Application for a Â§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 section 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 waiverï¿½s 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.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Washington** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of ?1915(c) of the Social Security Act.

B. Program Title:
COPES

C. Waiver Number:WA.0049
Original Base Waiver Number: WA.0049.4

D. Amendment Number:WA.0049.R09.01

E. Proposed Effective Date: (mm/dd/yy)
01/01/25

Approved Effective Date: 01/01/25
Approved Effective Date of Waiver being Amended: 01/01/24

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

- Update Adult Day Care service definition to remove the manual reduction of personal care service hours by 30 minutes for each hour of ADC and add that ADC services are accounted for in the CARE Assessment as informal support.
- Add six (6) years of professional/practical social service experience performing functions equivalent to a Social Service Specialist 2 to the qualifications of individuals performing evaluations/assessments.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	
☐ Appendix A ?	

Component of the Approved Waiver	Subsection(s)
Waiver Administration and Operation	
☒ Appendix B ? Participant Access and Eligibility	B-6-c
☒ Appendix C ? Participant Services	C-1/C-3 ADC, CST&WE
☒ Appendix D ? Participant Centered Service Planning and Delivery	D-1-a
☐ Appendix E ? Participant Direction of Services	
☐ Appendix F ? Participant Rights	
☐ Appendix G ? Participant Safeguards	
☐ Appendix H	
☐ Appendix I ? Financial Accountability	
☐ Appendix J ? Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☐ **Add/delete services**

☐ **Revise service specifications**

☐ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☐ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☐ **Other**

Specify:

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

1. Request Information (1 of 3)

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

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

COPES

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: WA.0049
Waiver Number:WA.0049.R09.01
Draft ID: WA.003.09.01

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 01/01/24
Approved Effective Date of Waiver being Amended: 01/01/24

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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 age 21 and under as provided in 42 CFR § 440.160**

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility 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:

No additional limits

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR § 440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of section 1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under section 1915(b) of the Act.**

Specify the section 1915(b) waiver program and indicate whether a section 1915(b) waiver application has been submitted or previously approved:

Specify the section 1915(b) authorities under which this program operates *(check each that applies):*

☐ **section 1915(b)(1) (mandated enrollment to managed care)**

☐ **section 1915(b)(2) (central broker)**

☐ **section 1915(b)(3) (employ cost savings to furnish additional services)**

☐ **section 1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under section 1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under section 1915(i) of the Act.**

☐ **A program authorized under section 1915(j) of the Act.**

☐ **A program authorized under section 1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

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 Community Options Program Entry System (COPES) provides home and community-based services targeted to older adults as well as individuals with disabilities who are at nursing facility level of care and meet financial eligibility requirements. This waiver provides services for individuals who reside in private residences or licensed residential settings.

The waiver is administered by the State Department of Social and Health Services (DSHS) through the Aging and Long-Term Support Administration (ALTSA). The State determines initial financial and functional eligibility for services. On-going case management for in-home participants is provided by local Area Agencies on Aging (AAA).

The goal of this waiver is to support participants to live in the community setting of their choice rather than in a nursing facility or other more restrictive settings. The objective of the waiver is to develop and implement supports and services to successfully maintain individuals in their homes and communities. Each applicant participates in completing an individual assessment and developing a written plan of care that is tailored to meet their individual needs. The waiver includes the following services:
- Adult Day Care
- Adult Day Health
- Client Support Training & Wellness Education
- Environmental Modifications
- Home Delivered Meals
- Skilled Nursing
- Specialized Medical Equipment and Supplies
- Transportation
- Community Choice Guiding
- Community Support: Goods and Services

More information on the waiver and other aging and disability services in Washington State can be found at: https://www.dshs.wa.gov/altsa.

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*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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 Improvement Strategy. Appendix H contains the quality improvement 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 section 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 section 1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ◉ **Not Applicable**
- ○ **No**
- ○ **Yes**

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

- ◉ **No**
- ○ **Yes**

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.
Specify 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 section 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 Act (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) age 21 and under and 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 frequency 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/IID.

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 §431.151, 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 Improvement. 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 Improvement Strategy specified in **Appendix H**.

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

The Tribal notice which was published on 07/25/2024.

Public Notice of the waiver amendment was filed in the State Register on 08/19/2024. The State Register notice may be reviewed online or by printing a copy at local libraries. Community members may also obtain a paid subscription to the State Register from the Office of Code Reviser.

Notice of draft application amendment and review period was posted on ALTSA's internet site on 08/29/2024 announcing public review and comment period. All notices invited the public to review and comment on the waiver amendment application.

One public comment/question was received based upon these actions. The comment received requested the home delivered meals service be added to the New Freedom and Residential Support waiver and allow for two meals per day for all of Washington State's 1915c waivers. Summary of Washington's response: Home Delivered Meals is available in the New Freedom waiver but is not allowed in the Residential Support Waiver because participants do not live in their own private residents. Also, the 1915c waivers do not allow for more than one meal per day. Therefore, no related modifications were made to the amendment.

The Operating Agency meets regularly with the following to share information and obtain input on program design and quality of care:
- The Washington Association of Area Agencies on Aging
- Indian Policy Advisory Committee
- Washington Health Care Association
- Washington State Adult Family Home Council
- ALTSA/HCS Regional and Deputy Regional Administrators
- LeadingAge Washington
- State Council on Aging
- Regional Long Term Care Ombudsman
- Home Care Agency Committee

The State maintains a government-to-government relationship with the federally recognized Tribes in the state. This includes written accords, a formal process for consultation and process for informal input.

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 is 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:

Last Name: Rector

First Name: Bea

Title: Assistant Secretary

Agency: Aging and Long-Term Support Administration

Address: PO Box 45600

Address 2:

City: Olympia

State: **Washington**

Zip: 98504-5600

Phone: (360) 725-2311 **Ext:** ☐ **TTY**

Fax: (360) 407-7582

E-mail: bea-alise.rector@dshs.wa.gov

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

Last Name: Moua

First Name: Anne

Title: Waiver Program Manager

Agency: Aging and Long-Term Support Administration/Home and Community Services Division

Address: P.O. Box 45600

Address 2:

City: Olympia

State: **Washington**

Zip: 98504-5600

Phone: (509) 590-3909 **Ext:** ☐ **TTY**

Fax:

(360) 438-8633

E-mail:

Anne.Moua@dshs.wa.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under section 1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: Bea Rector

State Medicaid Director or Designee

Submission Date: Dec 5, 2024

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Moua

First Name: Anne

Title: HCBS Waiver Program Manager

Agency: Aging and Long-Term Support Administration

Address: PO Box 45600

Address 2:

City: Olympia

State: **Washington**

Zip: 98504

Phone: (509) 590-3909 **Ext:** ☐ **TTY**

Fax: (360) 438-8633

E-mail: Anne.Moua@dshs.wa.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Completed

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix C: Qualified Providers - Performance Measures:
- sub-assurance (a), second PM:
  - Numerator: N = Number of waiver service providers who continue to meet licensure &/or standards at contract renewal delegated by the SMA & adhere to other
    standards prior to their furnishing waiver services.

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)*:

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

○ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

◉ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

Department of Social and Health Services/Aging and Long-Term Support Administration (ALTSA)

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-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the state Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. 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:

Schedule A5 of the Cooperative Agreement delegates the following functions to the operating agency:
- Submission of all necessary application, renewal and amendment materials to CMS in order to secure and maintain approval of all proposed and existing waivers
- Responsibility for the operation, management, and reporting of allowable Medicaid administrative activities for approved federal waivers
- Developing regulations, MMIS policy changes, and provider manuals

The Cooperative Agreement is reviewed and updated when needed as issues are identified.

The Medicaid agency is responsible for approving rules, regulations and policies that govern how waivers are operated and retains the authority to discharge its responsibilities for the administration of the Medicaid program pursuant to 42 CFR § 431.10(e). The assigned operational and administrative functions are monitored as part of ALTSA's annual Quality Assurance (QA) Review Cycle. Final QA outcome reports are provided to the Medicaid agency for review and follow-up.

At the end of each QA Review Cycle, a final report is generated which includes detailed data on a state-wide level. These results are analyzed and incorporated into a statewide Performance Improvement Plan (PIP). The State Medicaid Agency receives annual Quality Assurance Review reports and meets with the operating agency at the conclusion of the QA cycle to review results and provide input into the PIP. The PIP is reviewed and approved for implementation by executive management.

The Medicaid Agency Waiver Management Committee was created and includes representatives from divisions within the operating agency; HCS and RCS, as well as three other DSHS administrations: Adult Protective Services Administration, Developmental Disabilities Administration and Behavioral Health Administration. The committee meets to review all functions delegated to the operating agency, current quality assurance activity, pending waiver activity (e.g. amendments, renewals, etc.), potential waiver policy and rule changes and quality improvement activities.

Appendix A: Waiver Administration and Operation

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

○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or 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.:*

◉ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

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 (*Select One*):

○ **Not applicable**

◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
Check each that applies:

☒ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the state and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

The Operating Agency contracts with 13 Area Agencies on Aging (AAAs) to perform certain operational and administrative functions at the local level. AAAs are single or multi-county entities. Two AAAs are operated by Tribes (Colville Indian AAA and Yakama Nation AAA). In all cases, the operating agency has a contract that sets forth the responsibilities and performance requirements of the AAA. The AAA's enroll and contract with qualified providers of waiver services.

☐ **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:

Appendix A: Waiver Administration and Operation

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:

The Operating Agency is responsible for assessing the performance of the AAAs.

Appendix A: Waiver Administration and Operation

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:

ALTSA AAA Specialists, program managers, and ALTSA fiscal complete on-site or virtual contract and fiscal monitoring on a three year cycle. In years when there is not a full review, desk reviews and follow-up on corrective actions are completed.

ALTSA presents the contract monitoring information to the Medicaid agency at the quarterly waiver management meetings. This information provides a summary of the AAA on-site and/or virtual contract and fiscal monitoring, including identified trends when appropriate.

Appendix A: Waiver Administration and Operation

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. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Local Non-State Entity
Participant waiver enrollment	☐	☒	☐
Waiver enrollment managed against approved limits	☐	☒	☐
Waiver expenditures managed against approved levels	☐	☒	☐
Level of care waiver eligibility evaluation	☐	☒	☒
Review of Participant service plans	☐	☒	☒
Prior authorization of waiver services	☐	☒	☒
Utilization management	☐	☒	☐
Qualified provider enrollment	☐	☒	☒
Execution of Medicaid provider agreements	☐	☒	☒
Establishment of a statewide rate methodology	☐	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☒	☐
Quality assurance and quality improvement activities	☐	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PERFORMANCE MEASURE: Percent of required reports reviewed, commented, and/or acted upon by the State Medicaid Agency (SMA). N = Number of reports reviewed, commented on, and or acted upon by HCA. D = Number of required reports submitted to

HCA.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Administrative data

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PERFORMANCE MEASURE: Percent of required reports submitted within the required timeframe from the operating agency. N = Number of required reports submitted timely. D = Number of required reports submitted to HCA.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Administrative data

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

QA proficiency improvement plans are required for areas where required proficiency levels are not achieved or if improvement is not evident based upon previous proficiency improvement plans. Proficiency improvement plans are individualized and evaluated prior to approval to ensure that the plan will effectively address areas of needed improvement. Field staff are required to perform discovery and remediation activities.

Training elements of proficiency improvement plans are coordinated through DSHS and DSHS staff are made available to provide training and technical support to field staff. Field offices are required to provide QA with an update to report on their progress toward implementing proficiency improvement activities.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

QA and fiscal proficiency improvement plans are required for areas where required proficiency levels are not achieved or if improvement is not evident based upon previous proficiency improvement plans. Proficiency improvement plans include how individual problems are corrected as they are discovered. Some issues, such as health and safety, require immediate action. Regions are required to develop and submit to the QA unit a proficiency improvement plan within 30 days of

receiving their final report. Proficiency Improvement Plans are individualized and evaluated prior to approval to ensure that the plan will effectively address areas of needed improvement.

Training elements of proficiency improvement plans are coordinated through DSHS and DSHS staff are made available to provide training and technical support to field staff. Field offices are required to provide QA with an update to report on their progress toward implementing proficiency improvement plans.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

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 one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR § 441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	**Included**	**Target Sub Group**	**Minimum Age**	**Maximum Age**	
				Maximum Age Limit	**No Maximum Age Limit**
☒ **Aged or Disabled, or Both - General**					

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☒	Aged	65		☒
	☒	Disabled (Physical)	18	64	
	☒	Disabled (Other)	18	64	
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

Persons with disabilities may continue to participate in the waiver beyond the age of 64 as specified in the above chart. An anomaly in the web based application does not allow the maximum age limit in this section to be left blank.

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:

Persons with disabilities may continue to participate in the waiver beyond the age of 64 as specified in the above chart. An anomaly in the web based application does not allow the maximum age limit in this section to be left blank.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

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)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

◉ **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.**

Specify the percentage:

○ **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:**

Specify dollar amount:

The dollar amount *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the 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:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

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: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

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	56644
Year 2	59476
Year 3	62450
Year 4	

Waiver Year	Unduplicated Number of Participants
	65573
Year 5	68851

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	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

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).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

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:

The state does not anticipate deferring the entrance of otherwise eligible persons.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. 1. State Classification. The state is a *(select one)*:

◉ **Section 1634 State**

○ **SSI Criteria State**

○ **209(b) State**

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

◉ **No**

○ **Yes**

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.**

Specify percentage:

☒ **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 in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☐ **Other specified groups (include only 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)**

○ **A percentage of FBR, which is lower than 300% (42 CFR § 435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spend down 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%.**

Specify percentage amount:

☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Medically Needy with spend down consisting of the state's average monthly cost for Medicaid recipients in nursing facilities determined by multiplying the average daily Medicaid rate by 31. The Medicaid rate is adjusted every July and the state will update the standard in October to allow time to program this parameter in our eligibility system and to synch up with the private rate adjustment used for transfer of assets penalties. Occasional small adjustments in the Medicaid rate may occur at other times but these cannot be predicted. The rate used for eligibility will always be equal to or very close to our actual cost.

This standard will be used to reduce an individual's income to or below the medically needy income standard.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

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. 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:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **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 uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under section 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 section 1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR § 435.726 (Section 1634 State/SSI Criteria State) or under § 435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under section 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-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. 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)**
    - ○ **A percentage of the FBR, which is less than 300%**

      Specify the percentage: [ ]
    - ○ **A dollar amount which is less than 300%.**

      Specify dollar amount: [ ]
  - ○ **A percentage of the Federal poverty level**

    Specify percentage: [ ]
  - ○ **Other standard included under the state plan**

    Specify:

    [ ]
- ○ **The following dollar amount**

  Specify dollar amount: [ ] If this amount changes, this item will be revised.
- ◉ **The following formula is used to determine the needs allowance:**

  Specify:

1. For single recipients who live in their own home or married recipients living apart from their spouse in their own home, the personal needs allowance is 300% of the federal benefit rate. Married recipients living with their spouse in their own home receive 100% of the federal benefit rate.

2. For recipients who live in state-contracted residential facility (e.g., adult family home, assisted living facility), the personal needs allowance is 100% of the federal benefit rate (FBR).

In addition to the personal needs allowance in (1) or (2), an allowance will be made for (when applicable):

a)Any payee and/or court-ordered guardianship fees;
b)Any court-ordered guardianship-related costs; plus
c)An amount for employed individuals equal the first $65 of the recipient's earned income, plus one-half of any remaining earned income.

In any case, the total deductions under (1) or (2), plus additional deductions of (a), (b), and (c), will not exceed 300% of the federal benefit rate.

○ **Other**

Specify:

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

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in section 1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

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

○ **Not Applicable (see instructions)**

○ **AFDC need standard**

- (●) **Medically needy income standard**
- ( ) **The following dollar amount:**

  Specify 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:**

  Specify:
- ( ) **Other**

  Specify:

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:

- ( ) **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ( ) **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 imposition of a transfer of assets penalty is limited to zero.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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 and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

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**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- ◉ **The following formula is used to determine the needs allowance:**

  Specify formula:

1. For recipients who live in their own home and are not married; are married but live apart from their spouse; or are married and both spouses are recipients of 1915(c) waiver services; the personal needs allowance is 300% of the federal benefit rate (FBR).

2. For recipients who live in their own home and live with their spouse, the personal needs allowance is the effective medically needy income level (MNIL) in Washington (this is the same amount as 100% of the federal benefit rate).

3. For recipients who live in a state-contracted residential facility (e.g., adult family home, assisted living facility), the maintenance allowance is 100% of the federal benefit rate (FBR).

In addition to the personal needs allowance in (1), (2) or (3), an allowance will be made for (when applicable):

a) Any payee and/or court-ordered guardianship fees;
b) Any court-ordered guardianship-related costs; plus
c) An amount for employed individuals equal the first $65 of the recipient’s earned income, plus one-half of any remaining earned income.

In any case, the total deductions under (1), (2) or (3), plus additional deductions of (a), (b), and (c), will not exceed 300% of the federal benefit rate.

- ○ **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:

For a participant who lives at home with their community spouse (where such spouse is not also a 1915(c) participant), additional income is allocated to the community spouse under post-eligibility rules, and the lower personal needs allowance of the participant (100% of the MNIL as opposed to 300% of the FBR) is reasonable as the combined retained income of the participant and community spouse is sufficient to meet the participant's maintenance needs at home.

iii. 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:

- ○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ○ **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: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

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. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

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 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: 1

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:

The operating agency or a tribal case manager performs an assessment of need. Re-evaluations for participants in residential settings are performed by the local offices of the operating agency (Home and Community Services) or a Federally Recognized Tribe under contract with the operating agency; re-evaluations for in-home participants are performed by Area Agencies on Aging or a Federally Recognized Tribe who are under contract with the operating agency.

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:

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

Initial evaluations are performed by case managers who can be a Registered Nurse (licensed in the State), Tribal Case Manager, or a Social Service Specialist. For Social Service Specialists, minimum qualifications are as follows:

A Master's degree in social services, human services, behavioral sciences, or an allied field and one year of paid social service experience equivalent to a Social Service Specialist 2.

OR

A Bachelor's degree in social services, human services, behavioral sciences, or an allied field, and two years of paid social service experience performing functions equivalent to a Social Service Specialist 2.

OR

Six (6) years of professional/practical social service experience performing functions equivalent to a Social Service Specialist 2.

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

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

Job classification descriptions are available from the operating agency.

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.

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 is fully specified in WAC 388-106-0355 (eligibility for nursing facility care services).

