limited to) the waiver administrative entities identified in Appendix A, waiver participants, advocates, and service providers.**

   Roles and responsibilities may be described comprehensively; it is not necessary to describe roles and responsibilities assurance by assurance. This description of roles and responsibilities may be combined with the description of the processes employed to review findings, establish priorities and develop strategies for remediation and improvement as specified in #3 below.
3. **Quality Management Strategy must describe the processes employed to review findings from its discovery activities, to establish priorities and to develop strategies for remediation and improvement.** *The description of these process(es) employed to review findings, establish priorities and develop strategies for remediation and improvement may be combined with the description of roles and responsibilities as specified in # 2 above.*
4. **The Quality Management Strategy must describe how the State compiles quality management information and the frequency with which the State communicates this information (in report or other forms) to waiver participants, families, waiver service providers, other interested parties, and the public.** *Quality management reports may be designed to focus on specific areas of concern; may be related to a specific location, type of service or subgroup of participants; may be designed as administrative management reports; and/or may be developed to inform stakeholders and the public.*
5. **The Quality Management Strategy must include periodic evaluation of and revision to the Quality Management Strategy. Include a description of the process and frequency for evaluating and updating the Quality Management Strategy.**

If the State's Quality Management Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the specific tasks that the State plans to undertake during the period that the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Management Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

Attachment #1 to Appendix H

The Quality Management Strategy for the waiver is:

QMS ELEMENT H.1: WAIVER ASSURANCES

The Quality Management Strategy for the Division of Developmental Disabilities (DDD) is woven throughout all levels of the division and is an integral part of all elements of day-to-day functions. The division has formalized waiver quality assurance processes to meet and maintain high quality standards. The division also participates with other divisions in the Aging and Disability Services Administration (ADSA) to have a cohesive approach to Quality Management across the administration. This strategy is revised annually and approved by the Assistant Secretary of ADSA.

DDD currently administers four Home and Community-Based Service (HCBS) waivers which serve persons with developmental disabilities. The four waivers are the Basic (#0408), Basic Plus (#0409), Core (#0410) and Community Protection (#0411). They have a common foundation and approach to quality assurance, and use the same basic management structure. Though there is diversity in the needs of the clientele served on each waiver, basic management practices are followed on each waiver and the quality management activities and procedures are followed for all clients of the division.

H.1.a Level of Care (LOC) Determination

Assurance Requirements	Monitoring Activity	Monitoring Responsibilities	Data/Reports	Frequency	Timelines
1. **Waiver applicants for whom there is reasonable indication that services may be needed in the future are provided an individual LOC evaluation**.	The "client details" section of the DDD Assessment collects all service and program requests. Information on all individuals expressing interest in enrollment in one of Washington's 4 waivers is collected. The department will monitor by comparing waiver enrollment requests with the data collected in the DDD Assessment tool.	• Case Resource Manager/Social Worker documents client request in the DDD assessment. • State Waiver Requirements Program Manager	• The ICF/MR LOC assessment tool is integrated into the DDD assessment. • Management Reports	As needed Quarterly	Ongoing As needed
	Washington maintains a Waiver Enrollment Data Base – containing the names of people who have expressed interest in being	Waiver unit monitors movement.	Enrollment Request database.	Monthly	Ongoing

	on a waiver and who have been assessed to meet ICF/MR LOC.					
2. The level of care for enrolled participants is evaluated at least annually or as specified in the approved waiver.	• DDD CRM/SW assess waiver participants	• 100% of waiver participants are reevaluated for LOC annually.	Management Report	• Monthly	Ongoing	
	• **Yearly** audit of a random sample of waiver clients state-wide by QCC staff • **Monthly** audit of one case file by regional QCC. • **Quarterly** audit of one case file per case manager by supervisors	• The QCC team selects a 95% confidence level with +/- 4 which yielded **568** client files for review in **2005**. • QCC completes a total of **72** monthly regional file reviews each **year**. • Supervisors additionally complete approximately **517** file reviews per **year**.	Audit reports	• Monthly • Quarterly • Annual		
	Regions update Central Office on timeliness of LOCs and supply corrective action plans if needed.	This process is formally reviewed at each region's quarterly review with the Division Director.	Monthly Report to the regions Quarterly Regional Reports to the Director	Monthly Quarterly	Ongoing	

3. The process and instruments described in the approved waiver are applied to determine LOC	• QCC audits client files • The DDD Assessment is the ONLY instrument used to determine LOC. • Only CRM/SW does annual LOC determination	• See #2 of H-1a for number of files reviewed. • The DDD Assessment will not allow for the creation of a service plan without completion of the approved level of care assessment. • There are security rights attached to the DDD Assessment. Only approved assessors have access.	• Waiver Audit reports N/A N/A	Monthly Quarterly Annual	Ongoing
4. The state monitors LOC decisions and takes action to address inappropriate level of care determinations.	Regional staff and QCC review LOC determinations as a part of the file review process.	Supervisors and QCC complete file reviews.	Waiver Audit Reports	Monthly Quarterly Annually	Ongoing

H1.b Service Plan

Assurance Requirements	Monitoring Activities	Monitoring Responsibilities	Data/Reports	Frequency	Timelines

1. Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.	Information on clients' needs and preferences are gathered through The National Core Indicators Survey (NCI) plus specific waiver-related questions. Regional Quality Assurance staff conduct face-to-face interviews on a sampling basis.	Regional Quality Assurance staff	The NCI report. This report provides state specific information as well as national comparisons.	Annually	Ongoing	
	The QCC and supervisory file reviews are completed to ensure identified health and welfare needs have been addressed in the plan.	See #2 of H-1a for number of files reviewed.	Waiver Audit reports	Monthly Quarterly Annually	Ongoing	
	An ISP survey given to participants specifically asks the individual whether during the ISP process their needs and goals were addressed.	Waiver Oversight Committee reviews survey data	ISP Survey data base	Quarterly	Ongoing	
2. The state monitors service plan development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in service	QCC and supervisory file reviews are completed to ensure ISPs are correctly completed.	QCC and Supervisors	Waiver Audit Reports	Monthly Quarterly Annually	Ongoing	

plan development	An ISP survey given to participants and their families each year. The information is analyzed and used to improve the planning process.	Central Office QA staff	ISP Survey data base Quarterly Reports	Annually	Ongoing	
3. Service plans are updated/ revised at least annually and also when warranted by changes in waiver participant needs.	Regions report monthly	Regional Administrator reports to Division Director	Monthly ISP progress report Quarterly ISP progress report	Monthly Quarterly	Ongoing	
	CRM/SW training emphasizes the importance of revising ISP's throughout the year.	Waiver Program Manager	DDD Assessment records all changes during the year to the plan.	As needed	Ongoing	
	NCI survey face-to-face quality assurance visits include questions on any changes that may have occurred.	Regional QA staff	NCI data base NCI reports	Annually	Ongoing	
4. Services are delivered in accordance with the service plan, including in the type, scope, amount, duration, and frequency specified in the service plan.	QCC and supervisory file reviews/audits verify that authorizations for services that match ISP including the type, scope, amount, duration and frequency of the service.	Supervisors/QCC When findings occur regions have 30-90 days to correct problems.		Monthly Quarterly Annually	Ongoing	
	CRM/SW reviews last year's plan to confirm services were received in accordance with the ISP.	CRM/SW	ISP shows changes and updates by date each year.	Annually or more often if needed	Ongoing	

5. Participants are afforded choice between waiver services and institutional care.	This is a required component of the DDD assessment.	QCC and Supervisors	Waiver Audit reports	Monthly Quarterly Annually	Ongoing
	All client requests for admission to institutions are documented by the region in the client file. The requests are then sent to a statewide review committee for action.	RHC Admittance Review Committee (reviewed 37 requests in 2006)	RHC Request Data base	As needed	Ongoing
6. Participants are afforded choice between/among waiver services and providers.	QCC and supervisory file reviews/audits verify choice between/among waiver services and providers.	QCC and supervisors	Waiver Audit Reports	Monthly Quarterly Annually	Ongoing
	ISP survey NCI face-to-face interviews	Regional QA staff DDC volunteers. State QA Staff	ISP reports NCI reports	Annually	Ongoing