Nursing Facility Level of Care (NFLOC) is based on the following factors:
1. The Comprehensive Assessment Reporting Evaluation (CARE) tool is the assessment tool used to determine NFLOC. Functional criteria for NFLOC mean one of the following applies:
a. Care is required to be provided by or under the supervision of a registered nurse or a licensed practical nurse on a daily basis; or

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

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

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

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

d. The individual has a cognitive impairment and requires supervision due to one or more of the following: Disorientation, memory impairment, impaired decision making, or wandering and have an unmet or partially met need with at least one or more of the following:

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

"Self performance for ADLs" means what the individual actually did in the last seven days before the assessment, not what he/she might be capable of doing. Coding is based on the level of performance that occurred three or more times in the seven-day period and does not include support provided. Self-performance definitions and assessments are consistent with that used under the Minimum Data Set (MDS). This provides a common set of clinical data across all long-term care settings. Self performance level is scored as:

(a) Independent if the individual received no help or oversight, or if the individual needed help or oversight only once or twice;

(b) Supervision if the individual received oversight (monitoring or standby), encouragement, or cueing three or more times;

(c) Limited assistance if the individual was highly involved in the activity and given physical help in guided maneuvering of limbs or other non-weight bearing assistance on three or more occasions. For bathing, limited assistance means physical help is limited to transfer only;

(d) Extensive assistance if the individual performed part of the activity, but on three or more occasions, the individual needed weight bearing support or the individual received full performance of the activity during part, but not all, of the activity. For bathing, extensive assistance means the individual needed physical help with part of the activity (other than transfer);

(e) Total dependence if the individual received full caregiver performance of the activity and all subtasks during the entire seven-day period from others. Total dependence means complete nonparticipation by the individual in all aspects of the ADL; or

(f) Activity did not occur if the individual or others did not perform an ADL over the last seven days before the individual's assessment. The activity may not have occurred because:

(i) The individual was not able (e.g., walking, if paralyzed);

(ii) No provider was available to assist; or

(iii) The individual declined assistance with the task.

"Support provided" means the highest level of support provided to the individual by others in the last seven days before the assessment, even if that level of support occurred only once.

(a) No set-up or physical help provided by others;

(b) Set-up help only provided, which is the type of help characterized by providing the individual with articles, devices, or preparation necessary for greater self performance of the activity. (For example, set-up help includes but is not limited to giving or holding out an item or cutting food);

(c) One-person physical assist provided;

(d) Two- or more person physical assist provided; or

(e) Activity did not occur during entire seven-day period.

Washington uses an automated assessment system called the Comprehensive Assessment Reporting Evaluation (CARE) tool to evaluate and reevaluate level of care criteria required by the waiver. The CARE tool is available to CMS upon request through the Operating agency.

The functions, elements and scoring mechanisms of CARE are spelled out in the Washington State Administrative Code (WAC)388-106-0050 through 0145.

These WAC references are available to CMS upon request.

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:

Case managers complete Level of Care evaluations using the automated assessment tool CARE. CARE is used for both initial evaluations and re-evaluations. The re-evaluation process does not differ from the initial evaluation process. All initial, annual, and significant change assessments/evaluations/re-evaluations (plans of care) are conducted by case managers through a face-to-face, telephonic, or other technology media client interview. Interviews related to the waiver participant's ability to perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), strengths, and weaknesses could have all or parts of the assessment completed through telephonic or other technology media. When completing evaluations and re-evaluations, 42 CFR 441.535 will be followed. Telephonic or assessment through other technology media would be available for all individuals, and all individuals are provided the opportunity for an in-person assessment in lieu of one preformed telephonically. A home visit would be required if the results appear to be affected based on the use of telephonic or other technology media. Evaluations are completed when an applicant initially applies for long term services and support, annually, and less than annually when a significant change in the participant's condition occurs within the annual plan period. Information about the person's ability to perform Activities of Daily Living and Instrumental Activities of Daily Living, as well as their strengths and preferences is obtained via a client interview. Evaluators also obtain and verify information by collateral contacts with formal and informal supports including physicians, caregivers, and family.

The state will utilize HIPPA-compliant technology platforms and case managers will conduct assessments in private settings, maintain the participant's privacy at all times, and verify the participant's identity before conducting the assessment.

The timelines to complete each type of assessment is as follows:
- Initial assessments will be completed within 45 days of intake
- Annual and significant change assessments will be completed within 30 days of the assessment creation date

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 the other schedule:

Re-evaluations must be completed every twelve months and whenever there is a significant change in the participant's condition.

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.**

Specify the qualifications:

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):*

The ProviderOne payment system produces a report for each case manager that lists each service authorization that is expiring or about to expire. Case managers use this information to assure the timeliness of annual reviews in addition to tickler reports produced by CARE.

HCS and AAA supervisors have a required schedule of record reviews for individual case managers and are responsible for evaluating staff on assessment timeliness. In addition, supervisors use reports produced by CARE to track timeliness of assessments.

Quality assurance staff monitoring of records includes monitoring for timeliness.

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 § 92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Electronically retrievable documentation of all evaluations and reevaluations is maintained for a minimum of three years by ALTSA.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of initial applications with documentation that an assessment was submitted and reviewed for a level of care determination. N=Number of initial applications with documentation that an assessment was submitted and received for a level of care determination D=Number of applications received

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
 # & % of participants whose eligibility determined using the appropriate processes & instruments according to approved description to determine participant LOC N=# participants whose eligibility determined using the appropriate processes & instruments according to the approved description to determine participant LOC D=Total # participants who had an eligibility determination that were reviewed

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The CARE assessment as specified in the waiver is the only assessment tool used to determine LOC. To determine LOC, case managers use CARE which is a standardized assessment tool based on the MDS. QA staff and supervisors/managers monitor for appropriate application of the CARE instrument and processes to meet sub-assurance c: (The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care).

Social service supervisors/managers annually monitor worker case records to ensure LOC accuracy and that a LOC is determined annually or at significant change (approximately 2000 reviews statewide). For new staff, supervisors review the first 5 assessments. After the first five assessments, a minimum of 50% of LOCs are reviewed for the next three months of employment. After three months, additional reviews are completed at the supervisor's discretion based upon performance. Errors in assessment that can lead to an inaccurate LOC determination are corrected. ALTSA QA unit monitors LOC using a statistically valid sample of records statewide on a 12 month review cycle.

Monitoring activities and data provide evidence of use of the CARE application. LOC determinations that are not correctly determined are corrected and correction is verified at second review. Training to address use of the CARE application is developed based on the data: individual, unit, regional or statewide.

CARE enforces rules of eligibility. An algorithm in CARE determines LOC based on information entered in to the assessment by the participant and case manager. A LOC determination is completed on all applicants for whom there is reasonable indication that services may be needed in the future. If the participant is not COPES eligible, the option is not available for the case manager to select/ participant to choose and will not print on the service summary (plan of care).
-An Intake is completed at the state agency (HCS) within two working days of receiving the request/referral for services – referrals are entered within one working day for applicants discharging from the hospital.
- The case is assigned to a social worker (the primary case manager) within one working day of the intake date.
- A face-to-face contact is made within two working days of receipt of the referral for applicants coming home from the hospital.
- The assessment process must be completed and services authorized (if eligible) within 45 days of the date of assignment.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

- CARE, QA and payment reports are reviewed and corrective action taken on an on-going basis by supervisors and field managers. Case managers are required to take action within 30 days to address all inappropriate LOC determinations identified during the supervisory and QA unit monitoring. CARE management reports include data elements such as: intake date, first assigned date, primary case manager, date assessment created, date moved from pending to current (make payment), setting and transfer dates.

- Quality assurance proficiency and follow-up reports document prompt assessment and eligibility determinations, accuracy, and remediation. QA roll up reports are reviewed at all levels of the system: case managers - individualized proficiency reports; supervisors - unit reports; HCS Regional Administrators and AAA Directors - regional reports; and ALTSA headquarters - reviews/analyzes regional and statewide aggregate data.

Proficiency Improvement Plans (PIPs)are required for areas where required proficiency levels are not achieved or if improvement is not evident based upon previous corrective actions. PIPs are evaluated and individualized prior to approval to ensure that plan will effectively address areas that need improvement. Training elements of PIPs are coordinated through ATSA and ALTSA staff are made available to provide training and technical support.

Each Region/AAA develops an annual training plan that outlines how mandatory and optional training will occur for new and experienced staff (employed one year or longer). This document is revised annually at the regional/PSA level and may be reviewed by the QAS during the HCA/AAA review cycle.

Identified statewide trends are forwarded to the ALTSA program managers and Chronic Care, Well Being and Performance Improvement unit for training revision and development.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: Area Agency on Aging	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

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 Department uses a form called Acknowledgement of Services (DSHS 14-225) to document the applicant/recipient's freedom to choose between institutional and home and community-based services. The DSHS 14-225 is explained to the individual by the case manager or social worker and a signature is obtained stating that the individual understands they have a choice in the type of services received, where the service is provided as well as the right to a fair hearing. The individual signs this form to designate the service choice.

Fair Hearing information is contained on the DSHS 14-225, Acknowledgement of Services form. Rights to a fair hearing are explained to all clients during the Medicaid application process and again during the assessment process.

The client receives a copy of the DSHS 14-225 and a signed copy of the form is maintained in the applicant/recipient's case record.

b. Maintenance of Forms. Per 45 CFR § 92.42, 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.

Electronically retrievable copies of forms are maintained by ALTSA for a minimum of three years in the client record.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency 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):

Individuals with limited communication access due to disabilities or English proficiency will have access to a variety of services and supports to meet individual service delivery needs and assistance for fair hearing related activities. LEP services and supports include agency or contracted interpreters, bilingual case managers, and translation of written materials.

The following references govern access to services for Limited English Proficient Persons:

-RCW 74.04.025 Bilingual services for non-English speaking applicants and recipients -- Bilingual personnel, when -- Primary language pamphlets and written materials.

-WAC 388-03 Rules and regulations for the certification of DSHS spoken language interpreters, translators, employees, and licensed agency personnel (LAPL).

-WAC 388-271 Limited English proficient services.

-DSHS Administrative Policies

7.20 Communication Access for Persons Who are Deaf, Deaf/Blind and Hard of Hearing
7.21 Access to Services for Clients who are Limited English Proficient (LEP)

The Department of Social and Health Services and its contractors are required by statute, administrative code and department policy to deliver services that recognize individual and cultural differences. All clients must be given equal access to services, information, and programs whether the department or contracted vendors deliver services. The following are summaries of requirements:
1. Interpreters are used when interpreter services are requested by the client; necessary to determine a client's eligibility for services; necessary for the client to access services.
2. LEP and Sensory Impaired (SI) clients are informed of their right to request an interpreter or auxiliary aid and are offered interpreter services or auxiliary aids at no cost to them and without significant delay. Children under age 18 are not allowed to serve as interpreters. LEP Interpreters and Translators for spoken language must be certified and/or qualified by DSHS and comply with the DSHS code of professional conduct.
3. To assure access and quality, DSHS maintains a statewide translation contract, American Sign Language contract telephonic interpreters, written translation, Communication Access Real Time (CART), Telecommunication Relay Services and other auxiliary services, through the Department of Enterprise Services, the Health Care Authority, and the Office of the Deaf and Hard of Hearing.
5. Procedures are in place to obtain translation of official publications, forms and records as well as client specific requests for translations.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *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:*

Service Type	Service		
Statutory Service	**Adult Day Health**		
Other Service	**Adult Day Care**		
Other Service	**Client Support Training & Wellness Education**		
Other Service	**Community Choice Guiding**		
Other Service	**Community Support: Goods and Services**		
Other Service	**Environmental Modifications**		
Other Service	**Home Delivered Meals**		
Other Service	**Skilled Nursing Services**		
Other Service	**Specialized Medical Equipment and Supplies**		
Other Service	**Transportation**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04050 adult day health
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Adult Day Health is a daytime program in-person or remotely through telephonic or other technology media providing nursing and rehabilitative therapy services to adults with medical or disabling conditions that require the intervention or services of a registered nurse, or a licensed speech therapist, occupational therapist, or physical therapist acting under the supervision of the participant's physician, when required. Services provided are specified in the participant's service plan and encompass both health and social services needed to ensure the optimal functioning of the participant.

Meals provided as part of the Adult Day Health services shall not constitute a full nutritional regime.

A skilled nursing or rehabilitative therapy service must be provided by staff operating within their scope of practice under Washington State law and regulation on each service day for which reimbursement is claimed.

Transportation is available for participants attending Adult Day Health in-person from their place of residence to the Adult Day Health center.

To ensure duplicate billing does not occur, The P1 system will have a conflict edit that will result if skilled nursing and transportation are authorized at the same time as Adult Day Health.

The percentage of time telehealth will be the delivery method for ADH services will vary on the participants' needs and goals.

Participants will have an in-person initial intake and comprehensive assessment by a nurse and PT/OT (if part of the care plan) either in the participant's place of residence or in the Adult Day Health center. Participants will be required to be seen in-person a minimum of once per quarter after the initial intake and comprehensive assessment.

Adult Day Health providers offering services through telehealth are required to have IT policies to meet HIPAA requirements, as well as a business associate agreement with either Zoom or Microsoft Teams. These delivery methods have been approved by the WA HIPPA Compliance officer.

Participant's privacy will be protected by the Adult Day Health provider. Services such as toilet transfer, bed mobility, dressing, etc. will require the ADH staff member to be in-person at the participant's place of residence. The host of the telehealth meeting (ADH staff) will also have the ability to turn off the participant's camera to ensure there is no video camera/monitor in the bedroom or bathroom. The participant will have the ability to turn on or off the video camera/monitoring equipment at will.

Participants will be offered group sessions for nutritional training, presentations from local libraries, other community activities, etc. through Zoom or Microsoft Teams, in addition to their one-on-one time for medical treatment.

The initial intake and comprehensive assessment will evaluate tasks the participant is able to do without assistance. If the participant cannot follow instructions or cannot physically do what is asked without help and no help is available, then they would not be a candidate for telehealth services.

The initial intake and comprehensive assessment will evaluate the participant's and/or caregiver's ability to use the required technology, and provide any training needed. The participant may also receive assistance learning the technology required for the telehealth delivery of this service through a Client Training contracted provider.

Adult Day Health providers are required to have emergency protocols in place if staff are unable to reach a participant, as well as have staff trained on emergency situations that may occur during the telehealth session.

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

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Center

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Adult Day Health Center

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Certified under Washington Administrative Code which defines Adult Day Health Center employee requirements. (WAC 388-71-0702 through 388-71-0774)

Other Standard *(specify):*

The Adult Day Health Center must have a Core Provider Agreement with the State Medicaid Agency.

Minimum staffing requirements for adult day health centers include an administrator, program director, registered nurse, activity coordinator, a PT/OT or speech therapist, and a social worker. The administrator and program director may be the same person.

Employee qualifications are as follows:
The administrator must have a master's degree and at least one year of supervisory experience in health or social services setting (full-time equivalent), or a bachelor's degree and at least two years of supervisory experience in health or social services setting. The degree may be in nursing.

The program director must have a bachelor's degree in health, social services or related field with at least one year of supervisory experience (full-time equivalent) in health or social services setting. Upon approval by the department, an adult day health center may request an exception for an individual with an associate's or vocational degree in health, social services, or related field with four years of experience in a health or social service setting, of which two years must be in a supervisory position.

Therapists must have valid state credentials and one year of experience in a social or health setting.

Rehabilitative therapeutic assistants must be certified with valid state credentials, have at least one year of applicable experience and meet all statutory requirements.

A certified or registered nursing assistant must meet the requirements of RCW 18.88A.020.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging certify that all requirements outlined in Washington Administrative Code have been met.

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adult Day Care

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04060 adult day services (social model)

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Adult Day Care services provided by an adult day care center include provision of personal care; routine health monitoring with consultation from a registered nurse; general therapeutic activities; general health education; and supervision and/or protection for at least four hours a day but less than twenty-four hours a day in a group setting in-person or through a technology medium on a continuing, regularly scheduled basis.

Services may also include: provision of recipient meals as long as meals do not replace nor be a substitute for a full day's nutritional regime; and programming and activities designed to meet participants' physical, social and emotional needs.

Adult Day Care shall be included in a participant's approved plan of care only when the participant: has mild to moderate dementia and/or is chronically ill or disabled; is socially isolated and/or confused; has significant risk factors when left alone during the day; needs assistance with personal care; and will benefit from an enriched socially supportive experience.

Adult Day Care is codes as informal supports in the CARE Assessment, to ensure there is no duplication of personal care services when some personal care tasks will be met by Adult Day Care services.

The percentage of time telehealth will be the delivery method for ADC services will vary on the participants’ needs and goals.

Participants will have an in-person initial intake and comprehensive assessment by a nurse and PT/OT (if part of the care plan) either in the participant’s place of residence or in the Adult Day Care center. Participants will be required to be seen in-person a minimum of once per quarter after the initial intake and comprehensive assessment.

Adult Day Care providers offering services through telehealth are required to have IT policies to meet HIPAA requirements, as well as a business associate agreement with either Zoom or Microsoft Teams. These delivery methods have been approved by the WA HIPPA Compliance officer.

Participant’s privacy will be protected by the Adult Day Care provider. Services such as toilet transfer, bed mobility, dressing, etc. will require the ADC staff member to be in-person at the participant’s place of residence. The host of the telehealth meeting (ADC staff) will also have the ability to turn off the participant’s camera to ensure there is no video camera/monitor in the bedroom or bathroom. The participant will have the ability to turn on or off the video camera/monitoring equipment at will.

Participants will be offered group sessions for nutritional training, presentations from local libraries, other community activities, etc. through Zoom or Microsoft Teams, in addition to their one-on-one time for medical treatment.

The initial intake and comprehensive assessment will evaluate tasks the participant is able to do without assistance. If the participant cannot follow instructions or cannot physically do what is asked without help and no help is available, then they would not be a candidate for telehealth services.

The initial intake and comprehensive assessment will evaluate the participant’s and/or caregiver’s ability to use the required technology, and provide any training needed. The participant may also receive assistance learning the technology required for the telehealth delivery of this service through a Client Training contracted provider.

Adult Day Care providers are required to have emergency protocols in place if staff are unable to reach a participant, as well as have staff trained on emergency situations that may occur during the telehealth session.

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

Adult Day Care services may not be duplicative of any other waiver service.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care Center

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Day Care

Provider Category:

Agency

Provider Type:

Adult Day Care Center

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Must meet the requirements of WAC 388-71-0702 through 388-71-0774

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

1. Upon initial contracting
2. Annual review per WAC 388-71-0724(10)
3. Contract compliance monitoring every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Client Support Training & Wellness Education

HCBS Taxonomy:

Category 1:	Sub-Category 1:
13 Participant Training	13010 participant training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Participant training needs are identified in the CARE assessment or in a professional evaluation.

Client Support Training is provided in accordance with a therapeutic goal in the plan of care and includes for example, adjustment to serious impairment, maintenance/restoration of physical functioning, self management of chronic conditions, acquisition of skills to address minor depression, and development of skills to work with care providers including behavior management. Client support training is provided directly to the participant. Formal and informal care providers may participate in the training in order to continue to support the participant's goal outside of the training environment.

Wellness Education provides accurate, accessible and actionable information designed to assist participants to achieve goals and address conditions identified during their person-centered planning process. Materials are personalized to each participant based on the participant's assessment and person centered service plan. Each month, participants will be mailed printed information targeted to participant specific data identified in the participant's comprehensive assessment.

Wellness Education materials assist participants to obtain, process, and understand information needed to manage and prevent chronic conditions. Easily understood information provides participants with usable tools for informed decision making and prepares participants for conversations with medical professionals. Wellness Education materials also assist participants to achieve community living goals by providing simple to understand information and specific action items. Topics may include strategies for engaging in the community, nutrition and diet, adaptive exercise, falls prevention, strength and balance activities, locating and seeking medical care, developing a social network, medication management, achieving employment goals, planning for emergencies, creating effective back-up systems and information related to other social determinants of health.

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

Providers may only train within the scope of their professional training skills and abilities.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Board-Certified Music Therapist
Individual	Certified Dietician/Nutritionist
Individual	Human Service Professional
Agency	Centers for Independent Living
Agency	Wellness Education Vendor
Agency	Chronic Disease Self Management Trainer
Agency	Board-Certified Music Therapist
Individual	Evidence Based Trainer
Individual	Pharmacist
Agency	Community Mental Health Agency
Individual	Physical Therapist
Agency	Adult Day Health Center
Individual	Licensed Practical Nurse
Agency	Community College
Agency	YMCA
Individual	Assistive Technology Professional
Agency	Assistive Technology Professional
Agency	Physical Therapist
Individual	Independent Living Provider
Agency	Occupational Therapist
Individual	Registered Nurse
Agency	Evidence Based Trainer
Individual	Occupational Therapist
Agency	Home Care Agency
Agency	Home Health Agency
Individual	Chronic Disease Self Management Trainer

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Client Support Training & Wellness Education

Provider Category:

Individual

Provider Type:

Board-Certified Music Therapist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Music therapist- Board Certified (MT-BC) active credential.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Client Support Training & Wellness Education

Provider Category:

Individual

Provider Type:

Certified Dietician/Nutritionist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Dietician and Nutritionist certificate under Chapter 18.138 RCW

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Client Support Training & Wellness Education

Provider Category:

Individual

Provider Type:

Human Service Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Bachelor's degree or higher in Psychology, Social Work, medical, or a related field with a minimum of two years experience providing services to aging or disabled populations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Client Support Training & Wellness Education

Provider Category:

Agency

Provider Type:

Centers for Independent Living

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Community based non-profit organizations in Washington State which provide services by and for people with disabilities. Centers for Independent Living receive funding through the Federal Department of Education/Rehabilitation Services Administration and are contracted in the state of Washington through the Department's Division of Vocational Rehabilitation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Client Support Training & Wellness Education

Provider Category:

Agency

Provider Type:

Wellness Education Vendor

Provider Qualifications

License *(specify):*

Appropriate license to do business in Washington State

Certificate *(specify):*

Other Standard *(specify):*

The provider must have the ability and resources to:
• Receive and manage client data in compliance with all applicable HIPPA regulations and ensure client confidentiality and privacy.
• Translate materials into the preferred language of the participant.
• Ensure that materials are targeted to the participant's assessment and person centered service plan.
• Manage content sent to participants to prevent duplication of materials.
• Identify any undeliverable client/representative addresses prior to each monthly mailing and manage any returned mail in a manner that ensures participants receive the monthly information.

Verification of Provider Qualifications

Entity Responsible for Verification:

ALTSA

Frequency of Verification:

Upon contract and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Client Support Training & Wellness Education

Provider Category:

Agency

Provider Type:

Chronic Disease Self Management Trainer

Provider Qualifications

License *(specify):*

Public Health and Safety providers licensed under Chapter 70 RCW

Certificate *(specify):*

Other Standard *(specify):*

Individual Employee Qualification: Certification in an evidence based Chronic Disease Self Management training program such as the Stanford University Chronic Disease Self Management Program (CDSMP).

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Client Support Training & Wellness Education

Provider Category:

Agency

Provider Type:

Board-Certified Music Therapist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Music therapist- Board Certified (MT-BC) active credential.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Initial contracting and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Client Support Training & Wellness Education

Provider Category:

Individual

Provider Type:

Evidence Based Trainer

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The trainer must have successfully completed all required professional development activities and be sanctioned or certified by the by credentialing entity which oversees the evidence-based practice.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Client Support Training & Wellness Education

Provider Category:

Individual

Provider Type:

Pharmacist

Provider Qualifications

License *(specify):*

Licensed per Chapter 18.64 RCW and Chapter 246.863 WAC

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Client Support Training & Wellness Education

Provider Category:

Agency

Provider Type:

Community Mental Health Agency

Provider Qualifications

License *(specify):*

Licensed under WAC 388-877

Certificate *(specify):*

Other Standard *(specify):*

Capacity to provide services to individuals that do not meet access to care standards in the public mental health system

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Client Support Training & Wellness Education

Provider Category:

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

PT license under Chapter 18.74 RCW

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Client Support Training & Wellness Education

Provider Category:

Agency

Provider Type:

Adult Day Health Center

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified under Washington Administrative code which defines ADH Center employee requirements. WAC 388-71-0702 through 388-71-0774.

Other Standard *(specify):*

The Adult Day Health Center must have a Core Provider Agreement with the State Medicaid Agency.

Minimum staffing requirements for adult day health centers include an administrator, program director, registered nurse, activity coordinator, a PT/OT or speech therapist, and a social worker. The administrator and program director may be the same person.

Employee qualifications are as follows:

The administrator must have a master's degree and at least one year of supervisory experience in health or social services setting (full-time equivalent), or a bachelor's degree and at least two years of supervisory experience in health or social services setting. The degree may be in nursing.

The program director must have a bachelor's degree in health, social services or related field with at least one year of supervisory experience (full-time equivalent) in health or social services setting. Upon approval by the department, an adult day health center may request an exception for an individual with an associate's or vocational degree in health, social services, or related field with four years of experience in a health or social service setting, of which two years must be in a supervisory position.

Therapists must have valid state credentials and one year of experience in a social or health setting.

Rehabilitative therapeutic assistants must be certified with valid state credentials, have at least one year of applicable experience and meet all statutory requirements.

A certified or registered nursing assistant must meet the requirements of RCW 18.88A.020.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agencies on Aging must certify that all requirements outlined in WAC have been met.

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Client Support Training & Wellness Education

Provider Category:

Individual

Provider Type:

Licensed Practical Nurse

Provider Qualifications

License *(specify):*

Licensed under Chapter 18.79 RCW and Chapter 246-840 WAC

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Client Support Training & Wellness Education

Provider Category:

Agency

Provider Type:

Community College

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Higher Education Institution conducting programs under Chapter 28B.50.020 RCW

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Client Support Training & Wellness Education

Provider Category:

Agency

Provider Type:

YMCA

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Certification in Stay Alive and Independent for Life (SAILS)

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Client Support Training & Wellness Education

Provider Category:

Individual

Provider Type:

Assistive Technology Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Assistive Technology Professionals must have a degree in Special Education or a Rehab Science. If the Assistive Technology Professional does not have a degree in Special Education or a Rehab Science, they must complete either 10, 20, or 30 hours of Assistive Technology-related training. At least half of the hours must be fulfilled by Continuing Education Units (CEUs) awarded from recognized CEU providers, such as IACET-accredited organizations, professional associations (e.g., RESNA, APTA, ASHA, AOTA, etc.), academic institutions (e.g., University of Pittsburgh, etc.), or state licensing boards which preview courses for CEU approval. The balance of the hours may be fulfilled by other educational Continuing Education Credits (CECs) or documented education contact hours.

The Assistive Technology Professional shall have staff that meet one of the following criteria:
(a) Assistive Technology Professional Master's Level:
i. Educational Requirements: Master's Degree or Higher in Special Education or Rehab Science
ii. 1000 hours in 6 years

(b) Assistive Technology Professional Bachelor's Level:
i. Educational Requirements: Bachelor's degree in Special Education or Rehab Science; and 1500 hours in 6 years; or
ii. Bachelor's Degree in Non-Rehab Science; and 2000 hours in 6 years and 10 hours of Assistive Technology-related training.

(c) Assistive Technology Professional-Associate's Level:
i. Educational Requirements: Associate Degree in Rehab Science and 3000 hours in 6 years; or
ii. Associate Degree in Non-Rehab Science and 4000 hours in 6 years and 20 hours of Assistive Technology-related training.

(d) Assistive Technology Professional: High School Diploma or GED:
i. Candidates without a degree must complete 30 hours of Assistive Technology-related training and 6000 hours in 10 Years.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Client Support Training & Wellness Education

Provider Category:

Agency

Provider Type:

Assistive Technology Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agency employed Assistive Technology Professionals must have a degree in Special Education or a Rehab Science. If the Assistive Technology Professionals do not have a degree in Special Education or a Rehab Science, they must complete either 10, 20, or 30 hours of Assistive Technology-related training. At least half of the hours must be fulfilled by Continuing Education Units (CEUs) awarded from recognized CEU providers, such as IACET-accredited organizations, professional associations (e.g., RESNA, APTA, ASHA, AOTA, etc.), academic institutions (e.g., University of Pittsburgh, etc.), or state licensing boards which preview courses for CEU approval. The balance of the hours may be fulfilled by other educational Continuing Education Credits (CECs) or documented education contact hours.

The Assistive Technology Professional shall have staff that meet one of the following criteria:
(a) Assistive Technology Professional Master's Level:
i. Educational Requirements: Master's Degree or Higher in Special Education or Rehab Science
ii. 1000 hours in 6 years

(b) Assistive Technology Professional Bachelor's Level:
i. Educational Requirements: Bachelor's degree in Special Education or Rehab Science; and 1500 hours in 6 years; or
ii. Bachelor's Degree in Non-Rehab Science; and 2000 hours in 6 years and 10 hours of Assistive Technology-related training.

(c) Assistive Technology Professional-Associate's Level:
i. Educational Requirements: Associate Degree in Rehab Science and 3000 hours in 6 years; or
ii. Associate Degree in Non-Rehab Science and 4000 hours in 6 years and 20 hours of Assistive Technology-related training.

(d) Assistive Technology Professional: High School Diploma or GED:
i. Candidates without a degree must complete 30 hours of Assistive Technology-related training and 6000 hours in 10 Years.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Client Support Training & Wellness Education

Provider Category:

Agency

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

PT license under 18.74 RCW

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Client Support Training & Wellness Education

Provider Category:

Individual

Provider Type:

Independent Living Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A Bachelor's degree in social work or psychology with two years experience in the coordination or provision of independent living services; or two years experience in the coordination or provision of independent living services (e.g., housing, personal assistance services recruitment or management, independent living skills training, etc.) in a social service setting under qualified supervision; or four years personal experience with a disability.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Client Support Training & Wellness Education

Provider Category:

Agency

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

OT licensed under 18.59 RCW

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Client Support Training & Wellness Education

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

RN license under Chapter 18.79 RCW and Chapter 246-840 WAC

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Client Support Training & Wellness Education

Provider Category:

Agency

Provider Type:

Evidence Based Trainer

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The trainer must have successfully completed all required professional development activities and be sanctioned or certified by the credentialing entity which oversees the evidence-based practice.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Client Support Training & Wellness Education

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

OT license under Chapter 18.59 RCW

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Client Support Training & Wellness Education

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

Home Care Agency license under Chapter 70.127 RCW and Chapter 246-335 WAC

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Client Support Training & Wellness Education

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Home Health Agency license under Chapter 70.127 RCW and Chapter 246-335 WAC

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Client Support Training & Wellness Education

Provider Category:

Individual

Provider Type:

Chronic Disease Self Management Trainer

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification in an evidence based Chronic Disease Self Management training program such as the Stanford University Chronic Disease Self Management Program (CDSMP).

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Choice Guiding

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community Choice Guiding services are necessary to establish or stabilize an individual in a community living arrangement in either a provider-operated setting or in a private residence. Waiver participants are eligible for Community Choice Guiding services when a participant's community living situation is unstable and the participant is at risk of institutionalization as evidenced by any of the following:

• Frequent institutional contacts (ER visits, SNF stays, hospital admits, etc.).
• Frequent turnover of caregivers resulting in an inability to maintain consistency of care.
• Threat of imminent eviction or loss of current community setting.

Services are provided in a manner that protects and promotes the participant's health and welfare and is appropriate to the participant's physical and psychological needs. Community Choice Guiding services include:

• Identifying needs and locating necessary resources to establish and achieve successful integration into the participant's community setting of choice.
• Coordinating, educating, and linking the client to resources which will establish or stabilize their community setting, including arrangements with pharmacies, primary care physicians, financial institutions, utility companies, housing providers, social networks, local transportation options, household budgeting, and other needs identified in care plan.
• Providing and establishing networks of relevant participant partners: nursing or institutional facility staff, case managers, community providers (including AFH providers), medical personnel, legal representatives, paid caregivers, family members, housing agencies and landlords, informal supports and other involved parties.
• Ensuring all necessary paperwork and documentation is identified and completed to obtain and maintain entitlements and other services necessary for community integration.
• Assisting with the development of a plan for, and when necessary providing, emergency assistance to sustain a safe and healthy community setting.
• Assisting the participant in arranging for transportation to effectively connect the participant with the community.

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

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Community Choice Guiding Purchaser
Agency	Community Choice Guiding Purchaser
Agency	Community Choice Guide Professional
Agency	Centers for Independent Living
Individual	Community Choice Guide Professional

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Choice Guiding

Provider Category:

Individual

Provider Type:

Community Choice Guiding Purchaser

Provider Qualifications

License *(specify):*

Any applicable business license

Certificate *(specify):*

Other Standard *(specify):*

Must have and use a financial business account. In addition, providers will meet contractor requirements to receive a contract.

The general contract qualifications ensure that providers are able to render the service appropriately as in order to get a contract providers have to have at least one year of demonstrated experience and ability to provide services; have a current Washington State Business License; demonstrated capacity to ensure adequate administrative and accounting procedures and controls necessary to safeguard all funds; and have no history of significant deficiencies as evidenced by monitoring, reports or surveys, including Area Agency on Aging monitoring reports.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Choice Guiding

Provider Category:

Agency

Provider Type:

Community Choice Guiding Purchaser

Provider Qualifications

License *(specify):*

Any applicable business license

Certificate *(specify):*

Other Standard *(specify):*

Must have and use a financial business account. In addition, providers will meet contractor requirements to receive a contract.

The general contract qualifications ensure that providers are able to render the service appropriately as in order to get a contract providers have to have at least one year of demonstrated experience and ability to provide services; have a current Washington State Business License; demonstrated capacity to ensure adequate administrative and accounting procedures and controls necessary to safeguard all funds; and have no history of significant deficiencies as evidenced by monitoring, reports or surveys, including Area Agency on Aging monitoring reports.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Choice Guiding

Provider Category:

Agency

Provider Type:

Community Choice Guide Professional

Provider Qualifications

License *(specify):*

Any applicable business license

Certificate *(specify):*

Other Standard *(specify):*

Agency employed CCGs must have a Bachelor's degree or higher in Psychology, Social Work, Social Services, Human Services, Behavioral Sciences or other closely-related field including a medical field, with a minimum of one year experience providing services with one years' experience in the coordination of independent living skills (ILS; e.g., housing, personal assistance services recruitment or management, independent living skills training, etc.); or two years' experience in the coordination or provision of ILS in a social service setting under qualified supervision; or four years personal experience with a disability and has documented experience in the coordination of ILS in a social service setting.

In addition, providers will meet contractor requirements to receive a contract.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Choice Guiding

Provider Category:

Agency

Provider Type:

Centers for Independent Living

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Community based non-profit organizations in Washington State which provide services by and for people with disabilities. Centers for Independent Living receive funding through the Federal Department of Education/Rehabilitation Services Administration and are contracted in the state of Washington through the Department's Division of Vocational Rehabilitation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Choice Guiding

Provider Category:

Individual

Provider Type:

Community Choice Guide Professional

Provider Qualifications

License *(specify):*

Any applicable business license

Certificate *(specify):*

Other Standard *(specify):*

Bachelor's degree or higher in Psychology, Social Work, Social Services, Human Services, Behavioral Sciences or other closely-related field including a medical field, with a minimum of one year experience providing services with one years' experience in the coordination of independent living skills (ILS; e.g., housing, personal assistance services recruitment or management, independent living skills training, etc.); or two years' experience in the coordination or provision of ILS in a social service setting under qualified supervision; or four years personal experience with a disability and has documented experience in the coordination of ILS in a social service setting.

In addition, providers will meet contractor requirements to receive a contract.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Support: Goods and Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
17 Other Services	17010 goods and services
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community Support: Goods and Services are non-recurring set-up expenses for individuals that are not eligible for Community Transition Services provided under 1915(k) and who are transitioning from a provider operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.

Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and non-recurring cleaning prior to occupancy; (e) moving expenses; (f) necessary home accessibility adaptations; and, (g) activities to assess need, arrange for and procure needed/resources.

These services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources.

These services do not include monthly rental or mortgage expenses, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes.

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

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Centers for Independent Living
Individual	Community Vendor
Agency	Community Vendor
Individual	Community Transition Service Provider
Agency	Community Transition Service Professional

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Support: Goods and Services

Provider Category:

Agency

Provider Type:

Centers for Independent Living

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Community based non-profit organizations in Washington State which provide services by and for people with disabilities. Centers for Independent Living receive funding through the Federal Department of Education/Rehabilitation Services Administration and are contracted in the state of Washington through the Department's Division of Vocational Rehabilitation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Support: Goods and Services

Provider Category:

Individual

Provider Type:

Community Vendor

Provider Qualifications

License *(specify):*

Business licensing requirements per Title 308 WAC.
Based on service provided, a vendor may require a license through WA State Dept. of Agriculture per Chapter 15.58 RCW and Chapter 17.21 RCW

Certificate *(specify):*

Other Standard *(specify):*

Vendors will comply with standards that correlate to specific service type provided:
WA State Utilities and Transportation Commission (UTC) per Title 480 WAC, Title 80 RCW, Title 54 RCW, Chapter 480-15 WAC, Chapter 81.80 RCW
WA State Dept. of Labor and Industries: Chapter 18.27 RCW and Chapter 296-200A WAC
Additionally if the needed service is not one that is regulated, the State will ensure that such services are delivered as specified by waiver beneficiary and detailed in the plan of care.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Support: Goods and Services

Provider Category:

Agency

Provider Type:

Community Vendor

Provider Qualifications

License *(specify):*

Business licensing requirements per Title 308 WAC.
Based on service provided, a vendor may require a license through WA State Dept. of Agriculture per Chapter 15.58 RCW and Chapter 17.21 RCW

Certificate *(specify):*

Other Standard *(specify):*

Vendors will comply with standards that correlate to specific service type provided:
WA State Utilities and Transportation Commission (UTC) per Title 480 WAC, Title 80 RCW, Title 54 RCW, Chapter 480-15 WAC, Chapter 81.80 RCW
WA State Dept. of Labor and Industries: Chapter 18.27 RCW and Chapter 296-200A WAC
Additionally if the needed service is not one that is regulated, the State will ensure that such services are delivered as specified by waiver beneficiary and detailed in the plan of care.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Support: Goods and Services

Provider Category:

Individual

Provider Type:

Community Transition Service Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Bachelor's degree or higher in Psychology, Social Work, or other related field including a medical field, with a minimum of two years experience providing services to aging or disabled populations or A Bachelor's degree in social work or psychology with two years experience in the coordination or provision of independent living services (e.g., housing, personal assistance services recruitment or management, independent living skills training, etc.) in a social service setting under qualified supervision; or four years personal experience with a disability.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Support: Goods and Services

Provider Category:

Agency

Provider Type:

Community Transition Service Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

An agency that employs individuals to provide this service who meet the following qualifications: Bachelor's degree or higher in Psychology, Social Work, or other related field including a medical field, with a minimum of two years experience providing services to aging or disabled populations or A Bachelor's degree in social work or psychology with two years experience in the coordination or provision of independent living services (e.g., housing, personal assistance services recruitment or management, independent living skills training, etc.) in a social service setting under qualified supervision; or four years personal experience with a disability.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon Initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Those physical modifications to the private residence of the participant or the participant's family, identified by the participant's service plan, that are necessary to ensure the health, welfare, and safety of the participant or that enable the participant to function with greater independence in the home. Such modifications include the installation of ramps, grab-bars, widening of doorways, modifications of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Excluded are those modifications or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant.