H.1.c Qualified Providers

Assurance Requirements	Monitoring Activity	Monitoring Responsibilities	Data/Reports	Frequency	Timelines
1. The state verifies that providers meet required licensing and/or certification standards and adhere to other standards prior to their furnishing waiver services	The state will only license, contract or certify a potential contractor who meets all WA State requirements for contracting, licensing or certification	Residential Care Services (RCS) Certification Unit must certify/license a provider's qualifications	RCS Certification data base	Original certification & at least every two years thereon	Scheduled by RCS
	▫ DDD only contracts with providers or hires state employee who have a current background check	• RCS licensers monitor facilities • RCS evaluators monitor supported living providers	• ADSA All Contracts Data base (ACD) reports • RCS data base reports	As needed Quarterly Biennial	As needed Ongoing Ongoing

	clearance and required training. ▫ QCC and Supervisory file reviews	• Counties monitor sub-contractors. • QCC and DDD supervisors	• County monitoring visits • Waiver Audit Reports		
2. The State verifies, on a periodic basis, that providers continue to meet required licensure and or certification standards and/or adhere to other State standards.	• RCS tracks certification compliance for DDD certified residential providers; and licenses Adult Family Homes (AFH), Boarding Homes and Group homes. • DDD tracks contract compliance for DDD Companion Homes	• DSHS Operations Review conducts random audits. • WA State Office of Financial Management randomly audits • RCS and DDD hire evaluators for supported living and companion home evaluations. • RCS licenses AFHs, boarding homes and group homes	• RCS Certification Database • RCS tracks licensing information. • DDD database tracks companion homes.	At least every two years At least every 18 months Yearly	All Ongoing
3. The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.	Background checks are completed on all individual providers to monitor for records of abuse, neglect, exploitation and criminal activity. The state may not contract with a person who has a disqualifying crime.	• Background checks are done by the DSHS Background Unit (BCC) • Regional business managers	• BCCU data base and registry reports • ACD reports	At least every 3 years	As needed
	The state contracts with Counties who sub-contract with agencies for employment and community services. County contract requirements include monitoring on an at least	• County Coordinators are responsible for monitoring sub-contractors. • State QA office staff	County Monitoring reports State sampling report	At least every biennium Annual	During the fiscal biennium Ongoing

	bi-annual basis.				
	CRM/SW use the Automated Contacts Database (ACD) to monitor individual provider requirements, i.e. valid contract; background checks and training.	Regional CRM/SWs and business managers check the ACD data base for qualified providers.	ACD reports	At time of contract & every 3 years thereafter	As needed
4. The state implements its policies and procedures for verifying that training is provided in accordance with state requirements and the approved waiver.	• Certification reviews done by RCS evaluators include monitoring training. • Contract monitoring in Companion Homes include monitoring training. • Licensers of facilities are required to monitor training. • Counties monitoring includes the requirement to contract with qualified providers.	The following entities are responsible for training compliance monitoring: • RCS • DDD • Counties	The following reports are available from: • RCS database • Companion Home data base • AFH database • Boarding Home database	All reviews, certifications or licenses are within a two year period.	Ongoing
	CRM/SWs enter training information into the ACD for individual providers .	• CRM/SWs • Regional business managers • ADSA Contracts manager	ACD reports	As needed	Ongoing
	Annual Trainings (Community Protection Training;, Cross-Systems Training; and Foster Care Training) are tracked in	Central Office Training Manager compiles information for evaluating compliance with specialty training requirements.	Training calendar reports	As needed	Ongoing

	the automated training calendar system.				

H.1.d Health and Welfare

Assurance Requirements	Monitoring Activity	Monitoring Responsibilities	Data/Reports	Frequency	Timelines
1. There is continuous monitoring of the health and welfare of waiver participants and remediation actions are initiated when appropriate	CRM/SW use the DDD Incident Reporting System to report health and welfare issues. CRM/SWs prioritize and send to Central Office significant incidents for review and follow-up. All other items are followed up by the CRM/SW and noted in the client's record.	• CRM/SW enters information into IR system • State IR Program Manager Monitors IR activities. • DDD State IR Team reviews statewide trends and patterns and make recommendations. • DDD Mortality Review Team reviews trends and patterns and make recommendations.	• IR system data • Sigma six charts • Pareto Analysis • Mortality Reviews	Ongoing Ongoing Monthly Monthly	Ongoing
	• Regional Quality Assurance Managers report Quarterly to DDD State QA office on a set of client and system indicators for each Region. • The State QA staff summarizes data and reports to DDD management team quarterly.	• Regional QA managers • State QA Unit monitors statewide health and welfare . • State Incident Manager reports to Governor on sentinel events • DDD Management Team.	• Regional QA reports • Statewide QA reports • Letters to Governor as needed.	Quarterly Quarterly As needed	Ongoing When sentinel situations arise.
	Nursing Care Coordinators (NCC), using indicators in the DDD Assessment, CRM concerns, or special assignments; monitor health of waiver clients as needed.	NCCs evaluate the health care situations of waiver clients as requests.	• Service Episode records • Medically Intensive Children's reports • Private Duty Nursing Evaluations for adults • Nursing Assessments	All work is done "as needed', or on a sampling basis	Ongoing
	Yearly assessments of all waiver clients, using the DDD assessment is required. The DDD assessment is a robust tool for identifying health and welfare needs.	Supervisors and QCC Team audit to ensure identified health and safety needs are being met.	Waiver Audit report	Monthly Quarterly Annual	Ongoing

2. On an ongoing basis the state identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation.	Under WA State authority: • ADSA investigates abuse, abandonment, neglect, and financial exploitation for adults. • Children's Administration (CA) investigates abuse and neglect of children.	• ADSA Investigators have responsibility for investigating adult accusations. • CPS Investigators have responsibility for investigating children accusations.	• Adult Protective Services data base • RCS database • CPS database	As prioritized	Ongoing
	Reports are made to the DDD Incident Reporting (IR) system – these include incidents of neglect, abandonment, abuse and exploitation and are monitored at a state level and managed at a Regional level.	• CRM/SW is the first line of response; • Regional QA managers, NCCs and other Regional personnel are assigned to investigate. • The State Incident Reporting Manager monitors • The State Incident Review Team monitors and recommends needed changes. • All staff and contracted providers are mandatory reporters of abuse, neglect, abandonment and exploitation.	• Incident data base reports • Minutes of IR Team Meetings • APS database • RCS database	Monthly Monthly As needed As needed	Ongoing

H1.e Administrative Authority					
Assurance Requirements	**Monitoring Activities**	**Monitoring Responsibilities**	**Data/Reports**	**Frequency**	**Timelines**
1. The Medicaid agency retains ultimate authority and responsibility for the operation of the waiver by exercising oversight over the performance of waiver functions by other state and local/regional non-	▫ DDD contracts with Counties to contract with providers to provide employment and day program services to waiver clients. ▫ Counties have established processes to ensure providers are meeting their contract obligations. ▫ DDD reviews the county process.	• Counties • DDD Regions monitor counties • The DDD County Program Manager • DDD HQ staff reviews county service evaluation systems.	• County reviews • Contract Risk reviews • DDD QA Office Random Sampling report	Each biennium Annually Annual sampling	Ongoing

state agencies (if appropriate) and contracted entities.					

H.1.f Financial Accountability					
Assurance Requirements	**Monitoring Activities**	**Monitoring Responsibilities**	**Data/Reports**	**Frequency**	**Timelines**
1. Claims for federal financial participation in the costs of waiver services are based on state payments for waiver services that have been rendered to waiver participants, authorized in the service plan, and properly billed by qualified waiver providers in accordance with the approved waiver.	• The state does a crosswalk between payment systems such as the SSPS/FRS crosswalk in order to ensure that correct account coding is occurring.	• Office of Support Services	• SSPS Crosswalk	• As needed	• Ongoing
	• The state has built a front-end edit to its system to ensure that expenditures are coded to the correct waivers.	• Office of Technology	• CASIS Report	• As needed	• Ongoing
	• Counties are responsible for employment and community programs and they file CHRIS reports that include data on waiver expenditures for county based services.	• County Coordinators	• CHRIS Report	• Monthly	• Ongoing
	• ADSA coordinates relations with Medicaid Fraud	• Medicaid Fraud Unit	• Medicaid Fraud Unit Reports	• Routinely	• Ongoing
	• Management Services Division (MSD) monitors waiver expenditures and presents that information to upper management.	• Office of Decision Support	• Waiver Monitoring Report	• Monthly	• Ongoing
	• DSHS has implemented a Payment Review Program (PRP) that includes on-going monitoring of all payments made for waiver services	• Budget Office	• DDD PRP Report	• Monthly	• Ongoing
	• MSD does sample auditing of residential agencies each year.	• Office of Rates Management	• Agency Audit Reports	• Ongoing	• Ongoing
	• Residential Care Services				

	(RCS) reviews time cards and checks them against expenditure information during certification evaluations for every supported living agency.	• Residential Care Services	• Residential Evaluations	• Biennially	• Ongoing

QMS ELEMENT H.2: ROLES AND RESPONSIBILITIES

There are many entities that play a critical role and are essential to DDD's Quality Management Strategy:

- **The Department of Social and Health Services (DSHS)** is the State Department that is responsible for Medicaid Management.
- **The State Medicaid Agency** is also the State Operating Agency and conducts internal audits and management strategies on a routine basis.
- **The Aging and Disability Services Administration (ADSA)** is responsible for the implementation of the HCBS waivers.
- **The Division of Developmental Disabilities (DDD)**, **which includes six regions and contracts with thirty-nine counties,** assume responsibility for the implementing and management of the four HCBS waivers.
- **DDD staff, contracted and licensed agencies and individual providers** provide case management and required services for waiver participants.
- **Residential Care Services Division (RCS)** provides licensing and certification evaluations for service providers as well as investigates incidents of abuse, neglect, abandonment and exploitation in nursing homes, supported living, licensed facilities, and institutions.
- **Management Services Division (MSD)** provides financial oversight, information systems and data management for the waiver.
- **Child Protective Services (CPS)** provides investigation of incidents of abuse, neglect, abandonment and exploitation involving children.
- **Home and Community Services Division (HCS)** is responsible for Nurse Delegation services and investigation of incidents of abuse, neglect, abandonment and exploitation in community settings.
- **The CMS Waiver Oversight Committee (WOC)** oversees waiver implementation.
- **The State Quality Assurance Advisory Committee** (SQAAC) comprised of stakeholders, including participants, family members, advocacy groups and others meet to review the DDD Quality Management System and make recommendations for improvement.
- **The State Incident Review Team (IRT)** meets monthly to review aggregate data from the Electronic Incident Reporting System and define mechanisms to prevent incidents.
- **The State Mortality Review Team (MRT)** meets monthly to review all deaths of participants and monitor and make recommendations on trends and patterns.
- **Nursing Care Consultants** are assigned to Regions to review and monitor health and safety concerns.
- **The State Waiver Program Manager and Regional Waiver Coordinators** manage and report necessary waiver changes.
- **The Developmental Disabilities Council (DDC)** analyzes and provides recommendations for improvement using the National Core Indicators Survey as its tool.
- **Regional Quality Assurance Staff work in partnership with volunteers who are self-advocates or family members trained by the DDC** to do face-to-face surveys of waiver clients to ensure satisfaction with waiver services.