Environmental modifications include the performance of necessary assessments to determine the types of modifications that are necessary. Home modifications may be authorized up to 180 days in advance of the community transition of an institutionalized person.

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

Modifications that add to the total square footage of the home are excluded from this benefit except when necessary to complete the modification (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Environmental modifications may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

Home modification begun while a person is institutionalized is not considered complete until the date the person leaves the institution and enters the waiver.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Volunteer
Individual	Home Modifications Contractor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Environmental Modifications

Provider Category:

Individual

Provider Type:

Volunteer

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must sign confidentiality statement
Must have knowledge of building codes as applicable to the specific task
Cost must be less than $500 per Chapter 18.27.090(9) RCW (Volunteers are reimbursed for costs of supplies and materials but are not reimbursed for labor).

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Individual

Provider Type:

Home Modifications Contractor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Meet the standards of Chapter 18.27 RCW Registration of Contractors

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1:	Sub-Category 1:
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Home Delivered Meal services provide nutritional balanced meals delivered to the participant's home. Services may be delivered by mail or may include an additional face to face contact to monitor the client's well-being and safety. Face to face visits completed during in person meal delivery are in addition to ongoing health and safety monitoring responsibilities completed by case managers.

These meals shall not replace nor be a substitute for a full day's nutritional regimen but shall provide at least one-third (1/3) of the current recommended dietary allowance as established by the Food and Nutrition Board of National Academy of Sciences, National Research Council. A unit of service equals one meal. No more than one meal per day will be reimbursed under the waiver.

Home delivered meals are provided to an individual at home and included in the approved plan of care only when the participant is homebound, unable to prepare the meal and there is no other person, paid or unpaid, to prepare the meal. Receiving a meal is more cost effective than having a personal care provider prepare the meal. When a participant's needs cannot be met by a Title III provider due to geographic inaccessibility, special dietary needs, the time of day or week the meal is needed, or existing Title III provider waiting lists, a meal may be provided by restaurants, cafeterias, or caterers who comply with Washington State Department of Health and local board of health regulations for food service establishments.

Verification of the receipt of services is conducted by case managers during the face-to-face visits, client communication, and annual assessments.

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

Service is provided only as identified in the participant's CARE assessment and service plan.

No more than one meal per day is reimbursed under the waiver.

Face-to-face visits are provided with each in-person delivery of home delivered meals. The frequency of meal deliveries is determined by the participant's assessed needs and preferences and the number of meals authorized to the participant per month.

Participant must be home bound, unable to prepare the meal, and there is no other person paid or unpaid to prepare the meal.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Food Service Vendor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Food Service Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Title III Home delivered nutritional program standards and Chapter 246-215 WAC (food service)

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Skilled Nursing Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services listed in the service plan must be within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in the State. Skilled nursing services under the waiver differ from skilled nursing in the State Plan. Under the State Plan, skilled nursing is intended for short-term, intermittent treatment of acute
conditions or exacerbation of a chronic condition. The waiver skilled nursing service is used for treatment of chronic, stable, long-term conditions that cannot be delegated or self-directed.

The services under the waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization

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

Skilled Nursing services may not be duplicative of any other waiver service.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Registered Nurse
Agency	Home Health Agency

Provider Category	Provider Type Title
Individual	Licensed Practical Nurse

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Skilled Nursing Services

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

Licensed under Chapter 18.79 RCW and Chapter 246-840 WAC

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Skilled Nursing Services

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Licensed under Chapter 70.127 RCW

Certificate *(specify):*

Other Standard *(specify):*

Individual RNs and LPNs employed by the agency must be licensed under Chapter 18.79 RCW and Chapter 246-840 WAC.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Skilled Nursing Services

Provider Category:

Individual

Provider Type:

Licensed Practical Nurse

Provider Qualifications

License *(specify):*

Licensed under Chapter 18.79 RCW and Chapter 246-840 WAC

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

14 Equipment, Technology, and Modifications	14031 equipment and technology

Category 2: **Sub-Category 2:**

14 Equipment, Technology, and Modifications	14032 supplies

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Specialized medical equipment and supplies include devices, controls, or appliances, specified in the plan of care, which enable the participants 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, and durable/non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

This service also includes maintenance and upkeep of items covered under the service and training for the participant/caregivers in the operation and maintenance of the item. Training may not duplicate training provided in other waiver services.

The services under the waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

Service provided only as identified in the participant's CARE assessment and service plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the participant.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medical Equipment and Supply Contractor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Medical Equipment and Supply Contractor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must have a Core Provider Agreement with the State Medicaid Agency

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency

Frequency of Verification:

Upon purchase of specialized equipment

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transportation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Service offered in order to enable participants to gain access to waiver and other community services, activities and resources, as specified in the service plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State Plan, defined at 42 CFR 440.170(a)(if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's service plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge should be utilized.

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

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual
Agency	Public Transit
Individual	Taxi
Individual	Volunteer

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Standards are the same as those applied to vendors who provide access to State Plan medical services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Public Transit

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Standards are the same as those applied to vendors who provide access to State Plan medical services.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency
Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Individual

Provider Type:

Taxi

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Standards are the same as those applied to vendors who provide access to State Plan medical services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Individual

Provider Type:

Volunteer

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Standards are the same as those applied to vendors who provide access to state plan medical services. Volunteers receive reimbursement for gas mileage.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **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.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *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:

Case management is provided by State case managers, Tribal Case Managers, and Area Agency on Aging case managers as an administrative function.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

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):

○ **No. Criminal history and/or background investigations are not required.**

◉ **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):

The DSHS Background Check Central Unit (BCCU) is responsible for conducting the background check.

The types of positions for which such investigations must be conducted:
- Case manager, LPN, RN, nursing assistant, certified dietician, physical therapist, occupational therapist, and any waiver contractor who has unsupervised access to a vulnerable adult.

The scope of such investigations (e.g., state, national):
- The State's background check includes a comprehensive criminal history information including aliases, as well as information about the persons who are on a state registry for findings of abuse, neglect, abandonment, or exploitation against a minor or vulnerable adult (state).
- Completion of a national finger-print based background check (national)

The process for ensuring that mandatory investigations have been conducted:
- the entity originally requesting the background check receives a letter outlining the findings of the background check from BCCU. This letter is used to determine whether a potential provider is cleared for contracting. Contracts cannot be executed and providers cannot be paid without evidence of complete background check which includes abuse registry screening, and finger-print based check.

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):

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

◉ **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):

The DSHS Background Check Central Unit (BCCU) maintains the abuse registry and conducts screenings against the registry.

Case managers, LPNs, RNs, nursing assistants, certified dieticians, physical therapists, occupational therapists, and all other waiver contractors who have unsupervised access to vulnerable adults.

The entity originally requesting the background check receives a letter outlining the findings of the background check from BCCU. This letter is used to determine whether a potential provider is cleared for contracting. Contracts cannot be executed and providers cannot be paid without evidence of complete background check which includes abuse registry screening, and finger-print based check.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. 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-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

- [ ] **Self-directed**
- [ ] **Agency-operated**

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-1/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-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **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 establishes qualifications and offers the opportunity for any willing provider to demonstrate qualifications and enroll at any time through an application process managed by the Area Agencies on Aging. Provider enrollment information and forms are continuously available for provider enrollment via ALTSA's internet website. Providers who meet qualifications and are willing to contract will be contracted to serve waiver participants in the specified geographic areas covered by the waiver. Access problems identified will be addressed through enrollment of additional providers.

The State fully complies with open enrollment requirements for Wellness Education providers in that it:
• Establishes a provider application for Wellness Education that identifies specific provider requirements and service description
• Provides a Medicaid provider agreement template
• Posts the application and sample Medicaid provider agreement on ALTSA's internet website where other waiver service provider applications are posted
• Applications from potential providers are reviewed by program management staff in ALTSA headquarters.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
 # & % waiver service providers w/ initial contracts meet licensure &/or certification standards & adhere other standards prior furnishing waiver services N=# waiver service providers w/ initial contracts meet licensure &/or certification standards & adhere other standards prior furnishing waiver services D=Waiver service providers with initial contracts that require licensure &/or certification

Data Source (Select one):
Other
If 'Other' is selected, specify:
Contracts Administrative Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
 # & % waiver service providers who continue to meet licensure &/or standards at contract renewal delegated by the SMA & adhere to other standards prior to their furnishing waiver services N = see Main B. Optional for the numerator language D=All waiver service providers that require licensure &/or certification who were required to have contract renewals

Data Source (Select one):
Other
If 'Other' is selected, specify:
Contracts administrative data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The number and percent of non-licensed/non-certified providers that meet waiver requirements prior to providing waiver services, as delegated by the SMA. N = Number of non-licensed/non-certified providers that meet waiver requirements prior to providing services, as delegated by the SMA D = Number of non-licensed/non-certified providers

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The number and percent of waiver service providers that meet training requirements, as delegated by the State Medicaid Agency and in accordance with state requirements and the approved waiver. N = Number of waiver service providers that meet training requirements as delegated by the SMA and in accordance with state requirements and the approved waiver D = Number of waiver service providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCA monitoring tools used by AAAs

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: AAAs	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: 12 direct service worker files or 7% whichever is higher. 95% confidence level with +/- 5% margin of error
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number & percent of adult day health facilities that have met training requirements as delegated by the State Medicaid Agency and in accordance with state requirements & the approved waiver. N=Number of adult day health facilities that met training requirements as delegated by the SMA and in accordance with state requirements & the approved waiver D=Number of adult day health facilities reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

-Contracts for all waiver providers are maintained in a central database. Contract status is updated on a daily basis.

- Other waiver service contracts (Home Delivered Meals, Environmental Modifications, Skilled Nursing, etc.) are monitored by Area Agencies on Aging (AAAs) which is verified by the State.

- A home visit is conducted within required timelines for an initial transfer to in-home case management to ensure the plan of care is in place, services are being implemented, the provider is adhering to requirements, and no further changes are needed.

- Face-to-face monitoring and verification occurs at the annual review and/or if there is a significant change. A minimum number of other contacts is specified based on the level of case management to verify that the plan is being appropriately implemented.

- Waiver providers are monitored by the Area Agencies on Aging (AAA). Reports are provided to the operating agency (ALTSA) annually. Comprehensive contract monitoring is conducted every other year. On alternate years, a focus monitoring is conducted. The operating agency reviews reports on an ongoing basis that are provided by the AAA to verify that monitoring and remediation of providers are occurring.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

AAAs provide technical assistance if standards are not met for waiver provider contracts they manage. Failure to make required changes can lead to contract termination. Identified issues often determine where additional policy clarification is required or training is needed.

Case managers terminate payments and may request termination of contracts if qualifications are not sustained.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: AAAs	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- (●) **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ( ) **Applicable** - The state imposes additional limits on the amount of waiver services.

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; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- [ ] **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.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Washington's Statewide Settings Transition Plan received Final approval on October 24, 2017.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Comprehensive Assessment Reporting Evaluation (CARE) 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 *(select 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 C-1/C-3)

☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

RN: licensed under Chapter 18.79 RCW

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

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

- A master's degree in social services, human services, behavioral sciences, or an allied field and one year of paid social service experience performing functions equivalent to a social service specialist 2;
OR
- A bachelor's degree in social services, human services, behavioral sciences, or an allied field and two years of paid social service experience performing functions equivalent to a social service specialist 2;
OR
- Six (6) years of professional/practical social service experience performing functions equivalent to a Social Service Specialist 2.

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

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

Job classification descriptions are available from the Operating Agency, DSHS.

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

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:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

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.

Case managers review the "Client's Rights and Responsibilities" (DSHS 16-172) document with clients that outline their right to participate in the development of their plan of care and ensure that their preferences and the services they wish to receive are included in their plan of care.

The "Medicaid and Options for Long-Term Care Services for Adults (DSHS 22-619)" booklet is provided to all new clients at the initial assessment. This document outlines Medicaid eligibility and available long-term care services.

Service plan development always includes the client and their legal representative (if applicable). Clients may include any other individuals of their choice to participate in the planning meeting. ALTSA encourages clients to include family members and other informal supports as appropriate to the client's situation.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

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):

The process used by ALTSA to develop the participant-centered service plan is described as follows:

(a) The case manager, participant, and their legal representative (if applicable) develop the plan of care. The participant may include any other person(s) of their choosing including family and other formal and informal supports. The initial plan of care must be completed within 45 days of the intake date. The plan of care is updated at least annually and less than annual if a significant change occurs within the annual plan period. Annual and significant change assessments must be completed within 30 days of the assessment creation date.

A significant change assessment is an interview conducted when there has been a change in the client's cognition, ADLs, mood and behaviors, or medical condition. All initial, annual, and significant change assessments (plans of care) are conducted by case managers through a face-to-face or telephonic or other technology media client interview, for any client. Annual updates and significant change assessments could have all or parts of the assessment completed through telephonic or other technology media. When completing evaluations and re-evaluations, 42 CFR 441.535 will be followed. Telephonic or assessment through other technology media would be available for all individuals, and all individuals are provided the opportunity for an in-person assessment in lieu of one preformed telephonically. In addition to the contact at the time of assessment, case managers are required to make at least one additional contact (in-person or by phone) during the service plan year. Additional contacts are also required if the participant is identified as Targeted Case Management. Assessments conducted face-to-face is the primary method for participant interview, and telephonic or other technology media options may be used when a face-to-face option is not available due to certain circumstances or conditions. (i.e., health and safety of participant and/or provider, inclement weather, etc.).

(b) Case managers conduct assessments using CARE, which is a standardized and automated assessment tool. CARE leads the case manager and client systematically though a series of assessments covering multiple life domains. Assessment items are based on the Minimum Data Set (MDS) and all areas include information about client needs, preferences and goals, health status, strengths, limitations and caregiver instructions. The Case Manager documents and addresses health and safety interventions for participants such as the use of back-up care, a Personal Emergency Response System (PERS), evacuation in an emergency, and referrals to other community or Medicaid-funded services. Case management staff review the health and welfare of participants receiving COPES services at each assessment and participant contact. Registered Nurses respond to referrals by Case Managers when nursing indicators have been identified in the CARE assessment. When nursing indicators have been identified in the CARE assessment, Nurses document nursing service activities and collaborate with Case Managers on follow up recommendations.

CARE screens and assessment elements contain client demographics including: collateral contacts, financial eligibility, employment status, personal goals and caregiver status which includes the Zarit burden scale to assess provider burden, behavioral issues, psychosocial and legal issues.

CARE assesses indicators of medical risk including number of hospitalizations, skin breakdown, pain issues, history of routine and preventive medical care, current medications, medication regimen and multiple diagnoses. The medical section of the assessment also includes diagnoses, ability to manage medications, and treatments (both skilled and unskilled).

Communication skills and resources such as ability to use the phone, vision, speech, and hearing abilities, mobility and history/risk of falls are also assessed.

The psychosocial assessment includes completion of the MMSE, memory issues, current or past behavior and successful interventions, depression, suicide risk, sleep patterns, relationships and interests, decision making ability, client goals, alcohol and tobacco use, and substance abuse issues if any.

Any legal matters concerning the client are reviewed including: risk of abuse, neglect, and/or exploitation, no contact or protection orders, less restrictive order, guardianship, Power of Attorney, advanced directives, divorce proceedings, eviction, involuntary commitment, lawsuits, parole or probation, and pending civil or criminal proceedings.

The Activities of Daily Living (ADL) section of the assessment includes the following areas: walking, bed mobility, toileting, eating, nutritional/oral status, bathing, transfers, dressing, personal hygiene, household tasks, transportation, shopping, wood supply if wood is the sole source of heating or cooking, housework, and need for environment modifications and/or assistive equipment.

(c) Case managers provide and review with all individuals interested in services the Medicaid and Options for Long-Term Care Services for Adults (DSHS 22-619X) booklet. This publication outlines the eligibility, services, resources, and options available through ALTSA including benefits available in the COPES waiver. The booklet includes several links to information about services and resources for individuals who have internet access.

(d) CARE auto generates the results of the assessment including all identified needs (including health care, equipment, and environment needs), client goals, and preferences into a plan of care. The electronic plan of care will show as incomplete until the case manager and client have finished all mandatory sections of the assessment and addressed all identified needs. A nursing referral may be recommended or required based on certain data elements or combination of data elements (critical indicators) that were selected in the assessment. Potential critical indicators include: unstable/potentially unstable diagnosis, caregiver training required, medication regimen affecting plan of care, nutritional status affecting plan of care, immobility risks affecting plan of care, past or present skin breakdown, and risk of skin breakdown. The plan of care is reviewed with the client to assure that their goals and preferences are included and that the plan meets their needs. Client consent is required before the plan of care is considered complete and can be implemented. Signatures may be collected electronically. Case managers use a person-centered approach to work with the participant to obtain their signature. Methods that may be offered include, but are not limited to:

-Completing the assessment in the home and obtaining the participant's signature electronically in a PDF document using your touch pad, mouse, or touchscreen.
-Using an e-signature feature.
-Using the Fill & Sign feature in Adobe.
-Using the voice signature feature in CARE.
-Making an in-person visit once the assessment is completed and obtaining the signature by mail.
-Utilizing supports identified by the participant to assist them with reminders to return the signed form.

If a participant chooses electronic communication outside of e-signature, a faxed or electronic scanned signature is acceptable. If the participant prefers, the case manager may send the participant a PDF version of the Service Summary and Planned Action Notice/Personal Care Results/Personal Care Results Comparison using encrypted email. The person-centered service plan can be electronically signed when assessments are conducted in-person or through the use of telephonic or other permissible technology media.

In accordance with 42 CFR 441.301(2)(ix) and 42 CFR 441.301(2)(x), the person-centered service plan is signed by and distributed to all individuals and providers responsible for its implementation.

(e) During the assessment process, case managers obtain the client's permission to collect information and coordinate service planning with the client's primary care provider and other service systems such as mental health and/or alcohol and substance abuse. When considering how care needs are being met, the care plan takes into account services being received from allied systems. For clients who have very complex needs or who are involved in multiple systems, cross systems case staffing may be employed.

(f) The case manager has primary responsibility for implementing and monitoring the care plan. The case manager reviews the plan of care with providers prior to implementation to answer any questions and ensure the caregiver understands and is able to provide the care outlined in the plan of care. The client and his/her family or representative is encouraged to contact the case manager immediately if there are problems with the plan. As part of annual plan of care monitoring, case managers are required to make at least one additional contact (in-person or by phone) following the initial/annual client interview for in-home participants. For residential participants, frequency of contacts is based on the participant's care needs, cognition, emotional, psychiatric, behavioral problems, and his/her support system.

Care plans are also routinely monitored through the quality assurance process and a regular schedule of supervisor reviews.

For all participants, care management and coordination of services includes monitoring, providing education, facilitating and encouraging adherence to recommended treatment. This does not in any way limit the participant's right to refuse treatment.

(g) Care plans are updated annually or when a significant change occurs. Significant change is defined as a reported significant change, for better or worse, in the client's cognition, mood/behavior, ADL's or medical condition. If an

assessment is conducted in some place other than the client's residence, including through telephonic or other technology media, a visit to the home where services will be provided is required. Interim updates are made as necessary when there are changes in providers, schedules, etc.

(h) ALTSA policy stipulates that the client is the primary source of assessment information. The client and their legal representative (if applicable), along with the case manager develop the plan of care. The client may include any other person(s) of their choosing including family and other formal and informal supports. The client has free choice of qualified providers and employer authority for personal care services. Within the parameters of the program, clients can choose the services that will best meet their needs.

References:
- CARE, Chapter 3, Long-Term Care Manual
- Case Management, Chapter 5, Long-Term Care Manual
- Core Services, Chapter 7, Long-Term Care Manual
- 388-106 WAC, Long-Term Care Services

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

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.

Strategies to mitigate risk are incorporated directly into service planning. The CARE assessment identifies when a client is potentially or currently at risk, and the participant centered approach allows for incorporating strategies to reduce risk into the plan in a manner sensitive to the person's preferences. Risk assessment screens cover common areas of risk such as: mental and physical health, medication use and management, nutrition, behaviors, personal safety, environment, falls, and the decision making screen. CARE creates critical indicators based on certain data elements or combination of data elements identified by the case manager and client. These critical indicators require the case manager to address each element based on the level of risk and client choice. These indicators include: unstable/potentially unstable diagnosis, caregiver training required, medication regimen affecting plan of care, nutritional status affecting plan of care, immobility risks affecting plan of care, and past or present skin breakdown. In addition to critical indicators, policy states that if the client meets any of the following criteria, than they are placed on targeted case management, and an additional face to face visit and contact will need to be made to monitor the issue related to client's care plan as well as service plan delivery. The criteria includes the following:

• Has a potential for abuse and neglect as identified in the assessment on the Legal Issues screen or in the SER. This includes all clients who have had an Adult Protective Service (APS) referral in the last year or had an open APS case.
• Lives in an environment that jeopardizes his/her personal safety, as identified in the assessment on the Environment screen or in the SER
• Is not always able to supervise his/her paid provider as identified in the assessment on the Decision-Making screen and no one is identified on the Decision-Making screen as the person responsible for supervision.
• Has thought about suicide in the last 30 days, as indicated on the Suicide screen.
• Is sometimes or rarely understood, as identified in the assessment on the Speech/Hearing screen.

Responsibilities and measures for reducing risk include the following:

Every plan of care must include an evacuation plan, if the individual cannot independently evacuate. The case manager and client discuss the risks involved and possible outcomes. The case manager discusses long-term care settings that may meet the individual's needs and reduce risk. If the individual chooses to stay at home, the case manager documents the client's decision.

All critical indicators must be addressed during the service planning process and may include a referral for nursing services, mental health services, legal services, or other needed services to assist the participant in mitigating areas of risk.

Targeted case management criteria is reviewed during service planning and throughout the year as identified. The Case manager would identify the need for targeted case management in CARE by answering the TCM question, and creating an SER documenting the need for targeted case management.

An effective back-up plan that is unique to the participant's needs and circumstances, and may include:
- An agency caregiver who are able to provide on-call staff as needed.
- An emergency response system to access emergency services at all times.
- Informal support who are able and willing to assist when needed.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

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.

Clients are given free choice of all qualified approved providers of each service included in the plan of care. Clients are initially provided with a list of qualified and available service providers for that geographical area. On an on-going basis, the client can request a copy of the list, to have the Case Manager present the information over the phone, or they can access resource directories on the internet.
Case managers assist clients in locating qualified providers. All providers must meet the qualifications specified in Appendix C of this waiver.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

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):

ALTSA determines client eligibility. ALTSA or a Federally Recognized Tribal case manager are required to use the department's electronic assessment and service planning tool. ALTSA or Federally Recognized Tribal case managers complete an assessment of need. ALTSA or Federally Recognized Tribal case managers directly authorize all initial service plans. ALTSA has direct electronic access to all comprehensive assessments.

To ensure that plans have been developed in accordance with applicable policies and procedures and ensure the health and welfare of waiver participants, a statewide random sample of service plans is reviewed by the ALTSA quality assurance unit on a twelve-month cycle. ALTSA calculates the sample by drawing a statistically valid sample across the participant population on all waivers. The sample is derived using a 95% confidence level, a 50% response distribution, and a 5% margin of error.

In addition to review of electronic service plans, the ALTSA QA unit assess the accuracy and quality of service plans.

QA processes may result in corrective actions, adjustments to training curriculum, policy clarifications, forms revision, WAC revisions and targeting criteria for the next review cycle.

At the end of each QA Review Cycle, a final report is generated which includes detailed data on a state-wide level. These results are analyzed and incorporated into a statewide Performance Improvement Plan (PIP). The State Medicaid Agency receives annual QA Review reports and meets with the operating agency at the conclusion of the QA cycle to review results and provide input into the PIP. The PIP is reviewed and approved for implementation by executive management.

The Medicaid agency reviews a sample of service plans retrospectively each month to ensure that plans have been developed in accordance with applicable policies and procedures and to ensure the health and welfare of waiver participants.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

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 the other schedule:

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 §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**

☒ **Operating agency**

☐ **Case manager**

☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

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.

a) ALTSA, AAA Case Managers, and Tribal Case Managers have primary responsibility for monitoring the implementation of plans of care and client health and welfare. The implementation and monitoring of the plans of care through face-to-face contact or by telephone ensures that services are provided as outlined. Case managers adjust plans of care as needed or as requested by the participant. In addition, ALTSA quality assurance activities provide monitoring of service plan implementation.

Providers are bound by contract to notify the case manager when there are changes in the client's condition or needs. Participants are also responsible to contact their case manager when their condition or service needs change. Collateral contacts are encouraged to notify the case manager with any concerns.

(b) All initial, annual, and significant change assessments are conducted by case managers through a face-to-face or telephonic or other technology media client interview, for any client. Change assessments could have all or parts of the assessment completed through telephonic or other technology media. When completing evaluations and re-evaluations, 42 CFR 441.535 will be followed. Telephonic or assessment through other technology media would be available for all individuals, and all individuals are provided the opportunity for an in-person assessment in lieu of one preformed telephonically. In addition to contact at the time of assessment, case managers are required to make at least one additional contact (in-person or by phone) during the service plan year. If an assessment is conducted in some place other than the client's residence, including through telephonic or other technology media, a visit to the home where services will be provided is required. When problems/barriers with services or providers are identified, the case manager works with the participant to develop solutions and ensure access to waiver and non-waiver (including health) services and free choice of providers. Back-up plans are reviewed for effectiveness and revised accordingly.

(c) ALTSA quality assurance unit annually monitors, at a statewide level, a representative sample of case manager’s files. If problems are identified in individual records, supervisors/case managers are expected to remediate the problems at the individual level. The annual quality assurance review includes a review of the health and welfare of participants. Issues related to health and safety and payment are expected to be addressed immediately or within three working days depending on the situation. Other required corrections are completed and verified within 40 calendar days of the preliminary review. In addition, Supervisors/Managers at the local level monitor selected client assessments to ensure that they meet minimum standards.

Aggregate data is collected in/reported from the quality assurance monitoring application. This data is used at the local and state level for system improvement.

Additional monitoring and oversight is provided by established Quality Improvement and Management systems described in Appendix G.

A more detailed outline of QA monitoring is in Appendix H.

b. Monitoring Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: 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.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number & percent of service plans for waiver participants that address all assessed needs, including health & safety risk factors by the provision of waiver services or other means. N=Number of service plans for waiver participants that address all assessed needs, including health & safety risk factors by the provision of waiver services or other means D=Number of service plans reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(check each that applies):		
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The number and percent of service plans that address all participant goals by the provision of waiver services or other means. N=Number of service plans that address all participant goals by the provision of waiver services or other means D=Number of participant service plans reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The number and percent of service plans reviewed and updated prior to annual review date. N = Number of service plans reviewed and updated prior to annual review date D = Number of service plans reviewed

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants who experienced a significant change in condition who were given a significant change assessment when warranted & the service plan was updated. N=Number of participants who experienced a significant change in condition who were given a significant change assessment when warranted & the service plan was updated D=Number of participant files reviewed

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The number and percent of participant files where services were authorized & delivered in accordance with the type, scope, amount, duration, and frequency specified in the service plan. N=Number of participant files where services were authorized & delivered in accordance with the type, scope, amount, duration, and frequency specified in the service plan D=Number of participant files reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

The number and percent of participants who report receiving services as authorized. N = Number of participants who report receiving services as authorized D = Number of participants surveys returned

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid services verification survey

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The number and percent of participants who were provided an informed choice of services and providers by the case manager. N = Number of participants who were provided an informed choice of services and providers by the case manager D = Number of participants reviewed

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100%**

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

HOW THE CARE PLAN IS DEVELOPED (BACKGROUND)
The plan of care can only be developed using the CARE assessment application. The plan of care is developed with information entered into CARE by the participant and case manager during the assessment process. An algorithm in CARE runs when the assessment is complete to create the plan of care based on the data input by the case manager and participant. CARE tracks identified needs and the type of providers (formal or informal) who are assigned by the case manager to each identified need. CARE has the case manager address/plan for each topic as he/she moves through the assessment process. The Service Summary (Plan of Care) identifies areas such as:
- Formal and informal supports and the tasks that have been assigned to each;
- Participant goals and preferences; and
- Referrals including who will follow through with the referral and when.

HOW DISCOVERY IS DESIGNED AND IMPLEMENTED
ALTSA monitors plan of care decisions in several ways:
1. Local Supervisory Discovery Activities
Each year, social service supervisors/managers monitor records to ensure the plan of care is reviewed and adjusted and that all needs (including health and safety and risk factors) and preferences are included in the plan of care and delivered as outlined. For new staff, the first 5 assessments are reviewed and then a minimum of 50% of plans are reviewed during the next three months of employment. Errors in assessment that can lead to an inaccurate plan of care are corrected. Reports for experienced workers can be generated at any time for preliminary action, and annually for statistical analysis.

2. Statewide ADSA QA Unity Discovery Activities
ALTSA QA unit monitors participant plans of care using a statistically valid sample of records statewide on a 12 month review cycle.
- QA reports are reviewed with each AAA and HCS region, and corrective action is required within 30 days by case managers, supervisors and/or field managers.
- All participants assessed needs (including health and safety and risk factors) whether or not paid by ALTSA, are documented within CARE.
- Evacuation plans are required and are recorded in CARE.
- If lack of immediate care would pose a serious threat to the health and welfare of the participant, a backup plan is required.
- QA monitoring assures that all services are delivered in accordance with the service plan, including type, scope, amount, duration, and frequency as specified in the plan of care.

The Quality Assurance application and CARE reports, (QA monitoring data is current at the time monitoring occurred and CARE management reports are in real time), capture the following:
- Needs identified in CARE are adequately addressed in the participants POC
- POC development is participant directed and plans are completed in required time frame
- Participants receive all of the services identified in the POC
- Participants are provided the freedom to choose waiver services, institutional care, and service providers.
- Participants choices are not limited within the parameters of the waiver and choice of qualified providers is adequate to meet participant needs
- Plans are reviewed and revised in response to participant direction or change in needs.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on

the methods used by the state to document these items.

Upon completion of each record review, the case manager is expected to make necessary corrections. Corrections are verified by either the QA unit or the case management supervisor. The QA unit verifies that required corrections have been made at the individual level within 30 days of the preliminary review and document the verification in the QA monitoring application. Items related to health and safety and payment, require either immediate action or within three working days depending on the situation. Supervisors verify that corrections have been made at the individual level prior to completing the review and document this activity in the QA monitoring application.

Reports and aggregate data are reviewed throughout the year (based on an established review schedule) by individuals who make decisions on what improvements are needed individually or systemically. Regions and AAAs are required to develop a proficiency improvement plan (PIP) within 30 days of receiving their final report. PIPs address any area where required proficiency is not met. Draft plans are reviewed by ALTSA prior to approval and implementation. Progress reporting is unique to each item within the PIP and unique to each Region/AAA. The Region/AAA completes the “Progress Reporting Section” and sends to the QA lead when due with a cc: to the QA manager and AAA specialist, if appropriate. If the progress report is not received on time, the QA lead follows up with the Region/AAA.

Statewide systemic issues are addressed in on-going case management training, policy review/revision/development, and other areas as needed.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- ○ **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: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 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.

Fair Hearing policies and corresponding State regulations ensure that all persons have the right to apply for Long-term Care (LTC) services administered by the department, and all applicants/clients have the right to have their financial and program eligibility determined by the department, the right to appeal any decision made by AAA or HCS staff which they perceive as adversely impacting their LTC services including, but not limited to the choice of provider or service, denial of services, reduction in the level of services, suspension of services, or termination of service. Fair Hearing Policy and Procedure is outlined in Chapter 1 of the State Long Term Care Manual. Implementation and tracking of Fair Hearings is accomplished through an automated database.

All waiver clients sign and receive a copy the “Acknowledgement of Services” form (DSHS 14-225) when they choose to receive a service under a waiver. This form is used to inform clients of their choices regarding waiver and institutional services and of their fair hearing rights.

The case manager informs the applicant/client verbally AND in writing when the AAA or HCS approves, denies, suspends, reduces, or terminates services and explains the reason(s) for the action or decision in question, including the facts upon which the decision was based. This notice includes language that is found in Washington Administrative Code that informs the client that they have a right to continuing benefits pending the outcome of the administrative hearing if they request a hearing by the effective date of the department’s decision or the end of the month in which the effective date occurs.

The applicant/client must always be informed of the right to a fair hearing and how to make a fair hearing request. A fair hearing request form is included with the planned action notice (PAN) sent to the client. The client is informed that fair hearing requests may be made verbally or in writing. The Case Manager will assist and/or submit a request for a Fair Hearing on behalf of the client at their request. Planned Action Notices are currently retained in the client’s CARE record. Decisions are kept with the same retention as other client documents.

The case manager documents in the Service Episode Record (SER) the date, topic of discussion, that the fair hearing process has been explained; and the client’s decision.

References:
DSHS form 14-225 - Acknowledgement of Services
Chapter 388-02 WAC
DSHS hearing rules
WAC 388-02 and its successors
Long Term Care Manual Chapter 1

Appendix F: Participant-Rights

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:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

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: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **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**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

The system is operated by the Department of Social and Health Services (DSHS) through the Aging and Long-Term Support Administration (ALTSA).

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).

(a) the types of grievances/complaints that participants may register:
Participants may register complaints about anything the Department does or is responsible for that they perceive as affecting them negatively in any way. To protect participant rights, some types of complaints are immediately directed to other formal systems rather than being addressed through the grievance process.

All participants receive the document, “Your Rights and Responsibilities When You Receive Services Offered by Aging and Disability Services Administration”. This document informs participants that they have the right to make a complaint and also have the right to separately file a Fair Hearing. In addition, participants receive a Planned Action Notice informing them of all actions taken by ALTSA. This notice outlines the Fair Hearing process and offers participants the pamphlet entitled ”Your Hearing Rights in a DSHS Case”. The pamphlet, ”Your Hearing Rights in a DSHS Case”, explains that an optional opportunity to settle the case before the hearing is available and also explains that if an agreement cannot be reached the right to a Fair Hearing remains.

Complaints not handled through the grievance process include the following:
a. Complaints of abuse, neglect or financial exploitation of a vulnerable adult or child - referred to formal protective systems
b. Client disputes about services that have been denied, reduced, suspended, or terminated - client is informed of their rights and referred to the fair hearing process
c. Complaints about possible Medicaid fraud - referred to the Medicaid Fraud Control Unit

(b) the process and timelines for addressing grievances/complaints:
Complaints can be received and addressed at any level of the organization. However, ALTSA always strives to address grievances/complaints at the lowest level possible. Upon receipt at any level, all DSHS employees are required to respond to in-person or telephone complaints within 1 business day. Written complaints must receive a response within 7 business days. Complaints are referred to the case manager for action unless the complainant requests it not be. If the case manager is unable to resolve the complaint, the person is referred to the case manager's supervisor. The supervisor has ten working days from the date of receipt to attempt to resolve the issue. If the person feels their complaint is not resolved they are referred to the Regional Manager/AAA Director. The Manager/Director has ten working days to seek resolution. If the person continues to feel their complaint is not resolved, they are referred to the state level ALTSA headquarters. ALTSA has ten working days to resolve the complaint and must notify the person in writing of the outcome.

As part of the pre-hearing process, the administrative hearing coordinator is responsible for clarifying the issues that the client is disputing. If the dispute is in relation to a personality conflict with the case manager, for instance, or a dispute that falls outside of WAC/eligibility, the coordinator informs the client about their grievance procedure. A case manager, supervisor, etc. may also inform the client about the agency’s grievance procedure. If the issue is the denial of an Exception to Rule request, the Notice of Action, Exception to Rule that is given to the client contains the grievance procedure.

(c) the mechanisms that are used to resolve grievances/complaints:
Mechanisms that are used as appropriate to the type of complaint may include record review and correction of any errors; case conferences with the client; a change of providers; information and referral; additional information on program policies, statutes, administrative rules; and adjustment to the plan of care.

References:
(1) ALTSA Complaint/Grievance Policy for Home and Community Services Division
(2) Management Bulletin H05-018 Policy/Procedure Client Grievance Policy March 2005
(3) DSHS Administrative Policy No. 8.11

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. 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).

The State requires the following types of critical events or incidents be immediately reported for review and follow up action by an appropriate authority:
• Abandonment
• Abuse (including sexual, physical, mental, personal exploitation, and improper use of restraint)
• Financial exploitation
• Neglect
• Self-neglect

Types of Abuse under RCW 74.34.020
1. Abandonment means action or inaction by a person or entity with a duty of care for a vulnerable adult that leaves the vulnerable person without the means or ability to obtain necessary food, clothing, shelter, or health care.

2. Abuse means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, and personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult which have the following meanings:

a. Sexual abuse means any form of nonconsensual sexual contact including, but not limited to, unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse includes any sexual contact between a staff person, who is not also a resident or client, of a facility or a staff person of a program authorized under Chapter 71A.12 RCW, and a vulnerable adult living in that facility or receiving service from a program authorized under Chapter 71A.12 RCW, whether or not it is consensual.

b. Physical abuse means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to: striking with or without an object, slapping, pinching, choking, kicking, shoving, or prodding.

c. Mental abuse means a willful verbal or nonverbal action that threatens, humiliates, harasses, coerces, intimidates, isolates, unreasonably confines, or punishes a vulnerable adult. Mental abuse may include ridiculing, yelling, or swearing.

d. Personal exploitation means an act of forcing, compelling, or exerting undue influence over a vulnerable adult causing the vulnerable adult to act in a way that is inconsistent with relevant past behavior, or causing the vulnerable adult to perform services for the benefit of another.

e. Improper use of restraint means the inappropriate use of chemical, physical, or mechanical restraints for convenience or discipline or in a manner that: (i) Is inconsistent with federal or state licensing or certification requirements for facilities, hospitals, or programs authorized under chapter 71A.12 RCW; (ii) is not medically authorized; or (iii) otherwise constitutes abuse under this section.