QMS H.3: PROCESSES TO ESTABLISH PRIORITIES AND DEVELOP STRATEGIES FOR REMEDIATION AND IMPROVEMENT

The Quality Improvement (QI) process has been part of the Division's activities for decades. With the implementation of the Governor's Executive Order 97-03, a

statewide effort was launched to coordinate the implementation of Quality Improvement. A Quality Improvement Steering Committee (QISCs) was established in 1997. This committee, chaired by the division director, was comprised of management and line staff. The QISC met monthly to design and implement the Quality Improvement system that is currently in place. Process Improvement Teams are chartered and managed by the State Performance and Quality Improvement Program Manager.

The last several years have seen great improvements in not only data collection, but in data analysis and in chartering process improvement teams based on the information collected. Data that is currently studied and used to gather information on system issues include:

- The Common Client data base (CCDB) which is being phased out and information moved to the CARE platform
- The Case Management Information System (CMIS), which replaced the CCDB and was implemented 3/31/08 as part of the CARE platform
- DDD assessment has been integrated onto the CARE platform
- SSPS system for payment of services
- National Core Indicators Survey data base
- Olmstead Follow-Along Survey data base
- Quality Control data base
- DDD Incident Reporting data base
- Adult Protective Services data base
- Complaint Unit Resolution data base
- ADSA Fair Hearing data base
- Residential Care Services Evaluation data base
- Companion Home data base
- All Contracts Data base
- Plan of Care Satisfaction Survey data base
- Case Manager Satisfaction Survey data base
- Executive Management Information System data base.
- DDD Complaints data base

DDD uses a discovery and monitoring process to measure each service provided to recipients. Performance is measured in terms of outcomes. The various entities responsible for different service components develop measurable outcomes for the services they provide. DDD then gathers data to discover whether trends and patterns meet expected outcomes and begins an improvement process if they do not. The goal of Quality Improvement in DDD is to promote, encourage, empower and support continuous quality improvement. There are six major areas of focus:

1) customer visits and surveys;
2) audits to ensure consistency and conformance to requirements;
3) monthly evaluations of performance measures;
4) chartering process improvement teams;
5) periodic meetings with regions, counties, and stakeholders to review data and findings; and
6) training to ensure that the divisional employees are equipped with the skills and knowledge to accomplish ongoing improvement in the delivery of services.

State:	Washington
Effective Date	4/1/2007

QMS H.4: COMPILATION AND COMMUNICATION OF QUALITY MANAGEMENT INFORMATION

Various reports are disseminated to many different groups who are involved in evaluating the successful implementation of the waivers. Included in the distribution cycle are:

- Reports to the State Quality Assurance Advisory Committee (SQAAC) and other advocacy groups. These are provided at least twice a year, in the case of the SQAAC and monthly for other groups, such as the Community Advocacy Coalition, Arc and DDC. Reports prepared for these groups focus on individual subjects of interest to the community.
- Regional management reports on waiver services are provided to the Division Director and Headquarters Staff quarterly. These reports detail management concerns.
- Quality Assurance reports are compiled quarterly by Regional Quality Assurance Managers and presented at a State-wide meeting. The results from these presentations, including areas of concern and best practices are then presented to the DDD Full Management Team for analysis and review.
- Mortality reports are provided to management, stakeholders and interested parties yearly.
- Management reports are provided by MSD Decision Support to the ADSA Assistant Secretary on a monthly basis. These reports deal with the area of management that needs to be corrected.
- Budget and audit reports are provided to the State CMS Waiver Oversight Committee every other month.
- NCI Core Indicator reports are distributed to management and stakeholders when issued by HSRI. These reports focus on participant satisfaction or areas of concern.
- The DDC Review of National Core Indicator reports are shared with management and the SQAAC committee after every evaluation. These reports contain recommendations on areas of concern.
- CARE data is shared with state and regional staff monthly for better management of health care elements.

QMS H.5: PERIODIC EVALUATION AND REVISION OF THE QMS

In order to ensure continuous improvement in the Quality Management Strategy, this strategic document will be reviewed and updated, at least once a year, to reflect improvements made during the year. The following process will be followed in reviewing and updating the Quality Management Strategy.

- ADSA maintains an administration-wide Quality Management Strategy which is updated each summer and sent to the Assistant Secretary for approval. This strategy covers the over-all management of quality assurance for all administration services, including waiver services.
- DDD maintains waiver-specific management strategies and all processes and strategies are in a continuous state of being up-graded and changed as the need arises.
- DDD continually works with participants, families, advocates, and providers to identify performance indicators and then to report to stakeholders on performance in those areas.
- State staff, county staff, providers and stakeholders are continually monitoring the system. Changes may be recommended by any of the above entities.
- The CMS Waiver Oversight Committee reviews suggested changes and improvements and recommends actions that should be taken.
- Using the Quality Assurance Framework, CMS input, NCI Core indicators data, and other indicators; DDD looks at all suggestions for change and prioritizes the work it will do each year in improving waiver performance.
- ADSA also seeks the assistance of CMS and other entities through grants, conferences, or “Best Practices” information, to continue to refine benchmarks for improvement and evaluate the system against those benchmarks.

State:	Washington
Effective Date	4/1/2007

Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

a) Providers are not required to have an independent financial audit of their financial statements. They are required to submit a cost report. If the department has reason to be concerned the department will request an audit by Operations Review and Consultation or the State Auditors Office. Operations Review and Consultation is within DSHS. The State Auditors Office is a state agency outside the Department of Social and Health Services.

b) The ADSA Office of Rate Management conducts desk audits on all annual cost reports submitted by providers. The provider's reported revenues are reconciled to the payments made through SSPS for services and the provider's contract (s) in place during the period. The Office of Rates Management may require additional information from the provider (payroll records, other financial records, etc.) if there are concerns about the integrity of the cost report information. The Office of Rates Management may also conduct on-site reviews of provider financial records to ensure that the cost report is accurate and completed in accordance with contract requirements.

c) Operations Review and Consultation and/or the State Auditors Office.

APPENDIX I-2: Rates, Billing and Claims

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

- Residential Habilitation:
  - Contracted Supported Living: Rates are determined for each individual client based on the number of direct care staff hours needed as determined by the case manager and other regional staff. Staff hours are paid at a pre determined benchmark rate specific to county categories (MSA, Non-MSA and King County). In addition to the direct staff rate, an administrative rate is determined using the Administrative Rate Standard schedule (Attachment C to Policy 6.04), and a client transportation rate using the Client Transportation Assessment.

    Individual rates are negotiated regionally utilizing policy and standards developed by the central office cost reimbursement section and the residential program manager. This group works closely with regional personnel and with the residential provider group to formulate policy and standards used in setting reimbursement rates. . Final rates are based on residential support levels (assigned by the DDD assessment), specific support needs listed in the assessment, support provided by others (e.g., family members), and the number of people living in the household who can share the support hours. (4/1/08). All negotiated rates are reviewed by the cost reimbursement analyst and approved by the Residential Program Manager and the Division Director.

    Annual cost reports are required from each service provider itemizing the cost of providing the contracted service for the calendar year. The cost reports are desk audited by the Cost Reimbursement Analyst to determine accuracy and reasonableness of reported costs. Reported revenue receive is reconciled to DSHS/SSPS payment information to determine over/under payments for services.

    Settlements are calculated by the Cost Reimbursement Analyst to determine pay back amounts in cases where providers contracted for more direct service hours than they provided, or received more reimbursement for direct care costs than they paid for direct care costs. There is no settlement provision for the non-direct care staff components of the payment rate.