3. Financial exploitation means the illegal or improper use, control over, or withholding of the property, income, resources, or trust funds of the vulnerable adult by any person or entity for any person's or entity's profit or advantage other than for the vulnerable adult's profit or advantage. "Financial exploitation" includes, but is not limited to:

(a) The use of deception, intimidation, or undue influence by a person or entity in a position of trust and confidence with a vulnerable adult to obtain or use the property, income, resources, or trust funds of the vulnerable adult for the benefit of a person or entity other than the vulnerable adult;

(b) The breach of a fiduciary duty, including, but not limited to, the misuse of a power of attorney, trust, or a guardianship appointment, that results in the unauthorized appropriation, sale, or transfer of the property, income, resources, or trust funds of the vulnerable adult for the benefit of a person or entity other than the vulnerable adult; or

(c) Obtaining or using a vulnerable adult's property, income, resources, or trust funds without lawful authority, by a person or entity who knows or clearly should know that the vulnerable adult lacks the capacity to consent to the release or use of his or her property, income, resources, or trust funds.

4. Neglect means (a) a pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the

goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; or (b) an act or omission by a person or entity with a duty of care that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100.

5. Self-neglect means the failure of a vulnerable adult, not living in a facility, to provide for himself or herself the goods and services necessary for the vulnerable adult's physical or mental health, and the absence of which impairs or threatens the vulnerable adult's well-being. This definition may include a vulnerable adult who is receiving services through home health, hospice, or a home care agency, or an individual provider when the neglect is not a result of inaction by that agency or individual provider.

Intake referrals/reports are received in any format used by the referent including email, phone calls, our online reporting site or postal mail and the referrals are then routed to the appropriate investigative body. Referrals for abuse, neglect, exploitation, or abandonment can be made directly to APS or the CRU through the use of the Regional APS intake line or the RCS Complaint Resolution Unit (CRU) toll free number. The State also provides an End Harm hotline where any type of referral can be made and the referral is routed to the appropriate investigative entity.

Intake reports are first screened for the need for emergency response and the appropriate emergency responder is notified if indicated. Call line operators or intake workers use a decision tree to direct reports for jurisdiction to either APS or CRU, whether the intake will result in a full investigation and if so the time frames for the investigation. Reports are then prioritized and assigned for investigation as described in G 1-d.

Jurisdiction for either APS or RCS CRU is determined based on the following criteria:

* APS investigates reports of abuse, abandonment, neglect, self-neglect, or financial exploitation of vulnerable adults, when the alleged perpetrator is an individual, in any setting.

*RCS CRU investigates reports of alleged failed provider practice in facilities.

Required reporting of allegations involving waiver participants: What, when and to whom:
RCW 74.34.035 Reports (excerpt):

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

(2) When there is reason to suspect that sexual assault has occurred, mandated reporters shall immediately report to the appropriate law enforcement agency and to the department.

(3) When there is reason to suspect that physical assault has occurred or there is reasonable cause to believe that an act has caused fear of imminent harm:

(a) Mandated reporters shall immediately report to the department; and

(b) Mandated reporters shall immediately report to the appropriate law enforcement agency, except as provided in subsection (4) of this section.

(4) A mandated reporter is not required to report to a law enforcement agency, unless requested by the injured vulnerable adult or his or her legal representative or family member, an incident of physical assault between vulnerable adults that causes minor bodily injury and does not require more than basic first aid, unless:

(a) The injury appears on the back, face, head, neck, chest, breasts, groin, inner thigh, buttock, genital, or anal area;

(b) There is a fracture;

(c) There is a pattern of physical assault between the same vulnerable adults or involving the same vulnerable adults; or

(d) There is an attempt to choke a vulnerable adult.

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

Required reporters of allegations of abuse, abandonment, neglect and financial exploitation:
RCW 74.34.020 Definitions: (14) "Mandated reporter" is an employee of the department; law enforcement officer; social worker; professional school personnel; individual provider; an employee of a facility; an operator of a facility; an employee of a social service, welfare, mental health, adult day health, adult day care, home health, home care, or hospice agency; county coroner or medical examiner; Christian Science practitioner; or health care provider subject to chapter 18.130 RCW.
References:

-Chapter 74.34 RCW: Abuse of Vulnerable Adults statute
-WAC 388-71-0100 through 01280: Adult Protective Services
-HCS Long-Term Care Manual, Chapter 6, policies and procedures of the Adult Protective Services Program

c. 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 following resources illustrate ways that participants, family members, caregivers and/or legal representatives are provided information about protections from mistreatment and told how to report concerns or incidents of abuse, neglect, and exploitation:

Participants receive information at least annually during their annual assessment or more frequently if their situation changes significantly. Every CARE assessment addresses potential abuse, neglect and exploitation. This information is provided by the SW/CM verbally as well as in the ALTSA publication, “Medicaid and Options for Long-Term Care Services for Adults” which is provided during the assessment. This publication includes the appropriate state entity, which is DSHS/ALTSA/APS, to report incidents of abuse, neglect, and exploitation.

At the time of initial assessment each participant reviews and signs a form entitled “Your Rights and Responsibilities” (including the right to be free from abuse) at the time they accept services.

The participant financial eligibility process also includes a review of funds and information on client financial rights.

Other resources available to participants and representatives include:
1. Provider training (e.g., Caregiver Orientation, and Revised Fundamentals of Caregiving and Safety Training);
2. ALTSA and DSHS internet websites;
3. Eldercare Locator (AoA);
4. DSHS End Harm campaign and the activities associated with the annual statewide July Adult Abuse Prevention month.

d. 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.

The Department of Social and Health Services (DSHS)/Aging and Long-Term Support Administration (ALTSA)/Adult Protective Services (APS) is responsible for review of and response to critical incidents, as well as for evaluating incident reports (e.g., determining whether follow-up is necessary) and conducting investigations into incident reports.

DSHS/ALTSA/APS' responsibilities include:
• Initiating a response to a report no later than 24 hours after knowledge of the report.
• Making an immediate report to the appropriate law enforcement agency when the initial report or investigation indicates that the alleged A/N/E may be criminal.
• Sharing information contained in reports and findings of A/N/E of vulnerable adults with law enforcement when requested, within confidentiality laws.
• Notifying the proper licensing authority concerning any report received that alleges that a person who is professionally licensed, certified, or registered under Title 18 RCW has abandoned, abused, financially exploited, or neglected a vulnerable adult.

DSHS/ALTSA/APS receives reports of the abuse, abandonment, neglect, financial exploitation or self-neglect of a participant by fax, email, mail, telephone, TTY, in-person or online. Within 24 hours of receipt of the report, APS will enter the report into the APS system (TIVA2) and contact the reporter to gather information to determine if the report meets the criteria for investigation (screen-in) based on Chapter 74.34 RCW. Every report received by APS becomes an intake and a screening decision (screen in or screen out) is made based on the information received regarding vulnerable adult status, the allegation and jurisdiction. Additionally, APS provides resource information and makes necessary referrals to the appropriate entities.

Intake reports are assigned for investigation with a response priority timeframe of 24 hours, 5 business days or 10 business days. Intake reports are assigned as 24-hour responses when there is serious or life-threatening harm occurring or appears to be imminent. Five business day assignments are used when harm is more than minor but does not appear to be life threatening at the time or may be ongoing. Ten business day assignments are used when harm poses a minor risk at the time to health or safety and does not appear to be ongoing. Investigators will conduct initial visits with the alleged victim within the assigned response priority timeframe and the investigation is worked until completed. Investigations open longer than 90 days require an identified reason with supervisor approval.

APS notifies the participant or legal representative when the investigation is closed or at time of initial recommended initial substantiated finding.

When indicated, APS will summon an appropriate emergency resource during intake (e.g., law enforcement when a crime against a person or property is in progress; emergency medical services when the vulnerable adult is in need of immediate medical assistance; or a mental health agency when the vulnerable adult is threatening to harm self or others or cognitive impairment is so severe that it is unsafe to be alone).

Each intake report is reviewed and preliminary information is gathered in order to determine if APS has jurisdiction; whether the allegations will be investigated by APS; and the timeframe for initiation of each investigation.

Based on the facts and circumstances known at intake, reports are prioritized and assigned for investigation based on the severity and immediacy of actual or potential physical, mental or financial harm to the alleged victim, as follows:

1. High priority when serious or life threatening harm is occurring or appears to be imminent. APS will conduct an unannounced private interview with the alleged victim within 24 hours of receipt of the report.

2. Medium priority when harm that is more than minor, but does not appear to be life threatening at this time, has occurred, is on-going, or may occur. APS will conduct an unannounced private interview with the alleged victim within 5 working days of receipt of the report.

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

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

APS investigations are completed within 90 days of assignment unless necessary investigation or protective services activity continues. APS supervisors review cases at the 60 day and 90 day marks, and every 30 days after the 90 day mark if the case remains open for necessary protective services activity.

The participant or the participant's representative is informed of the results of the investigation. For unsubstantiated results the participant/representative receives verbal notification at the end of the investigation. For substantiated results, the participant receives verbal notification (written when requested) at two stages throughout the investigation; (1) when a determination by the investigator to recommend that the allegation be substantiated and (2) when this determination has been reviewed by the regional investigation review team.

As soon as possible at the time of investigation closure, APS will provide the finding verbally, and if requested, a written outcome report.

For an initial substantiated finding, APS will, in person or over the telephone, attempt to verbally inform the alleged victim that:
- The allegation was substantiated; and
- If the alleged perpetrator is 18 years of age or older, tell the alleged victim that APS will send a letter to notify the alleged perpetrator of the initial finding and their opportunity to request an administrative hearing to challenge the finding.
- If the alleged victim expresses objections to a letter being sent to the alleged perpetrator because of fear for the alleged victim's physical safety, attempt to problem solve and offer protective services (e.g., protection order) or suggest a referral to other resources (e.g., domestic violence program) before sending the letter to the alleged perpetrator.
- Upon request, APS will provide the alleged victim with a copy of the APS outcome report, a courtesy copy of the notification letter APS sends to the alleged perpetrator, or both.

RCS investigates licensed or certified residential providers. The complaint investigation response times are 2-days, 10-days, 20-days, 45-days, 90-days, and Quality Reviews. For allegations that involve named individuals that may have perpetrated abuse, neglect, or misappropriation of resident funds response times are 10-days, 20-days, 30-days, and 60-days. All of these categories require an on-site investigation, except for the Quality Review category. In general, the shorter the investigation response timeframe, the more serious the alleged issue. Any report received from a public caller is assigned an on-site investigative response time.

References:
1. RCW 74.34: Abuse of Vulnerable Adults statute
2. WAC 388-71-0100 through 01280: Adult Protective Services rule
3. HCS Long-Term Care Manual, Chapter 6, policies and procedures of the Adult Protective Services Program

e. 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.

Adult Protective Services (APS) is a statewide program within the State Operating Agency. Aging and Long-Term Support Administration (ALTSA) built, owns, operates, and oversees the system, Tracking Incidents of Vulnerable Adults 2 (TIVA2), which automatically interfaces with ALTSA's Comprehensive Assessment Reporting & Evaluation (CARE) system providing automatic notifications regarding clients served by Home and Community Services (HCS), Area Agency on Aging (AAA) and the Developmental Disabilities Administration (DDA). The notifications include receipt of reports, initiation of investigations and the findings.

Additionally, while conducting an investigation involving an alleged victim or alleged perpetrator known by APS to be receiving case management from HCS/Aging Network, DDA or Department of Children, Youth and Families (DCYF):
- APS will inform the case manager that an investigation is occurring.
- The case manager will continue on-going case management functions while APS conducts the APS investigation.
- APS will maintain contact with the case manager during the investigation to inform the case manager of safety concerns, legal interventions, or progress of the investigation.
  - Consent from the DSHS client is not required for APS and HCS, Aging Network, DDA or DCYF to share confidential information pertinent to the investigation, case planning or services.
  - A case staffing may be requested by case management or APS to facilitate understanding and resolution when there are complex issues, multiple APS reports, or disagreements regarding the investigation findings.
  - APS may review or request all pertinent records, such as the current CARE, service plan, and financial records maintained by the case manager.
- APS and the case manager will coordinate activities as needed (e.g., conduct a joint home visit).
  - APS may communicate with the case manager regarding identified issues and options for the continued protection of the client (e.g., protection order).
  - The APS worker may provide a verbal courtesy notice to the case manager or designated case management contact person that the APS worker is going to forward, for case review, the recommendation for an initial substantiated finding of abandonment, abuse, financial exploitation, or neglect.

Following an investigation:
- APS will provide an outcome report with an initial substantiated finding to an agency or program specified in RCW 74.34.068 providing direct services to the alleged victim receiving case management services.

As a result of the APS investigation findings, HCS, DDA, DCYF or Aging Network may determine the provider is unsuitable and terminate the contract of a provider. APS may be requested to testify at fair hearings regarding how they reached their decision to substantiate the APS findings.

APS has DataMart and PowerBI applications which enables APS to run reports and analyze data regularly. The PowerBI reports show trends and track findings, outcomes, and protective services provided in specific timeframes. In PowerBI, the reports supervisors and program managers have access to are:
- APS Investigations Assigned by month
- APS Investigations 90-day performance measure
- Timely Initial Response based on APS Intake Priority
- APS Case Note timeliness

Investigators have access to the Investigator Data Dashboard which provides information about the investigator's entire caseload including finding summaries and protective services summaries.

APS also conducts Quality Assurance (QA) and Quality Improvement (QI) reviews. For QA, APS looks at 20 questions for investigations and 13 questions for intake. These questions include but aren't limited to:
- Was an initial AV interview conducted per policy
- Were the response priority timeframes met
- Was an AP interview conducted
- Were collateral(s) used to support the investigation
- Were protective services offered
- Were appropriate referrals completed
- Was intake prioritized per requirement
- Was AV's vulnerable adult status documented

Quality Improvement conducted reviews from 2019-2022 looking at 12 questions specific to what is included in a quality

investigation. These questions include but are not limited to:
- Was prep work completed prior to AV interview
- Were allegations addressed comprehensively in the documentation
- Were documentation principles used as required
- Was the finding template completed per policy
- Was all available supporting evidence collected

APS has both self-neglect specialists and financial exploitation specialists statewide that specifically handle the most complex investigations and those that involve individuals with the most reoccurrences to try and reduce occurrences in the future.

APS is actively working with Research and Data Analysis (RDA) to develop data and better identify trends for reoccurrences and mitigating reoccurrences.

APS provides ongoing community education to promote awareness of vulnerable adult mistreatment.

APS Data and Operations unit runs monthly intake reports, monthly region reports, and quarterly performance measure reports. These reports are sent to DSHS RDA and data is included in an annual National Adult Maltreatment Reporting System (NAMRS) report.

APS staff can run Power BI reports which show trends and data at a glance for supervisors and program managers. QA is conducted every quarter in the regions as well as annually by our Quality Assurance Team.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

Aging and Long-Term Support Administration is responsible for detecting the unauthorized use of restraints or seclusion.

Required training for all paid caregivers includes clear instructions that any use of seclusion or restraint is prohibited. Caregivers are among the people that Washington State Law (RCW 74.34) lists as mandatory reporters of suspected abuse. Mandatory training includes detailed information on types of prohibited restraint (physical, chemical, mechanical), risks related to the use of restraints, and alternatives to the use of restraints.

The Aging and Long-Term Support Administration detects use of restraint and seclusion through reports received in the Adult Protective Services system, through the face-to-face CARE assessment process conducted yearly and at significant change, through the grievance process, through quality assurance activities that may include face-to-face observations and interviews of clients that determine compliance with rules and related statutes and regulations, and investigation of complaints.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. 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). State laws, regulations, and policies that are referenced are available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

ALTSA is responsible for detecting the unauthorized use of restrictive interventions.

Required training for all paid caregivers includes clear instructions that any use of restrictive intervention is prohibited. Mandatory training includes detailed information on types of restrictive interventions that are beyond the obvious use of restraint and seclusion. Training also includes multiple alternatives to restrictive intervention and instructs the caregiver to consult with others involved in the person's care such as family and case managers.

The Aging and Long-Term Support Administration detects use of restrictive intervention through reports received in the Adult Protective Services system, through the face-to-face CARE assessment process conducted yearly and at significant change, through the grievance process and through quality assurance activities that may include face-to-face interviews of clients and review of complaints.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

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.

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:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

ALTSA is responsible for detecting the unauthorized use of restrictive interventions.

Required training for all paid caregivers includes clear instructions that any use of restrictive intervention is prohibited. Mandatory training includes detailed information on types of restrictive interventions that are beyond the obvious use of restraint and seclusion. Training also includes multiple alternatives to restrictive intervention and instructs the caregiver to consult with others involved in the person's care such as family and case managers.

The Aging and Long-Term Support Administration detects use of restrictive intervention through reports received in the Adult Protective Services system, through the CARE assessment process conducted yearly and at significant change, through the grievance process and through quality assurance activities that may include face-to-face interviews of clients and review of complaints.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of 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).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

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:

◉ **No. This Appendix is not applicable** *(do not complete the remaining items)*

○ **Yes. This Appendix applies** *(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.

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.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

○ **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)*

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).

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:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

○ **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.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

#3. The number and percent of critical incidents that were properly reported to Adult Protective Services (APS) N = Number of critical incidents that were properly reported to Adult Protective Services (APS) D = Number of records reviewed

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
#1. The number and percent of deaths investigated where appropriate follow-up action was taken when warranted. N = Number of deaths investigated where appropriate follow-up action was taken when warranted D = Number of deaths investigated

Data Source (Select one):
Other
If 'Other' is selected, specify:
APS Fatality Review SharePoint site

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
#2. The number and percent of critical incidents, by type, where follow-up action was taken when warranted. N = Number of critical incidents, by type, where follow-up action was taken when warranted D = Number of critical incidents requiring follow-up action

Data Source (Select one):

Other
If 'Other' is selected, specify:
Administrative data from TIVA

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
#4. The number and percent of participants informed of how to identify and where to report abuse, neglect, and exploitation. N=Number of participants informed of how to identify and where to report abuse, neglect, and exploitation D=Number of records reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
#5. Number and percent of APS investigations completed within mandatory timeframe N = Number of APS investigations completed within mandatory timeframes D = Number of APS investigations

Data Source (Select one):
Other
If 'Other' is selected, specify:
Administrative data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of critical incident trends where systemic interventions were implemented N=Number of critical incident trends where systemic interventions were implemented D=Number of critical incident trends

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participant records with no instances of the use of seclusion or restraints N=Number of participant records with no instances of the use of seclusion or restraints D=Number of records reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of adult day service providers with policies and procedures in place that prohibit the use of restrictive interventions, including restraints and seclusion. N = Number of adult day service providers with policies and procedures in place that prohibit the use of restrictive interventions, including restraints and seclusion D = Number of adult day service providers reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☒ **Other** Specify: AAA	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The number and percent of participants who received information about the importance of receiving the flu vaccine at the time of annual assessment N = Number of participants who received information about the importance of receiving the flu vaccine during their annual assessment D = Number of participants who had an annual assessment reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other**	☒ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The number and percent of waiver participants who received a referral for nursing services when the assessment warrants the need for a referral. N=Number of waiver participants who received a referral for nursing services when the assessment warrants the need for a referral D=Number of participant files reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

ALTSA has strong systems in place to address this assurance and to protect vulnerable adults in home and community settings from critical incidents and other life-endangering situations. The Quality Management Strategy for ensuring compliance with the Health and Welfare Assurance includes prevention training; community education and participation; continuous access to reporting, data collection, analysis, and policy review; monitoring provider actions taken when substantiation of abuse, neglect, abandonment or exploitation are found; monitoring, evaluation and actions taken by ALTSA when required; investigation by law enforcement, adult protective services, residential care services and children's protective services for allegations of abuse, neglect, abandonment or exploitation.