  - State-Operated Supported Living: A prospective (daily) rate is established each year for each location (region) based on the projected costs and number of resident days for the ensuing fiscal year. The established rates are transmitted to the Office of Financial Recovery. OFR uses the daily reimbursement rates and the number of Medicaid eligible days at each location to recalculate the federal share of cost for each facility. The OFR calculation report goes to the Office of Accounting Services and to ADSA. The fiscal unit at ADSA prepares a journal voucher to record the federal share under the federal funds appropriation in the FRS. Reported resident days and FFP claims are reconciled with the Office of Financial Recovery each month. At the close of each year, a settlement calculation is prepared to recover additional federal funds, or to pay back funds previously received.

- Day Habilitation
  - Person to Person: Unit rates are negotiated between the counties and their providers.

- Expanded Habilitation
  - Prevocational: Unit rates are negotiated between the counties and their providers.
  - Supported Employment
    - Group Supported Employment: Unit rates are negotiated between the counties and their providers.
    - Individual Supported Employment: Unit rates are negotiated between the counties and their providers.
- Behavior Management and Consultation: Regional DDD staff negotiate rates on a provider-specific basis.
- Staff/Family Consultation and Training: Regional DDD staff negotiate rates on a provider-specific basis.
- Environment Accessibility Adaptations: Rates are based upon bids received by potential contractors.
- Transportation: The rate per mile is based upon historical reimbursement to state staff for transportation to and from meetings. Effective 7/1/08, the rate per mile is based on the Collective Bargaining Agreement (CBA) with the State Employees International Union (SEIU).
- Specialized Medical Equipment and Supplies: All rates are based upon the usual and customary charges for the specialized medical equipment/supplies.
- Community Transition: Based upon local housing (e.g., rent deposit) and utility costs and the specific needs of the individual (e.g., for furnishings).
- Skilled Nursing: The rate for skilled nursing services is the Medicaid unit rate with no vacation or overtime.
- Sexual Deviancy Evaluation: The rate per evaluation is provider-specific and is negotiated by DDD regional staff.
- Specialized Psychiatric Services: DDD regional staff negotiate with providers on a client-specific basis unit rates that are at or below the DSHS standard rate.
- Mental Health Stabilization Services
  - Behavior Management and Consultation: Rates are negotiated by DDD regional staff with the Regional Support Networks and/or individual providers.
  - Skilled Nursing Service: Rates are negotiated by DDD regional staff with the Regional Support Networks and/or individual providers. (Removed as a mental health stabilization service effective 1/1/10.)
  - Specialized Psychiatric Services: Rates are negotiated by DDD regional staff with the Regional Support Networks and/or individual providers.
  - Mental Health Crisis Diversion Bed Services: Rates are negotiated by DDD regional staff with the Regional Support Networks and/or individual providers.
- Extended State Plan Services
  - Occupational Therapy: Rates are negotiated by DDD regional staff on a provider-specific basis.
  - Speech, Hearing and Language: Rates are negotiated by DDD regional staff on a provider-

specific basis.
- Physical Therapy: Rates are negotiated by DDD regional staff on a provider-specific basis.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The Department of Social and Health Services (DSHS) receives funding appropriated by the Legislature in the biennial budget. Funding (both state dollars and federal dollars) is provided to DSHS and within DSHS to the Aging and Disability Services Administration (ADSA) and within ADSA to the Division of Developmental Disabilities (DDD). The DDD receives the appropriation and allots funds to its operating regions via Regional Budgets for most services (e.g., residential, personal care, professional) categories.

Direct Service Payments

The DSHS/DDD contracts directly with providers of service for all services except day program/day habilitation (community access, person to person, prevocational, supported employment) and state-operated living alternatives (supported living) (SOLA) services. The DDD authorizes services via the Social Services Payment System (SSPS), and providers bill the agency directly for services using the SSPS service voucher. Payments are made directly from DSHS/DDD to the providers of service.

Payments to the Counties

The Division contracts with 38 Washington counties for day program/day habilitation (community access, person to person, prevocational, supported employment) services. In most cases, the county contracts with the direct providers of services. (In a few cases, the counties are the providers of services.) Counties bill the state on behalf of providers of service (providers have the option to bill the state directly, but virtually all providers elect to have the counties handle the billing). Counties in turn bill the state, and the state reimburses the counties, who in turn reimburse providers of service. Counties are paid for their administration, and administrative dollars are in addition to service dollars. Counties reimburse providers at 100% of the contracted unit rate for services provided.

Counties maintain an infrastructure, including program manager, accounting, and information technology (IT) staff who ensure that Division funding is spent in accordance with the Division/County contract and that clients of the Division of Developmental Disabilities receive high quality day program/supported employment services. To support that infrastructure, per WAC 388-850-045(3) (DDD administrative code concerning allocation of funds to the counties) the Division allows the counties to devote up to 7% of the funding received from the Division to program administration. "Funding received" refers to the funding provided by the Division to each county via direct contract with each county. The total funding amount provided to the counties includes both administrative and service dollars (i.e., paid to vendors of community access, person to person, prevocational, and supported employment services (4/1/08)

The dollars devoted to administration are considered an "indirect rate", and the Department is claiming FFP for funding devoted to administration based on a cost allocation that reflects the proportion of county funding that is spent on Title XIX services. (4/1/08)

Payments to State Employees

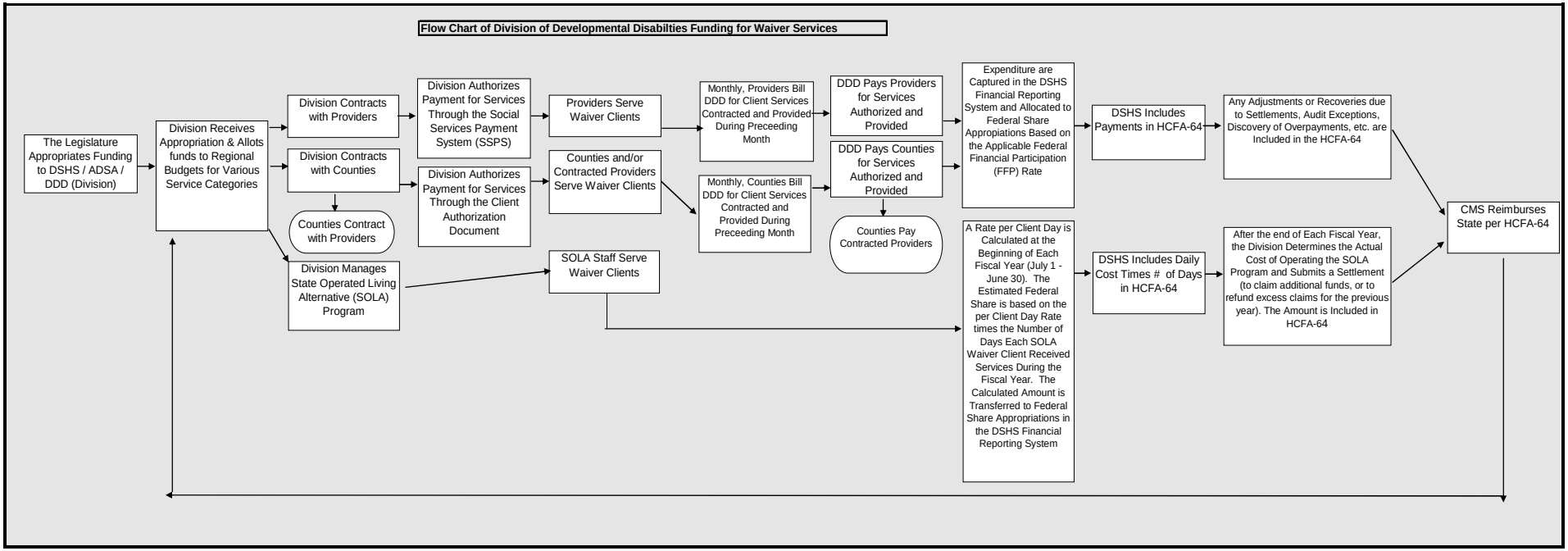
State:	Washington
Effective Date	4/1/2007

The State-Operated Living Alternatives (SOLA) programs are supported living program staffed with state employees. SOLA programs undergo the same certification, quality assurance and oversight activities as contracted supported living providers. Employee salaries are included in the appropriate provided to the Division by the Legislature. SOLA employees are paid twice a month like other state employee, with the payment amount determined by their job classification and experience.

Claim for FFP for Services Provided by State Employees

A prospective (daily) rate is established each year for each location (region) based on the projected costs and number of resident days for the ensuing fiscal year. The established rates are transmitted to the Office of Financial Recovery (OFR). OFR uses the daily reimbursement rates and the number of Medicaid eligible days at each location to recalculate the federal share of cost for each facility. The OFR calculation report goes to the Office of
Accounting Services and to ADSA. The fiscal unit at ADSA prepares a journal voucher to record the federal share under the federal funds appropriation in the FRS. Reported resident days and FFP claims are reconciled with the Office of Financial Recovery each month. The DSHS includes the daily cost times the # of days in the HCFA-64 Report to collect FFP for SOLA services provided to waiver clients. At the close of each year, a settlement calculation is prepared to recover additional federal funds, or to pay back funds previously received.

Flow Chart
The flow chart provides a graphic depiction of the flow of dollars for waiver services.



State:	Washington
Effective Date	4/1/2007

c. Certifying Public Expenditures *(select one)*:

○	**Yes**. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid (*check each that applies*):
☐	**Certified Public Expenditures (CPE) of State Public Agencies**. Specify: (a) the public agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)
☐	**Certified Public Expenditures (CPE) of Non-State Public Agencies**. Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)
☒	**No**. Public agencies do not certify expenditures for waiver services.

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

a.) Individual was eligible for Medicaid waiver payment on the date of service

1) a) Waiver Status in CCDB Waiver Screen

The Division of Developmental Disabilities' Common Client Data Base includes a "Waiver Screen" that contains the type of waiver (if any) an individual is on, the waiver begin date, and waiver end date (if any). An individual is placed on a waiver in the Waiver Screen by the Waiver Requirements Program Manager, who works in DDD Central Office. A waiver begin date (i.e., referral and effective date) is entered by the Waiver Requirements manager once regional staff have completed all steps necessary to verify waiver eligibility. Those steps include verification of the need for ICF/MR Level of Care (LOC), verification of financial eligibility (as established by Community Services Office-CSO staff), completion of the waiver Voluntary Participation form (DSHS # 10-296), verification of a disability per criteria established in the Social Security Act, and completion of an Individual Service Plan (ISP).

Once waiver eligibility is verified, waiver referral and effective dates are entered into the CCDB Waiver Screen. The effective date serves as the begin date for claiming of federal financial participation for waiver services.

1) b) Waiver Status in CMIS Waiver Screen

Effective 3/31/08, the CCDB was replaced by the Case Management Information System (CMIS), which is integrated into the CARE Platform. The CMIS also has a "Waiver Screen" that contains the type of waiver (if any) an individual is on the, the waiver begin date, and waiver end date (if any). The CARE platform automatically inserts a waiver begin date into the Waiver Screen when an approved waiver enrollment request (also contained in the CARE platform) is present and the individual service plan containing the name of the waiver and waiver services to be received is moved to "current" status.

The Waiver Requirements Program Manager, who works in DDD Central Office, verifies the appropriateness of the waiver effective date based on the completion dates indentified in the "Waiver Eligibility Determination Checklist (DSHS # 10-274), which includes verification of the need for ICF/MR Level of Care (LOC), verification of financial eligibility (as established by Community Services Office-CSO staff), voluntary acceptance of waiver services, verification of a disability per criteria established in the Social Security Act, and completion of an Individual Service Plan (ISP).

The Waiver Requirements Program Manager either confirms that the waiver effective date is appropriate or enters the appropriate date into the Waiver Screen. The waiver effective date serves as the begin date for claiming of federal financial participation for waiver services.

2) Waiver Status and Service Authorization/Payment

SSPS: The Client Authorization Services Input System (CASIS) is used by regional case

managers to create social service payment system (SSPS) authorizations for client services using an automated electronic form. CASIS validates all client data through the Division of Developmental Disabilities' Common Client Data Base (CCDB), all provider data through SSPS's provider tables, and all service code data through SSPS's accounts and service codes tables before submitting the authorization to the SSPS.

A CASIS edit validates the waiver status of an individual when an authorization for a SSPS code for a waiver service is to be opened. The SSPS contains service codes unique to the Community Protection Waiver.

The current waiver status (in the CCDB Waiver Screen) of the individual must be consistent with the code being authorized; otherwise CASIS will not allow the authorization. The result is that Community Protection Waiver services via SSPS can only be authorized for clients shown to be on the Community Protection Waiver as indicated in the CCDB Waiver Screen.

CHRIS: Billings for services (e.g., prevocational services, supported employment services, person to person) contracted through the counties are submitted monthly by each county to the department using the County Human Resource Information System (CHRIS). Billing includes the program name (e.g., supported employment services that were in the program that month, identification of those clients on each waiver, the total units of service provided by the program and the cost per unit of service.

Waiver clients are identified by a source of funds (SOF) code. A Management Bulletin and attachments are used to inform regional staff (who complete authorizations for day programs that include the SOF) of the current SOFs for each waiver.

A-19 Invoice Vouchers: Payment is made on A-19 invoice vouchers for all day programs and supported employment services, as well as for most Mental Health Stabilization services. Information on total payments for Waiver and non-waiver clients by service type is carried forward to the A-19 from the CHRIS billing by ADSA accounting staff. Regional accounting staff code payments for Mental Health Stabilization services to the A-19 based upon the waiver status of the individual client.

Look-behind reviews/audits of the coding of services for waiver clients is conducted by ADSA/DDD QCC staff and by ADSA Decision Support staff. Any necessary corrections in account coding are made by DDD regional accounting staff or ADSA Headquarters accounting staff.

b) Service was include in the participant's approved service plan

To ensure that ISPs reflect the current needs of the individual, ISPs are updated as needed and at least annually (please see Appendix H-1-b-3 for a description of the steps taken to ensure ISP's are updated).

ADSA/DDD QCC (Quality Compliance Coordinators) review a sample of clients annually by region. Their review includes a comparison of service payments with the services contained in approved ISPs to ensure to ensure that services claimed against the Community Protection Waiver were contained in the approved ISP.

c.) The services were provided.

Monitoring of the provision of services is outlined in Appendix H-1-b-4. Steps taken

include:

- QCC and supervisory file reviews/audits verify the authorization match ISP including the type, scope, amount, duration and frequency of the service. When findings occur regions have 30-90 days to correct problems. QCC monitors the corrective action plans.
- CRMs complete a review of last year's plan with the waiver recipient prior to beginning the planning process for the upcoming year. A portion of the review is to confirm services were received in accordance with the ISP.
- The State participates in the National Core Indicators Survey. Waiver related questions have been added to the survey. This annual face-to-face sampling of waiver participants provides an opportunity for DDD management to evaluate ISP outcomes from the recipient's perspective.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

APPENDIX I-3: Payment

a. Method of payments — MMIS *(select one)*:

○	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
○	Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
☒	Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

a.) The process by which payments are made and the entity that processes payments and
b.) How and through which system(s) the payments are processed.

Most waiver services are paid and tracked through the State's automated Social Services Payment System (SSPS). The State's A-19 invoice review and payment system is used to pay for services (e.g., prevocational services, supported employment, person to person) funded through the counties and therefore not incorporated into the SSPS system, with electronic verification of client eligibility and vendor charges. The County Human Resource Information System (CHRIS) is used to track services funded through the counties. The A-19 invoice voucher is also used to reimburse for most mental health stabilization services.

Overview of the Social Service Payment System (SSPS)

The Social Service Payment System (SSPS) authorizes the delivery and/or purchase of services for recipients, collects required state and federal statistical and management data, and initiates the payment process for purchased services. DSHS organizational and program units use this system to authorize expenditures for social services.

On the basis of SSPS Community Protection Waiver service codes, SSPS expenditure information interfaces with the department's accounting system (Financial Reporting System/Agency Financial Reporting System-FASTRACK/AFRS). Aging and Disability Services Administration (ADSA) Headquarters staff maintain an account coding crosswalk that links Community Protection Waiver SSPS service codes with the FASTRACK/AFRS system.

Overview of the County Human Resource Information System (CHRIS)

Billings for services (e.g., prevocational services, supported employment services, person to person) contracted through the counties are submitted monthly by each county to the department. Each billing includes the program name (e.g., supported employment services), a list of clients that were in the program that month, identification of those

clients on each waiver, the total units of service provided by the program, the cost per unit of service, and the amount billed the Division for each client.

Charges billed to the waiver program for supported employment services exclude any wages earned by recipients. Client hours worked or spent on site are listed on billings separately from the hours of service provided the client. Department of Social and Health Services-DSHS (i.e., Single State Agency) payments are only for hours of service provided.

Payment is made on A-19 invoice vouchers for all day programs and supported employment services. Information on total payments for Waiver and non-waiver clients by service type is carried forward to the A-19 by ADSA accounting staff.

Overview of the A-19 Invoice Voucher

The A-19 invoice voucher is a state payment form that identifies a request for reimbursement of prevocational services, supported employment, or person to person services and most mental health stabilization services. The A-19 contains and/or is accompanied by support documentation (e.g., CHRIS forms) that identifies all Community Protection Waiver services for Community Protection Waiver clients, units of service, and rates per unit of service. The A-19 invoice vouchers are manually coded and processed through the state's vendor payment system.

c.) How an audit trail is maintained for all state and federal funds expended outside the MMIS;

All payments are backed by an audit trail. The trail begins prior to delivery of service to the individual recipient, and follows through to the claim for federal financial participation (FFP). Key steps in the audit trail include:

- Verification of client and provider eligibility for Medicaid;
- Service authorization;
- Verification of service delivery;
- Invoicing and payment; and
- Calculation of FFP.

Client Eligibility: Individual client case records document the recipient's eligibility for the waiver. Persons verified by the DDD case manager as meeting all eligibility requirements and placed on the waiver are identified in the Common Client Data Base (CCDB). The CCDB is a Division-specific database consisting of client characteristic/status information provided and maintained by regional DDD staff. It is a computer-based system for which Division staff have data input and systems responsibility. Information on client eligibility is maintained in client case records for a minimum of five (5) years.