Adult Protective Service (APS) supervisors monitor four randomly selected investigation records per experienced investigator per year and complete one observation of an interview. For new staff, within the first year of hire, supervisors monitor the first five investigations assigned, then five others throughout the year along with two interview observations. Corrections are expected if appropriate and are verified by the supervisor. ALTSA program managers at headquarters annually monitor a statistically valid sample of cases that have been screened out or closed with no APS investigation.

Adult Protective Services reports can be accessed in a variety of ways. Standard reports created by the Forecasting and Data Analysis unit are made available to all of ALTSA. Ad hoc management reports, available from the ALTSA website, can be customized and created upon demand through the APS automated system. These reports are available on a three level hierarchy of access: an individual APS worker may access reports about his/her own cases; APS supervisor/manager access reports about his/her own region, units, and workers; ALTSA headquarters access reports about all individual workers, units, regions, and statewide. These reports are used for on-going evaluation to ensure that appropriate actions are taken in addition to the analysis of abuse, neglect and exploitation trends, and to facilitate day-to-day workload management.

The case manager documents and addresses health/safety interventions for waiver participants such as: evacuation in an emergency, minimum case management contacts, case management, environmental modifications, client training, skin observation protocol, nursing referral indicators from triggered referral screen, assistance obtaining durable medical equipment, cognitive deficits, person(s) responsible for supervising caregivers, screen to document client falls, drug/alcohol assessments, depression screening, caregiver burnout, suicide risk, and other high risk indicators.

Home and Community Services/Area Agencies on Aging (HCS/AAA) nursing services RNs respond to referrals by HCS/AAA case managers based on nursing indicators identified in CARE. Nurses document nursing services activities in CARE and collaborate with case managers on follow up recommendations.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Adult Protective Services (APS) reports are reviewed by individuals at each level (investigator, supervisor/manger, program manager, executive management) who decide on individual and systemic levels what, if any, corrections and improvements are needed. Reports to other licensing/certification agencies are made if needed, in some circumstances citations are written and followed up on by Residential Care Services. Based on data analysis and monitoring, training and/or mentoring is provided by local and regional offices. "Dear Provider" letters are issued by ALTSA policy as guidance to residential providers based on trend areas such as: use of restraints or medication errors, problems with participant's funds, or certain types of abuse, neglect, or exploitation incidents.

Each Home and Community Services/Area Agency on Aging (HCS/AAA) record reviewed during the supervisory and quality assurance review cycle is checked to determine if a mandatory referral to adult protective services should have been made. If appropriate, the HCS/AAA case manager is expected to make necessary corrections. Corrections are verified by either the Quality Assurance (QA) unit or the case management supervisor. Reports and aggregate data are reviewed at all levels by individuals that make decisions on what improvements are needed individually or systemically. HCS regions and AAAs are required to develop proficiency improvement plans to address any area where required proficiency is not met. Draft plans are reviewed by ALTSA prior to approval and implementation. Progress reports are generated and reviewed. Statewide systemic issues are addressed in on-going case management training, policy review/revision/development, and other areas as needed.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

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 Improvement 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.

CMS recognizes that a state's waiver Quality Improvement 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 Improvement 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 Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement 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 Improvement Strategy, including the specific tasks the state plans to undertake during the period 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 Improvement 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/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

This Quality Management Strategy encompasses the following Medicaid programs and waivers: State Plan Medicaid Personal Care, Community First Choice, Roads to Community Living (Money Follows the Person), Community Options Program Entry System waiver (COPES - #0049), Residential Support Waiver (#1086) and New Freedom waiver (#0443).

The design of the New Freedom, COPES, and the Residential Support waiver are all similar in that all three are designed to ensure each waiver encompasses all requirements and assurances required by CMS. This is evidenced by the following components throughout the waiver application appendices:
a. Participant services- all waivers offer similar services to participants to remain in the community with the focus on the provision of personal care and/or provide wrap around services that support the delivery of personal care.
b. Participant Safeguards- All three waivers follow the same participant safeguards outlined throughout this waiver.
c. Quality Management. The information below outlines ALTSA quality management approach which is the same for all waivers.

The quality management approach is the same across waivers:
a. Methodology for discovering information: The state draws a statistically valid sample of waiver participant records across the three waivers, and adds participant records in order to stratify the sample for individual waivers.

b. Manner in which individual issues are remedied: The state continues to remediate all QA issues at an individual level. Remediation actions and timelines are recorded and tracked via the QA monitoring application. For all issues in which the state does not meet the 86% compliance, the state conducts a quality improvement project initiated at ALTSA HQ.

c. Process for identifying and analyzing trends/patterns: The QA monitoring application generates reports that allows patterns/trends to be tracked at both the individual office and statewide level. The state analyzes these trends/patterns annually and publishes a Quality Assurance annual report.

d. Majority of the performance indicators are the same: The majority of performance measures associated with CMS assurances are the same. In addition the state does a focused review on the FMS for the New Freedom waiver only.

The provider network is the same across the waiver programs. All provider types within the three waivers are required to meet the same training and background check requirements and become licensed or certified if required.

Provider oversight is the same across the waivers. The same agencies conduct oversight monitoring on the same time frame and using the same tools.

All waiver services are included in the consolidated reporting.

Ongoing discovery and remediation is facilitated by regular reporting and communications among the ALTSA HCS QA unit, Home and Community Programs, State Unit on Aging, State regional offices, Area Agencies on Aging, and other stakeholders including service providers and agencies. As delegated by the Health Care Authority (the single State Medicaid Agency), ALTSA is the operating entity responsible for conducting quality monitoring reviews, trending, prioritizing and determining system improvements based on the data analysis and remediation information from the ongoing quality improvement strategies. These processes are supported by the integral role of other waiver partners in providing data, which may also include data analysis, trending and the formulation of recommendations for system improvements. These partners include Residential Care Services, Waiver Service Providers, Adult Protective Services, ProviderOne, the Health Care Authority, Behavioral Health Administration, Developmental Disabilities Administration, Department of Health, and participants. Regular reporting and communication among waiver partners facilitate ongoing discovery and remediation.

ALTSA analyzes and trends data received from QA/QI activities and waiver partners. The analysis includes monitoring reviews of all HCS and AAA field offices statewide, and year-to-year comparisons of statewide proficiencies. When data analysis identifies areas needing improvement, ALTSA along with waiver partners,

develops proficiency improvement plans. These plans are prioritized and changes are implemented based on ALTSAs strategic goals, stakeholder input, and available resources.

A Proficiency Improvement Plan (PIP) outlines a plan for addressing items that do not meet proficiency. Both HCS Headquarters (HQ) and the AAAs/Regions are responsible for developing and implementing a PIP. The AAAs/Regions complete a PIP for any QA question where the AAA/Region does not meet expected proficiency. The QA unit reviews each PIP to ensure it is completed. A headquarters PIP is completed for any QA question that does not meet the expected statewide proficiency. The PIP process involves identifying the proficiency history for the QA questions, analyzing possible ways to improve the proficiency, and implementing those methods. System improvements which may be implemented include training, process revision, and policy clarification. The PIP process includes a re-evaluation component to see if improvements have been made after system changes have been implemented. Adjustments to the system are made based on the re-evaluation findings.

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

The annual QA Audit Report and Headquarters proficiency improvement plans developed as a result of this process are reviewed, discussed with, and approved by the State Medicaid Agency through the Medicaid Agency Waiver Oversight Committee. This committee meets and discusses administration and oversight issues. All performance measure activities and findings are discussed and addressed in detail with the oversight committee. The state Medicaid agency provides feedback and recommendations regarding waiver activities. Plans are also shared with stakeholders for review and recommendations.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☒ **Other** Specify: Area Agency on Aging	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The QA monitoring application is an integral part of the discovery process and integrates the CMS quality framework and assurances. Data/reports produced from the QA application and CARE are key components of the overall Quality Management Strategy and are used for quality assurance/quality improvement activities and remediation.

After implementation of system improvements, the QA findings are reviewed to determine statewide trends and the impact of the past system improvements. Where needed, feedback from the AAAs/Regional staff is sought to determine the effectiveness of the system improvements and to identify further modifications which may be required to effectuate a positive change. The roles and responsibilities of the various groups involved in the processes for monitoring and assessing system design changes are described below:

Quality Assurance Unit
The Quality Assurance Unit monitors consumer satisfaction, program eligibility, accuracy and quality of file documents, and adherence to policy, procedures, state and federal statutes including waiver requirements.

The QA unit is responsible for monitoring three state regional areas and 13 Area Agencies on Aging for each review cycle. The QA unit uses a standardized monitoring process which includes:
• Pulling a statistically significant sample from the total population of all 1915(c) waivers (New Freedom WA.0443, COPES WA.0049, and Residential Support Waiver WA.1086) operated by the Aging and Long-Term Support Administration. This is based on a five percent margin of error, a 95% confidence level, and a response distribution of 50%. The state then stratifies the sample for each specific waiver by drawing a minimum number of records for each waiver. The stratification standards the state uses for minimum sampling is 8% margin of error, 95% confidence level (with .7 distribution assumption).
• Completing an initial review statewide.
• Meeting with the local management team, QA Program Manager, AAA lead and AAA liaison, and other members of the HCS Management Team as appropriate to review preliminary reports and discuss the next action steps.
• Verifying that remediation has occurred, and
• Providing final reports for analysis and action.

At the completion of each office's monitoring, data is analyzed and used to develop local proficiency improvement plans, policy/procedural changes and training or guidance at the regional /AAA/case management entity, unit, and/or worker level. Ongoing analysis of data is conducted. If a trend becomes evident after reviewing several offices, action is taken at the headquarters level to increase the statewide proficiency compliance levels.

The QA unit verifies that corrections have been made to all items within 30 days of the area receiving the regional/AAA final report and that health and safety concerns are corrected immediately. The QA unit reviews and approves HCS and AAA local Proficiency Improvement Plans (PIP) to ensure all required issues have been addressed. They also perform other quality improvement activities each review cycle (e.g., focused reviews, consultation and technical assistance, and participant surveys, etc.), in addition to participant record reviews.

Upon completion of the 12 month review cycle, statewide systemic data is analyzed for trends and patterns by managers, the HCS Chronic Care, Well Being and Performance Improvement Unit and executive management staff. The Chronic Care, Well Being and Performance Improvement Unit conducts research into methods of improvement and training which are also incorporated into quality improvement activities.
Decisions for action are made based on analysis of the data and determination of priorities. A Headquarters Proficiency Improvement Plan is developed. The PIP may include statewide training initiatives, policy and/or procedural changes and identification of further quality improvement activities/projects.

State Unit on Aging (SUA)
The SUA is responsible for oversight of Area Agency on Aging operations. The oversight duties include:
• Monitoring implementation and compliance with contract requirements, state and federal laws and regulations, policies and procedures,
• Reviewing and making suggestions to the PIPs submitted by AAAs with the QA unit to improve proficiencies, and
• Reviewing monitoring reports submitted by AAAs for subcontractors to determine compliance with interlocal

agreement and related laws and regulations.

Home and Community Programs (HCP) Unit responsibilities include:
• Developing policy and procedures related to HCS quality assurance/improvement activities,
• Overseeing assessment, service planning and delivery models, and
• Monitoring compliance to Home and Community Programs (HCP), including HCBS.

Chronic Care, Well Being and Performance Improvement Unit measures the effectiveness of assessment, care planning and interventions and recommends performance improvements.

The Residential Care Services Division conducts inspections of adult family homes and assisted living facilities at least every 18 months to ensure that they meet licensing requirements and are in compliance with all state laws and rules. RCS also conducts complaint investigations of adult family homes and assisted living facilities in response to reports of abuse, abandonment, neglect and misappropriation of resident funds. RCS may take enforcement actions based on the findings from licensing inspections and complaint investigations. Enforcement actions range from civil fines to license revocation to referral of criminal allegations to law enforcement.

Adult Protective Services (APS) Unit investigates and makes official findings on any accusations of abuse, neglect or exploitation of a vulnerable adult except those who live in a licensed setting or is served by a certified residential service provider. Local and statewide reports are available and reviewed by APS headquarters managers and field managers.

Area Agency on Aging and Home and Community Services Field Supervisors are responsible for monitoring participant records for each of their staff every year. All supervisory reviews are required to be completed in the QA Monitoring Tool. The QA Unit Manager at HCS Headquarters, as well as the field office management staff and individual workers, can see the results of the supervisory reviews. The monitoring is conducted to ensure the quality of assessments and service plans and that policies and procedures are followed and are timely. Reports and aggregate data generated by the QA application are available on a continuous basis for use by managers, supervisors and the QA Unit. HCS QA policy and procedure mandates that reports be used for discovery, remediation and to identify strengths and areas of improvement, training needs, areas of deficiencies and to identify the need for proficiency improvement plans.

The Residential Care Services Division conducts inspections of adult family homes and assisted living facilities at least every 18 months to ensure that they meet licensing requirements and are in compliance with all state laws and rules. RCS also conducts complaint investigations of adult family homes and assisted living facilities in response to reports of abuse, abandonment, neglect and misappropriation of resident funds. RCS may take enforcement actions based on the findings from licensing inspections and complaint investigations. Enforcement actions range from civil fines to license revocation to referral of criminal allegations to law enforcement.

The Waiver Management Committee ensures regular opportunities for discussion and waiver oversight between the State Medicaid agency and the Operating agency. The committee includes representatives from administrations within the operating agency: the Developmental Disabilities Administration (DDA), Aging and Long-Term Support Administration, and the Behavioral Health Administration. The committee meets at least quarterly to review all functions delegated to the operating agency, current quality assurance activities and performance, pending waiver activity (e.g., amendments, renewals, etc.), potential waiver and rule changes and quality improvement activities.

The State’s targeted standards for systems improvement include reviewing the proficiency of every QA question to ensure that proficiency is obtained Any QA question that has not met proficiency requires a proficiency improvement plan, as described earlier in this document. The entire QA and QI process is reviewed at least annually to ensure quality issues are identified and addressed, and that system improvements are implemented and evaluated.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

The Quality Improvement Strategy is evaluated and adjusted prior to the beginning of each yearly review cycle and at each waiver renewal and when appropriate at waiver amendments. Workgroups consisting of ALTSA HQ program managers, Home and Community Services and Area Agency on Aging Supervisors, Joint Requirement Planners (JRPs), and hearing coordinators evaluate the QA strategy/program.

Modifications/expectations are developed based on changes in federal or state rules and regulations, ALTSA policy and procedures, CMS assurances and sub assurances, input from technical consultants, participants, providers, and data from various reports including recommendations from the previous review cycle. The QI Strategy is reviewed and approved by the ALTSA executive management team and the Medicaid Agency Waiver Management Committee, which is overseen by the Health Care Authority (the single Medicaid State Agency).

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ◉ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

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)Requirements concerning the independent audit of provider agencies:
Home Care Agencies and all waiver service providers are required to have an independent financial audit without findings covering the two year period prior to contracting. The audit must be conducted by a licensed CPA or a recognized financial firm.

The state uses Electronic Visit Verification (EVV) as part of the post-payment review of Personal Care Services for in-home personal care. The EVV data collected is uploaded to Washington's MMIS/ProviderOne for review and monitoring financial integrity and accountability.

Federal rules are followed for agencies that have non-profit status per the Single Audit Act and OMB CIRCULAR A-133. A single or program specific audit is required for the AAA and other subcontractors who expend more than $750,000 in federal assistance in a year.

If the subcontractor is a for-profit organization, it may be a subrecipient, but it will not fall under the OMB CIRCULAR A-133 requirements for a federal single or program-specific audit. In this unique case, the for-profit is monitored annually as follows:
1.By performing a desk review of the vendor's annual audit
2.By on-site monitoring and completion of the monitoring worksheet

Based on the risk assessment, the provider will receive at least one of the following types of monitoring during the year: on-site comprehensive review, focused review, or desk review. A comprehensive review is on-site and triggered when the risk is determined to be high. The following elements are used to determine a provider's risk:

Required elements:
1.Client health and safety: Provider has unsupervised contact with clients or access to their belongings or finances; the nature of the service or vulnerability of the clients subjects the clients to health and safety risks.
2.Contractor expertise: Experience and competency of the provider in providing services for which the contract is written.
3.Key staff turnover: Recent turnover of key staff, new personnel, or abnormal frequency of personnel turnover.
4.Performance history: Compliance issues which include known audit findings, litigation, or corrective actions.
5.Policy changes: Major policy changes regarding program or service.

Additional elements may include:
6.Budget: A large percentage of a provider's funding comes through contracts with the AAA.
7.Reporting, billing, responsiveness: Frequency of reports, response times and accuracy of submitted budgets, reports, billings, and other contract deliverables.
8.Time since last monitoring: No on-site monitoring in the last two years.
9.Length of time providing services under the current contract: Contracted for less than one year.
10.Clinical and/or administrative expertise: Level of clinical and/or administrative expertise required to provide service.
11.Service level fluctuations: Significant expansion or decline in services.
12.Media: High profile entity or negative press in the past two years.
13.Data sharing: Electronic sharing of confidential or protected health information.
14.Subcontracting of services: Key activities are subcontracted and monitored by the provider.

3. Review of subcontractor's relevant cost information when contract is renewed.

The State Auditor's Office conducts the periodic independent audit of the waiver program as required by the single audit act.

(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:

AAAs are responsible for monitoring service contractors with whom they have executed contracts. An evaluation of provider risk is completed annually by the AAA to determine the type and frequency of monitoring that must be conducted. All contracted providers must receive at least one type of monitoring during the year. Review tools and policies are available annually through ALTSA Management Bulletins. The criteria from the provider records that are audited, and the scope of the audit, includes an administrative review, client record review, plan of care review, and fiscal review. The samples from the audit are statistically valid, i.e., 95% confidence level with a +/-5% margin of error.

Audits do not differ by service or provider.

The results of the audit are communicated to providers through a draft written report that give the provider an opportunity to review a draft of the monitoring findings. Then a final written report is provided with the final written results of the monitoring visit. The final written report is due to the provider within 90 days. Corrective action plans are required when warranted. AAAs review each provider's progress toward corrective actions, and in the event the provider does not demonstrate adequate progress, sanctions may be imposed. If sanctions are imposed, the AAA notifies the state of these sanctions. The state reviews monitoring reports during on-site monitoring of AAA contract management or whenever requested.