Provider Eligibility: All providers of waiver services must hold current contracts/provider agreements that define the services to be provided, and the payment for those services. Contract agreements additionally require providers to document and retain records of all

services and charges for at least three (3) years after service delivery, and to make such records available on request for state and federal inspection and audit.

Service Authorization: Waiver services are authorized prior to service delivery by the DDD case manager responsible for the recipient's individual written plan of care. Case managers ensure that those services authorized are included in the approved plan of care. Service authorizations specify the client; the type and amount of service to be provided; the begin and end dates for delivery of the service, the provider; the payment rate for the service; a source of funds code designating if the service is to be provided and charged under the waiver; and identification of the case manager authorizing the service.

Services paid under the automated SSPS system are authorized electronically. Records of electronic authorizations are retained for a minimum of three (3) years on microfiche. Paper authorization forms for services paid under the manual A-19 system are retained in the official client records for a minimum of five (5) years.

Service Delivery: All providers are required to retain records which document actual service delivery on an individual recipient basis. These records must be in addition to and document information contained on the billing document. The specific format and content of such records varies according to the particular service provided. Typical documentation includes records of days attended, hours of services delivered, specific service interventions used, and progress toward individual training plan objectives.

Records Maintained by Providers

Contract agreements with providers of waiver services require providers to document and retain records of all services and charges for at least three (3) years after service delivery. Typical documentation includes records of days attended, hours of services delivered, specific service interventions used, and progress toward individual training plan objectives.

Acute care and other regular state plan services are paid and tracked through the State's Medicaid Management Information System (MMIS). No waiver services are paid or tracked through the MMIS.

Service Invoicing and Payment: Completion of the electronic SSPS service authorization results in automatic issuance of an invoice to the provider for each authorized service. The invoice identifies the individuals authorized to receive the particular service. The provider includes on the invoice the type of unit (e.g., hour, day), the number of units delivered during the month to each client, signs a certification statement, and returns it to the state for processing. Upon return to the state, it is entered into an electronic database and electronically cross-checked to verify consistency with authorized service types, delivery dates, service amounts, and unit rates; after which a warrant is issued.

Records Maintained by the Aging and Disability Administration/Division of Developmental Disabilities

Information on client eligibility is maintained in official client case records for a minimum of five (5) years. These records are maintained in DDD regional and local offices.

Copies of provider contracts are maintained for a minimum of five years in ADSA/DDD regional offices.

	Records of electronic authorizations for payment are retained for a minimum of three years on microfiche, and on a computer tape indefinitely. Paper authorization forms for services paid under the manual A-19 system are retained in the official client records for a minimum of five years. Back-up documentation for CMS-64 reports are maintained for a minimum of three years. d) Basis for the draw of federal funds and claiming of these expenditures on the CMS-64. The federal financial participation (FFP) for Community Protection Waiver services is calculated through the state's approved and automated cost allocation plan. The FFP is collected through two payment systems: one automated (SSPS) and one manual (Invoice voucher A-19). Both payment systems' accounting information is processed through the State of Washington Agency Financial Reporting System (AFRS) and the Department of Social and Health Services FASTRACK System which includes the Federal Cost Allocation Plan. The basis for the dollars claimed under the Community Protection Waiver in the CMS 64 is account coding contained in the Departments FASTRACK/AFRS financial reporting system. Separate account coding is maintained for Community Protection Waiver services. All expenditures for services claimable (i.e., services covered under the Community Protection Waiver that are provided to a Community Protection Waiver recipient and are included in the ISP) under the Community Waiver are coded using the Community Waiver account coding. Those expenditures are included in the CMS-64 under the Community Protection Waiver.
○	Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities:

b. Direct payment. Payments for waiver services are made utilizing one or more of the following arrangements (*check each that applies*):

☒	The Medicaid agency makes payments directly to providers of waiver services.
☐	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
☒	The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent. Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:
	Payments for Day Programs/Supported Employment are made to Counties. Some Counties are direct service providers. Most contract with and reimburse direct service providers.
☐	Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity. Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

☒	**No**. The State does not make supplemental or enhanced payments for waiver services.
○	**Yes**. The State makes supplemental or enhanced payments for waiver services. Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

d. Payments to Public Providers. *Specify whether public providers receive payment for the provision of waiver services.*

☒	**Yes.** Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. *Complete item I-3-e.*
	Payments for Day Programs/Supported Employment are made to Counties. Payments for Supported Living are made to State Operated Living Alternatives (SOLA). SOLAs are a state run program.
○	**No**. Public providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

e. **Amount of Payment to Public Providers**. Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one*:

○	The amount paid to public providers is the same as the amount paid to private providers of the same service.
☒	The amount paid to public providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
○	The amount paid to public providers differs from the amount paid to private providers of the same service. When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

☒	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
○	Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):
○	Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment. Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

☒	**Yes**. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e). Specify the governmental agency (or agencies) to which reassignment may be made.
	Counties
○	**No**. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. Organized Health Care Delivery System. *Select one:*

○	**Yes**. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10. Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:
☒	**No**. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

○	The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.
○	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain *waiver* and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
☒	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

APPENDIX I-4: Non-Federal Matching Funds

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Check each that applies:*

☒	**Appropriation of State Tax Revenues to the State Medicaid agency**
☐	**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:
☐	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2- c:

b. Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Check each that applies:*

☐	**Appropriation of Local Revenues.** Specify: (a) the local entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
☐	**Other non-State Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
☒	**Not Applicable**. There are no non-State level sources of funds for the non-federal share.

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources. *Check each that applies.*

☐	Provider taxes or fees
☐	Provider donations
☐	Federal funds (other than FFP)
	For each source of funds indicated above, describe the source of the funds in detail:
☒	None of the foregoing sources of funds contribute to the non-federal share of computable waiver costs.

APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○	No services under this waiver are furnished in residential settings other than the private residence of the individual. (*Do not complete Item I-5-b*).
☒	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. (*Complete Item I-5-b*)

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Individuals Residing in Their Own Residence

Waiver clients who live in their own home (e.g., house, apartment) pay for their room and board out of their own resources (e.g., SSA, SSI, earnings from supported employment). Since supportive living services (either state-staffed or privately contracted) do not include room and board, payments for those services (which are claimed under Title XIX) do not include the cost of room and board.

APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.
Select one:

○	**Yes**. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services. *The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:*
☒	**No.** The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services as provided in 42 CFR §447.50. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

☒	**No**. The State does not impose a co-payment or similar charge upon participants for waiver services. (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes**. The State imposes a co-payment or similar charge upon participants for one or more waiver services. (*Complete the remaining items*)

i. Co-Pay Arrangement Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*	
☐	Nominal deductible
☐	Coinsurance
☐	Co-Payment
☐	Other charge *(specify)*:

ii Participants Subject to Co-pay Charges for Waiver Services. Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded. The groups of participants who are excluded must comply with 42 CFR §447.53.

iii. Amount of Co-Pay Charges for Waiver Services. In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge. The amount of the charge must comply with the maximum amounts set forth in 42 CFR §447.54.

Waiver Service	Amount of Charge	Basis of the Charge

iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
○	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. Assurance. In accordance with 42 CFR §447.53(e), the State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one:*

☒	**No**. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
○	**Yes**. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income as set forth in 42 CFR §447.52; (c) the groups of participants subject to cost-sharing and the groups who are excluded (groups of participants who are excluded must comply with 42 CFR §447.53); and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care *(specify)*:							
Col. 1	**Col. 2**	**Col. 3**	**Col. 4**	**Col. 5**	**Col. 6**	**Col. 7**	**Col. 8**
Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total: G+G′**	**Difference (Column 7 less Column 4)**
1	97,489	6,994	104,483	164,416	2,006	166,422	61,939
2	98,166	7,117	105,283	150,717	2,019	152,736	47,453
3	109,606	7,242	116,848	167,165	2,033	169,198	52,350
4	111,837	4,970	116,807	162,912	2,033	164,945	48,138
5	113,504	4,970	118,474	167,131	2,033	169,164	50,690

Appendix J-2 - Derivation of Estimates

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
Year 1	461	ICF/MR	
Year 2	483	ICF/MR	
Year 3	484	ICF/MR	
Year 4 (renewal only)	481	ICF/MR	
Year 5 (renewal only)	483	ICF/MR	

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-d.

The 331-day projected average length of stay for Waiver Renewal Year 1, 325-day projected length of stay for Waiver Renewal Year 2, 355-day projected length of stay for Waiver Renewal Year 3, 346-day projected length of stay for Waiver Renewal Year 4, and 350-day projected length of stay for Waiver Renewal Year 5 are based upon the number of individuals that will be on the waiver for the entire waiver renewal year and the projected number of days on the waiver of those added to the waiver and those leaving the waiver during each waiver year.

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D estimates for Waiver Renewal Years 1,2 and 3 are based on the pattern of utilization and expenditures for each waiver service contained in the Initial CMS-372 Report for Waiver Year 1, with the exceptions noted below. (The Lag Report was not available at the time these estimates were completed.) Waiver Year 1 costs were trended forward to the waiver renewal period based on service-specific vendor rate increases provided by the Legislature.

Trend factors applied through Waiver Renewal Years 1, 2 and 3 were based on the average vendor rate increases provided from 7/104 through 7/1/06 and are as follows:

- **Residential Habilitation Services**: **Contracted Supported Living** = 1.76%
- **Residential Habilitation Services: State-Operated Supported Living** =1.60%.
- **All other services** (except for Transportation) = 0.67%.
- **Medicaid State Plan Services** = 0.67%
- **Transportation**: the reimbursement amount per mile has been adjusted for Waiver

Renewal Years 2- 6 per the rates negotiated by the Service Employees International Union (SEIU) for personal care (PC) transportation.

Trend factors through Waiver Renewal Years 1, 2 and 3 have been adjusted to reflect the following service-specific vendor rate increases provided by the Legislature:

- **Residential Habilitation Services-Contracted Supported Living** = 4.5% on 7/1/07 and 1.6% on 7/1/08.
- **Supported Employment, Pre-Vocational Services and Person to Person** = 1.6% on 7/1/07 and 1.0% on 7/1/08.

No trend factors were applied for Waiver Renewal Years 4 and 5 due to reduced state revenue which has resulted in no vendor rate increases.

Projections for the following services for Waiver Renewal Years 1, 2 and 3 were based on the Initial 372 Report for Waiver Year 1:

- Contracted Supported Living
- State-Staffed Supported Living
- Person to Person
- Prevocational Services
- Supported Employment Services
- Behavior Management and Consultation
- Community Transition
- Skilled Nursing
- Sexual Deviancy Evaluation

Projections for all Waiver Renewal Years (i.e., 1 though 5) not based on the Initial CMS-372 Report for Waiver Year 1 are as follows.

- **Specialized Medical Equipment and Supplies**: Projections are based on use by Core Waiver (#0410) recipients during Waiver Year 1.
- **Occupational Therapy Services**: Projections are based on use by Core Waiver (#0410) recipients during Waiver Year 1.
- **Speech, Hearing and Language Services**: Projections are based on use by Core Waiver (#0410) recipients during Waiver Year 1.

Projections for Waiver Renewal years 1,2 and 3 not based on the Initial CMS-372 Report for Waiver Year 1 are as follows.

- **Environmental Accessibility Adaptations**: Projections are based on use by Core Waiver (#0410) recipients during Waiver Year 1.
- **Staff/Family Consultation and Training**: Projections are based on the use of these services from 7/03 – 3/04 by individuals who went on the Core Waiver on 4/1/04.
- **Specialized Psychiatric Services**: The use of specialized psychiatric services should have been reported under Mental Health Stabilization Services. Nevertheless, the state of Washington would like to maintain this as a stand-alone service. An estimated 0.23% of waiver recipients are projected to receive the service during Waiver Renewal Years 1, 2 and 3.. The number of units of service and the cost/unit estimates for those renewal years are derived from the use of this service as a mental health stabilization service.
- **Mental Health Stabilization Services-Behavior Management and Consultation**: Projections are based upon expenditures during Waiver Year 2 and utilization (cost per unit and # of units per user) during Waiver Year 1.
- **Mental Health Stabilization Services-Mental Health Crisis Diversion Bed Services**:

Projections are based upon expenditures during Waiver Year 2 and utilization (cost per unit and # of units per user) during Waiver Year 1.

- **Mental Health Stabilization Services-Skilled Nursing Services**: An estimated 0.23% of waiver recipients are projected to receive the service each waiver year. The number of units of service and the cost/unit estimates are derived from the use of skilled nursing as a stand-alone service. (Skilled nursing has been removed as a Mental Health Stabilization Service effective 1/1/10)
- **Mental Health Stabilization Services-Specialized Psychiatric Services**: Projections are based on expenditures during Waiver Year 2 and utilization (cost per unit and # of units per user) during Waiver Year 1. Projections are based upon data that include the utilization reported in the CMS-372 Report for Waiver Year 1 under regular specialized psychiatric services. That utilization should have been reported under Mental Health Stabilization Services.

Projections for the following services for Waiver Renewal Years 4 and 5 are based on the Initial 372 Report prepared for Waiver Renewal Year 3:

- Contracted Supported Living
- State-Staffed Supported Living
- Person to Person
- Prevocational Services
- Supported Employment Services
- Behavior Management and Consultation
- Staff/Family Consultation and Training
- Environmental Accessibility Adaptations
- Community Transition
- Skilled Nursing
- Sexual Deviancy Evaluation
- Mental Health Stabilization Services-Behavior Management and Consultation
- Mental Health Stabilization Services-Mental Health Crisis Diversion Bed Svcs
- Mental Health Stabilization Services-Specialized Psychiatric Services

Since the use of specialized psychiatric services has been reported under Mental Health Stabilization Services, no use of these as a stand-alone service is projected for Waiver Renewal Years 4 and 5.

ii. Factor D′ Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' estimates for Waiver Renewal Years 1, 2 and 3 are based on expenditures contained in the Initial CMS-372 Report for Waiver Year 1. (The Lag Report was not available at the time these estimates were completed.) The Waiver Year 1 amount ($6,754) was increased by 1.76% (to trend it through Waiver Year 3) to reflect vendor rate increases of 1% on 7/1/05 and 7/1/06.

A yearly trend factor of 0.67% (the average increase since 7/1/04) was used to project values for Waiver Renewal Years 1, 2 and 3.

Factor D' estimates for Waiver Renewal Years 4 and 5 are based one expenditures prepared for an Initial CMS-372 Report for Waiver Renewal Year 3. No trend factors were applied, due to reduced state revenue and a corresponding lack of vendor rate increases.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Estimates of Factor G values are based upon actual per day costs for ICF/MR care in the state of Washington during State Fiscal Year (SFY) 2005 (7/1/2004 – 6/30/2005) times the number of days clients on the waiver would be in an ICF/MR if the waiver did not exist. In the absence of the waiver, waiver clients would be on an ICF/MR for the same number of days that they are projected to be on the waiver. The average number of days on the waiver is contained in the projections of Factor D.

The daily cost of ICF/MR services in State Fiscal Year (SFY) 2005 is a composite rate because 7.2% of ICF/MR bed days are in privately-operated facilities and 92.8% of ICF/MR bed days are in state-operated institutions, and each facility has its own individualized rate. Private vendors received 1.0% rate increases on 7/1/2005 and 7/1/2006. Vendor rate increases of 0.67% (the average increase since 7/1/04) on July 1 of future years are projected through Waiver Renewal Year 3. No trend factors were applied for Waiver Renewal Years 4 and 5, due to reduced state revenue and a corresponding lack of vendor rate increases.

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Pay raises provided by the Legislature for state (union) employees are 3.2% on 7/1/2005 and 1.6% on 7/1/2006. Pay raises for state (union) employees of 1.6% (the average increase since 7/1/04) on July 1 of future years are projected.

Combining actual and projected rate/pay increases yields a total adjustment (to reflect all vendor rate increases since the base period) to the base rate of 5.85% to bring the average daily cost through Waiver Renewal Year 1. Thereafter, vendor rate increases of 1.54% per year for Renewal Years 2 and 3 are projected to reflect yearly vendor rates increases of 0.67% on July 1 and state employee pay raises of 1.60% on July 1. No trend factors were applied for Waiver Renewal Years 4 and 5, due to reduced state revenue and a corresponding lack of vendor rate increases.

iv. Factor G′ Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' projections are based on the actual per person cost ($1,953.77) of State Plan services by ICF/MR residents during SFY05 (7/1/21004 – 6/30/2005) trended forward to Waiver Year 3 by 2.01% to reflect vendor rate increases of 1.0% on 7/1/2005 and 7/1/2006. Vendor rate increases of 0.67% (the average increase since 7/1/04) on July 1 of future years through Waiver Renewal Year 3 are projected. No trend factors were applied for Waiver Renewal Years 4 and 5, due to reduced state revenue and a corresponding lack of vendor rate increases. .

d. Estimate of Factor D. *Select one:* Note: Selection below is new.

☒	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
○	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year

Waiver Year: Year 1					
Waiver Service	Col. 1 **Unit**	Col. 2 **# Users**	Col. 3 **Avg. Units Per User**	Col. 4 **Avg. Cost/ Unit**	Col. 5 **Total Cost**
Habilitation					
-Residential Habilitation					
Contracted Supported Living	Day	453	331	$267.97	$40,180,226
State Staffed Supported Living (SOLA)	Day	6	331	$311.73	$619,096
-Day Habilitation					
Person to Person	Month	33	11	$630.37	$228,824
Expanded Habilitation					
Prevocational	Month	62	11	$486.51	$331,800
Supported Employment	Month	263	11	$669.54	$1,936,979
Behavior Management and Consultation	Hour	425	47	$72.17	$1,441,596
Staff/Family Consultation and Training	Hour	1	79	$25.16	$1,988
Environmental Accessibility Adaptations	Each	1	1	$3,845.25	$3,845
Transportation	Mile	1	1,745	.31	$541
Specialized Medical Equipment and Supplies	Each	1	1	$384.84	$385
Community Transition	Each	0	1	$1,759.58	0
Skilled Nursing	Hour	1	13	$33.11	$430
Sexual Deviancy Evaluation	Each	28	1	$504.09	$14,115
Specialized Psychiatric	Hour	1	7	$145.69	$1,020
Mental Health Stabilization					
Behavior Management and Consultation	Hour	119	11	$112.69	$147,511
Mental Health Crisis Diversion Bed	Day	2	14	$281.33	$7,877
Skilled Nursing	Hour	1	2	$33.11	$66
Specialized Psychiatric	Hour	35	3	$217.45	$22,832
Extended State Plan Services					
Occupational Therapy	Hour	1	60	$16.85	$1,011
Speech, Hearing and Language	Hour	1	71	$15.55	$1,104
Physical Therapy	Hour	2	6	$80.86	$970
GRAND TOTAL:					$44,942,216
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					461

Waiver Year: Year 1					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
FACTOR D (Divide grand total by number of participants)					$97,489
AVERAGE LENGTH OF STAY ON THE WAIVER					331

Waiver Year: Year 2					
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
Waiver Service	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Habilitation					
-Residential Habilitation					
Contracted Supported Living	Day	477	325	$274.07	$42,487,702
State Staffed Supported Living (SOLA)	Day	6	325	$318.82	$621,699
-Day Habilitation					
Person to Person	Month	35	10	$638.56	$223,496
Expanded Habilitation					
Prevocational	Month	65	10	$492.83	$320,340
Supported Employment	Month	276	11	$678.24	$2,059,137
Behavior Management and Consultation	Hour	445	46	$72.65	$1,487,146
Staff/Family Consultation and Training	Hour	1	78	$25.33	$1,976
Environmental Accessibility Adaptations	Each	1	1	$3,871.01	$3,871
Transportation	Mile	1	1,686	.49	$838
Specialized Medical Equipment and Supplies	Each	1	1	$387.42	$387
Community Transition	Each	0	1	$1,771.37	0
Skilled Nursing	Hour	1	13	$33.33	$433
Sexual Deviancy Evaluation	Each	29	1	$507.47	$14,717
Specialized Psychiatric	Hour	1	6	$146.67	$880
Mental Health Stabilization					
Behavior Management and Consultation	Hour	125	11	$113.45	$155,994
Mental Health Crisis Diversion Bed	Day	2	14	$283.21	$7,930
Skilled Nursing	Hour	1	2	$33.33	$67
Specialized Psychiatric	Hour	37	3	$218.91	$24,299
Extended State Plan Services					
Occupational Therapy	Hour	1	59	$16.96	$1,001
Speech, Hearing and Language	Hour	1	70	$15.65	$1,096
Physical Therapy	Hour	2	6	$81.40	$977
GRAND TOTAL:					$47,413,986
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					483
FACTOR D (Divide grand total by number of participants)					$98,166
AVERAGE LENGTH OF STAY ON THE WAIVER					325

Waiver Year: Year 3					
Waiver Service	Col. 1 **Unit**	Col. 2 **# Users**	Col. 3 **Avg. Units Per User**	Col. 4 **Avg. Cost/ Unit**	Col. 5 **Total Cost**
Habilitation					
-Residential Habilitation					
Contracted Supported Living	Day	478	355	$280.31	$47,565,804
State Staffed Supported Living (SOLA)	Day	6	355	$326.08	$694,550
-Day Habilitation					
Person to Person	Month	35	11	$646.86	$249,041
Expanded Habilitation					
Prevocational	Month	65	11	$499.24	$356,957
Supported Employment	Month	276	12	$687.06	$2,275,543
Behavior Management and Consultation	Hour	446	51	$73.14	$1,663,642
Staff/Family Consultation and Training	Hour	1	85	$25.50	$2,168
Environmental Accessibility Adaptations	Each	1	2	$3,896.95	$7,794
Transportation	Mile	1	1,869	.55	$1,028
Specialized Medical Equipment and Supplies	Each	1	2	$390.02	$780
Community Transition	Each	0	1	$1,783.24	0
Skilled Nursing	Hour	1	14	$33.55	$470
Sexual Deviancy Evaluation	Each	29	1	$510.87	$14,815
Specialized Psychiatric	Hour	1	7	$147.65	$1,034
Mental Health Stabilization					
Behavior Management and Consultation	Hour	125	12	$114.21	$171,315
Mental Health Crisis Diversion Bed	Day	2	15	$285.11	$8,553
Skilled Nursing (Removed as a Mental Health Stabilization Service effective 1/1/10.)	Hour	1	2	$33.55	$67
Specialized Psychiatric	Hour	37	4	$220.38	$32,616
Extended State Plan Services					
Occupational Therapy	Hour	1	64	$17.07	$1,092
Speech, Hearing and Language	Hour	1	77	$15.75	$1,213
Physical Therapy	Hour	2	6	$81.95	$983
GRAND TOTAL:					$53,049,465
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					484
FACTOR D (Divide grand total by number of participants)					$109,606
AVERAGE LENGTH OF STAY ON THE WAIVER					355

Waiver Year: Year 4 *(renewal only)*					
Waiver Service	Col. 1 **Unit**	Col. 2 **# Users**	Col. 3 **Avg. Units Per User**	Col. 4 **Avg. Cost/ Unit**	Col. 5 **Total Cost**
Habilitation					
-Residential Habilitation					
Contracted Supported Living	Day	477	340	$303.13	$49,161,623
State Staffed Supported Living (SOLA)	Day	3	346	$366.44	$380,365
-Day Habilitation					
Person to Person	Month	73	9	$650.92	$427,654
Expanded Habilitation					
Prevocational	Month	41	10	$484.56	$198,670
Supported Employment	Month	286	10	$625.11	$1,787,815
Behavior Management and Consultation	Hour	470	42	$82.46	$1,627,760
Staff/Family Consultation and Training	Hour	278	2	$60.74	$33,771
Environmental Accessibility Adaptations	Each	8	1.9	$559.33	$8,390
Transportation	Mile	1	1,821	.503	$916
Specialized Medical Equipment and Supplies	Each	1	1	$218.58	$219
Community Transition	Each	3	1	$1,258,.71	$3,776
Skilled Nursing	Hour	23	18	$32.96	$13,645
Sexual Deviancy Evaluation	Each	31	1	$905.34	$28,066
Specialized Psychiatric	Hour	0	7	$148.64	$0
Mental Health Stabilization					
Behavior Management and Consultation	Hour	69	10	$134.00	$92,460
Mental Health Crisis Diversion Bed	Day	2	5.5	$332.88	$3,662
Specialized Psychiatric	Hour	27	4	$199.51	$21,547
Extended State Plan Services					
Occupational Therapy	Hour	1	63	$17.07	$1,075
Speech, Hearing and Language	Hour	1	75	$15.75	$1,181
Physical Therapy	Hour	2	6	$81.95	$983
GRAND TOTAL:					$53,793,578
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					481
FACTOR D (Divide grand total by number of participants)					$111,837
AVERAGE LENGTH OF STAY ON THE WAIVER					346

Waiver Year: Year 5 *(renewal only)*					
Waiver Service	Col. 1 **Unit**	Col. 2 **# Users**	Col. 3 **Avg. Units Per User**	Col. 4 **Avg. Cost/ Unit**	Col. 5 **Total Cost**
Habilitation					
-Residential Habilitation					
Contracted Supported Living	Day	479	344	$303.13	$49,948,549
State Staffed Supported Living (SOLA)	Day	3	350	$366.44	$384,762
-Day Habilitation					
Person to Person	Month	73	9	$650.92	$427,654
Expanded Habilitation					
Prevocational	Month	42	10	$484.56	$203,515
Supported Employment	Month	287	11	$625.11	$1,973,472
Behavior Management and Consultation	Hour	472	43	$82.46	$1,673,608
Staff/Family Consultation and Training	Hour	472	2	$60.74	$33,893
Environmental Accessibility Adaptations	Each	8	1.9	$559.33	$8,390
Transportation	Mile	1	1,840	.51	$938
Specialized Medical Equipment and Supplies	Each	1	1	$218.58	$219
Community Transition	Each	3	1	$1,258.71	$3,776
Skilled Nursing	Hour	23	18	$32.96	$13,645
Sexual Deviancy Evaluation	Each	31	1	$905.34	$28,066
Specialized Psychiatric	Hour	0	7	$147.65	$0
Mental Health Stabilization					
Behavior Management and Consultation	Hour	69	10	$134.00	$92,460
Mental Health Crisis Diversion Bed	Day	2	5.5	$332.88	$3,662
Specialized Psychiatric	Hour	28	4	$199.51	$22,345
Extended State Plan Services					
Occupational Therapy	Hour	1	63	$17.07	$1,075
Speech, Hearing and Language	Hour	1	75	$15.75	$1,181
Physical Therapy	Hour	2	6	$81.95	$983
GRAND TOTAL:					$54,822,193
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					483
FACTOR D (Divide grand total by number of participants)					$113,504
AVERAGE LENGTH OF STAY ON THE WAIVER					350

i. Estimate of Factor D – Concurrent §1915(b)/§1915(c) Waivers. Complete the following table for each waiver year.

Waiver Year: Year 1						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 2						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 3						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 4 (Renewal Only)						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 5 (Renewal Only)						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						