Inappropriate claims are recouped through an overpayment process. Staff modify the social service authorization, then completes an "Adjustment Request Form", and emails it to program staff. HCA will then adjust the submitted claims in ProviderOne and the claims will be re-adjudicated against what is on the current authorization service line for the affected dates of service.

Fiscal Review: Comparison of a sample of contractor billings/payment system reports to contractor-maintained documentation of work performed. The minimum sample size is 10 files and is at the discretion of the AAA depending on assessment of risk and size of the relevant records. The monitoring activity verifies that work billed for was performed, that the contractor is maintaining documentation of work performed and that employees are paid for work performed.

An abbreviated review consists of a review of complaints and review of any items where compliance was not met during the full review. The abbreviated review must be expanded to a full review when a subcontractor exhibits significant problems that are not corrected as required by corrective action.

Desk monitoring consists of a review of program and financial reports to determine whether providers are fulfilling service-level contract obligations and to detect any issues that may result in unspent funds, underserved clients, or unnecessarily costly services/units throughout the course of the contract.

Home and Community Services (HCS) now have program staff who identify billing and payment errors and process overpayments for any errors.

Adult Day Service providers are reviewed at least annually per WAC 388-71-0724 by AAAs. Review includes administrative procedures, client record review, plan of care review, and a required audited financial statement. Samples from the audit are statistically valid, i.e., 95% confidence level and a +/-5% margin of error. Audits do not differ by service or provider.

An annual risk assessment is completed to determine the type and frequency of monitoring. Full monitoring of other waiver service contractors includes a comparison of contractor billings to contractor-maintained documentation of work performed. Verification that the work was performed should also be obtained from the client if possible. The sample size is at the discretion of the AAA depending on assessment of risk and size of relevant records. Monitoring includes review of individual files where they exist for services such as skilled nursing, client training, adult day care, and home delivered meals.

(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).

ALTSA is responsible for conducting the financial review program of AAAs. AAAs are responsible for conducting financial review activities of subcontracted providers. The State Auditor's Office conducts the periodic independent audit of the waiver program as required by the single audit act.

ALTSA's financial review of AAA's include the criteria from the provider records that are audited include processes and procedures undertaken to ensure that subrecipients, contractors, and vendors are complying with applicable statutes, regulations, or the terms and conditions of contract or grant agreement provisions, and that performance goals are being achieved. As part of ensuring legal requirements are met, it also includes processes and procedures to verify that applicable audit requirements are satisfied, and audit findings are reviewed for timely corrective action.

The samples are statistically valid, i.e., 95% confidence level and a +/-5% margin of error. Audits do not differ by service or provider. The scope of these audits include:
1.Entity's invoices and supporting documentation
2.Entity's program/service and financial reports and records

3.Entity's audit report or financial report and follow up to ensure all appropriate corrective action has been taken
4.Follow-up on identified problems from previous visits, corrective action plans, audit findings, or through any other means ensuring appropriate action has been taken
5.Entity's indirect rate certification, if applicable
6.Entity's compliance with contract terms and conditions
7.Discussions about the entity's problems or challenges
8.Interview of staff to determine whether they are familiar with the program(s)
9.Review of, and compliance with, the entity's policies and procedures governing service delivery and financial processes
10.Review of, and compliance with, the entity's monitoring policies and procedures
11.Review of any independent limited scope program audits
12.Verification of performance from outside sources
13.Review of the entity's self-risk assessment survey
14.Review of internal controls
15.Review of billing and payment practices
16.Review of allocation of costs
17.Review of timesheets or activity reports

Based on the risk assessment, providers will receive at least one type of monitoring during the year: on-site comprehensive review, focused review, desk review, or an agreed-upon procedure engagement for certain aspects of entity activities. A comprehensive review is on-site and is triggered when the risk is determined to be high.

ALTSA must issue a Management Letter, within six months of the finding, and require a Corrective Action Plan for any AAA audit findings related to programs funded by ALTSA.

The AAA will develop a corrective action plan and will take the necessary steps outlined in the plan and work with ALTSA to resolve issues as rapidly as possible. An updated corrective action plan will be submitted to ALTSA monthly until all issues are resolved.

Inappropriate claims are recouped through an overpayment process. Staff modify the social service authorization, then completes an "Adjustment Request Form", and emails it to program staff. HCA will then adjust the submitted claims in ProviderOne and the claims are re-adjudicated against what is on the current authorization service line for the affected dates of service. After staff complete the overpayment process, they are then submitted to Office of Financial Recovery for processing. Office of Accounting services returns the federal share of the overpayment amount via Journal Voucher monthly.

DSHS/ALTSA/HCS has staff who identify billing and payment errors and process overpayments for any errors. Claims are selected for review based on a statistically valid random sample. Each sample is a statistically valid representative sample with a 95% confidence level and +/-5% margin of error. Authorization reviews are completed annually through electronic file and on-site reviews. These reviews do not differ by service types.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver

actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
#4. Number and percent of waiver service claims paid to a qualified provider. N = Number of waiver service claims paid to a qualified provider D = Number of waiver service claims paid that were reviewed

Data Source *(Select one):*
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level with +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
#1. The number and percent of participants who died and whose authorizations were terminated appropriately. N = Number of participants who died and whose authorizations were terminated appropriately D = Number of participants who died

Data Source *(Select one):*
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☒ ***Operating Agency***	☒ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*

☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
#3. Number and percent of claims paid only when a participant is eligible to receive the service. N = Number of claims paid only when a participant is eligible to receive the service D = Number of claims paid that were reviewed

Data Source *(Select one):*
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level with +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other***	☒ ***Annually***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
Specify:	
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
#5. The number and percent of participants with claims coded and paid in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. N = Number of participants with claims coded and paid in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered D = Number of participants reviewed

Data Source *(Select one):*
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level with +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and***	☐ ***Other***

	Ongoing	*Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The number and percent of claims coded and paid using the published rate developed by the approved waiver methodology. N=Number of claims coded and paid using the published rate developed by the approved waiver methodology D=Number of paid claims reviewed

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Administrative data

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level with +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Number and percent of claims paid at the published rate. N=Number of claims paid at the published rate D=Number of records reviewed

Data Source *(Select one):*
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level with +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*

	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

Performance Measure, #2 - The Aging and Long-Term Support Administration review of authorizations against service plans is a proxy for claims review. Payment authorizations are manually generated by the case manager upon completion of the approved service plan, and then entered into the electronic payment system. The payment system generates and mails an authorization notice to the provider which includes the authorization number. The payment system prevents fraudulent claims from being paid through the electronic system's enforcement edits. In order to make a payment claim against an authorization, qualified providers must have an authorization number. In addition to this protection, the payment system prevents payment of claims greater than the payment authorization.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the State's method for addressing individual problems as they are discovered. Include information*

regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Upon completion of each record review, the case manager is expected to make necessary corrections. Corrections are verified by either the ALTSA QA unit or the case management supervisor. Reports and aggregate data are reviewed at all levels by individuals that make decisions on what improvements are needed individually or systemically. Regions and AAAs are required to develop proficiency improvement plans to address any area where required proficiency was not met. Draft plans are reviewed by ALTSA prior to approval and implementation. Progress reports are generated and reviewed. Statewide systemic issues are addressed in on-going case management training, policy review/revision/development, and other areas as needed.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

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).*

Entity responsible for rate determination:

The Department follows the federal guidelines found in 42 U.S.C. § 1396a(a)(30)(A) ("Section 30(A)") when establishing rates. The Office of Rates Management (ORM), within Management Services Division, is the office of DSHS that handles long-term care rates. ORM holds workgroups, conducts stakeholder meetings, involves program managers, and provides this information as well as data to the Legislature as requested. Funding for the rates is authorized by the state legislature.

Rate Methodology:

The rate methodologies for Home and Community Based Services service rates that DSHS/ALTSA pays directly to the provider are updated at least every other year. The models are intended to estimate the relative cost of the associated service and take into account variables such as labor and administrative costs. The models are updated to reflect more recent Bureau of Labor Statistics (BLS) wage data. BLS wage data is used to inform the labor component, and Washington state nursing facility cost report data is used to inform administrative costs, benefits (where applicable), and other overhead.

For most services, the rate models will be updated with the 2023 data in anticipation of the biennial legislative session that dictates appropriation levels and ultimately the rates paid to providers. This process also includes a review of similar services and the prevailing rates of those services in an effort to ensure like-services remain in general alignment. For goods and services, rates are based on the actual cost of the good/service being provided and may vary by geographic location, demand, etc.

Multiple times throughout each year (summer, fall, and winter forecast cycles), caseloads are tracked and discussed by program and fiscal staff to assess if there are any problematic trends associated with Medicaid caseloads that would indicate a lack of providers or adequacy of rates.

Through ALTSA's audits of AAAs, network adequacy is evaluated, as well through monthly meetings between ALTSA and AAA program staff. This ensures there are sufficient providers throughout the state.

Skilled Nursing Rates:
Rates were reviewed and brought into alignment with similar services based on the funds allocated by the Legislature for these services.

Adult Day Services rate methodology:
The rate methodology is a flat fee, per-day-per-client rate for all services rendered based on geographic area. Adult Day Service rate methodology is based on legislative appropriation and determined based on multiple cost centers. For Adult Day Services provided in-person, a higher rate will be paid to compensate for transportation. The rates will be posted here:
https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.dshs.wa.gov%2Fsites%2Fdefault%2Ffiles%2FALTSA%
For Adult Day Services provided in-person, the rate methodology cost centers are direct care, administration and operations, transportation and capital costs; and for Adult Day Services provided through telephonic or other technology media, the rate methodology cost centers are direct care, administration and operations, and capital cost. The rate also incorporates geographic adjustment factors to reflect the differences in the costs of furnishing services in King County (Seattle), Metropolitan Service Areas, and Non-Metropolitan Service Areas. Payment will not exceed the prevailing charges in the locality for comparable services under comparable conditions.

Wellness Education portion of Client Support Training:
The rate methodology used actual costs for:
• IT- matching client specific data to relevant articles for the client's monthly mailing
• Article development-providing some content for monthly articles
• Translation of articles
• Design and Production
• Conduct test runs prior to print production
• Process, printing, and mailing materials

Waiver services other than Adult Day Services:

AAAs negotiate rates within ranges published by ALTSA for each service based on legislative appropriation. Payment cannot exceed 1) the prevailing charges in the locality for comparable services under comparable circumstances, or 2) the rates charged by the AAA for comparable services funded by other sources. The AAA must have written procedures for determining rates that are reasonable and consistent with market rates. Acceptable methods for determining reasonable rates include periodic market surveys, cost analysis and price comparison.

In addition, waiver service definitions and provider qualifications are all standardized. This too helps to ensure that rates are comparable across the state as AAAs are negotiating rates for identical services with providers that meet the same qualifications.

The Administrative Procedure Act, Chapter 34.05 RCW, is followed when soliciting public comments on rate determination methods. Changes to rates that are made by the legislature in the biennial and supplemental budget process are part of public hearings on budget and policy legislation. Rates are posted on public web sites. See Main Section 6-I for the public input process for public comments on rate determination methods. Rates are posted on public web sites.

Changes to rates:

All waiver services: Rate changes (both increases and decreases) to waiver services are determined through legislative action and appropriation. Data and information is provided to the legislature upon request by Management Services Division.

The most recent rebase included in an update to 2021 calendar year Bureau of Labor Statistics wage data and nursing facility cost reports for Washington state. The last rate rebase for ADH was July 2022. The last rate rebase for the other services was July 2023. ADH and ADC rates were last increased 7/1/2022 and reviewed as part of the 2023 Legislative session. Skilled Nursing services rates were last increased 7/1/2023. Community Choice Guiding and Home Delivered Meals services are currently being reviewed using Bureau of Labor Statistics wage data and associated operational cost estimates. All other services last rate change was effective 7/1/2023.

All rate changes will be made consistent with the methodology described in this section and will be reflected in the published fee schedule based upon the state fiscal year July 1 through June 30. The fee schedule is updated at least annually to reflect any rate changes resulting from legislative action or collective bargaining. Some published rates may be exceeded through an exception process. Since the majority of waiver rates are ranges rather than a flat rate, the Estimate of Factor D tables in J-2(d) contains rates that are blended averages.

The provider fee schedule can be found at this link:
https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.dshs.wa.gov%2Fsites%2Fdefault%2Ffiles%2FALTSA%

Participants receive rates from ProviderOne. When an authorization is made to a provider, the participant receives a social service notice showing what service was authorized, the name of the provider, the start and end date of the authorization, the rate per unit, and the total amount of the authorization.

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:*

Washington utilizes ProviderOne, the State's Medicaid Management Information System (MMIS) to process claims pertaining to the services provided to waiver recipients.

ProviderOne maintains data on waiver participants including name, birth date, social security number and case number. The participant data is associated with the provider name, provider payment identification number, waiver service begin and end dates, unit rate, authorized service code, amount paid, date paid, etc.

Aging and Long-Term Support Administration (ALTSA) social service specialists, community nurse consultants and Area Agency on Aging direct service and contracted case managers authorize waiver service payments for applicant/recipients meeting financial and service eligibility factors by completing the authorization electronically through CARE. Information on the electronic authorization is sent to ProviderOne. The service provider receives a notice regarding the payment authorization which includes the authorized dates of service, the type of service and the amount of service.

All service providers claim electronically each service period through ProviderOne for the services/goods they provided. Payments are made directly to the provider and historical records of all payments are maintained for seven years in ProviderOne data warehouse.

Providers may directly bill the state. Payments are made outside of the MMIS system as the need arises using an A-19 Invoice Voucher. These types of payments occur rarely and are event driven. Instructions are provided on an individual basis as the need arises.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- (●) ***No. state or local government agencies do not certify expenditures for waiver services.***
- ( ) ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government 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 Local Government Agencies.***

Specify: (a) the local government 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.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

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) Aging and Long-Term Support Administration social service specialists, community nurse consultants and Area Agency on Aging direct service and contracted case manager will authorize waiver program services (as listed on the individual service plan) effective on the date all the following program factors constituting Medicaid eligibility for waiver services are satisfied:

(1) Categorical relatedness and financial eligibility are approved.
(2) The assessed applicant/recipient is eligible for nursing facility level care and is, or likely to be, institutionalized.
(3) The individual service plan is developed and approved by the Aging and Long-Term Support Administration social worker, community nurse consultant or the Area Agency on Aging direct service or contracted case manager.
(4) The recipient has approved the service plan.
(5) The provider is qualified for payment.
(6) The provider contract procedures are completed.

The MMIS enforces functional and financial eligibility requirements and provider qualifications and contract.

(b) The service was included in the participant's approved service plan: The waiver services in the approved plans are not authorized until steps in the description of the mechanism for assuring payments are made only for eligible service recipients are completed. Claims for payments can be made only after Aging and Long-Term Support Administration staff or Area Agency on Aging direct service or contracted case managers have authorized the payment in the payment systems via CARE. The only services authorized are those services listed in the client's plan of care.

(c) Verification that the services were provided:

1. Verification is obtained during face to face annual and significant change reviews with the recipient/representative.
2. Verification is obtained via quality management record reviews which may include face to face contact.
3. Verification may be obtained through the ALTSA client grievance process - The policy and procedure for this process was updated and disseminated in 2005 (MB H05-018 – Policy/Procedure)
4. ALTSA Medicaid Services Verification survey

If billing problems are identified via the client, the QA process or the grievance process ALTSA corrects the payment and adjusts the claim for FFP accordingly.

EVV is not part of the pre-payment review program for PCS.

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 § 92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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) and 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:

○ ***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:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☒ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***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:

☐ ***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.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. 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.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- (●) ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ( ) ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ( ) ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ( ) ***The amount paid to state or local government 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 state or local government providers differs from the amount paid to private providers of the same service. When a state or local government 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:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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 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.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***

○ ***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.

ii. Organized Health Care Delivery System. *Select one:*

◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***

○ ***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:

iii. Contracts with MCOs, PIHPs or PAHPs.

- (●) ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ( ) ***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 section 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 section 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 section 1915(b)/section 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 section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***This waiver is a part of a concurrent section 1115/section 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 section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver 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 section 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.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

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. Select at least one:*

☒ ***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 state 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 state 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 state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government 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. Select One:*

○ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

◉ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government 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 local government agencies as CPEs, as specified in Item I-2-c:

☒ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government 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 local government agencies as CPEs, as specified in Item I-2-c:

(a) the local entity or entities that have the authority to levy taxes or other revenues: County and Municipal Governments

(b) the source(s) of revenue: County and Municipal general fund

(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: Funds are directly expended as CPEs

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

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: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- (●) ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ( ) ***The following source(s) are used***

Check each that applies:

- [ ] ***Health care-related taxes or fees***
- [ ] ***Provider-related donations***
- [ ] ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

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.***
- ( ) ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

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:*

Do not complete this item.

Appendix I: Financial Accountability

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:*

- (●) ***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.

○ ***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:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. 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.***

○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

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:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. 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; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

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 (Col 7 less Column4)
1	376.39	36515.38	36891.77	36734.51	7106.37	43840.88	6949.11
2	379.61	39071.46	39451.07	38571.23	7461.69	46032.92	6581.85
3	383.12	41806.46	42189.58	40499.79	7834.78	48334.57	6144.99
4	386.79	44732.91	45119.70	42524.78	8226.52	50751.30	5631.60
5	390.73	47864.22	48254.95	44651.02	8637.84	53288.86	5033.91

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

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:
		Nursing Facility
Year 1	56644	56644
Year 2	59476	59476
Year 3	62450	62450
Year 4	65573	65573
Year 5	68851	68851

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

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-a.*

Average length of stay is determined by summing the total enrolled days for participants receiving any waiver service and then dividing by the number of unduplicated participants. 372 Reports were used from WY1 (CY2019), WY2 (CY2020), and WY3 (CY2021) to determine the average length of stay.

Although the state projected an increase in unduplicated participants through the five-year renewal, the ALOS is projected to remain the same base on the data from the 372 Reports, there were minor changes from WY 1/1/2020 – 12/31/2020 and WY 1/1/2021 – 12/31/2021.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

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 and methodology for these estimates is as follows:*

The state estimates the number of users, average units per user, and average cost per unit by individually trending services based on the data from 372 Reports for WY 4/1/2016-3/31/2017 through WY 1/1/2021-12/31/2021.

Based upon the last 5-year waiver period and the data from the 372 Report for 4/1/2016-3/31/2017 through WY 1/1/2021-12/31/2021, the state saw relatively minimal average units per person and cost per unit increases. Because of this, the average units per person and cost per unit remains constant across all five years of the waiver renewal.

WY5 (1/1/2023 – 12/31/2023) unduplicated participant estimate was used for WY1 (1/1/2024 – 12/31/2024), because there cannot be a reduction of participants per the MOE requirements. A 5% growth was applied to the WY1 (1/1/2024 - 12/31/2024) estimate and annually each year after to establish WY2 - WY5 estimates of unduplicated participants.

The state used WY3 372 Report (1/1/2021 - 12/31/2021), which was the most current available data, to develop estimates for the number of users, average units per user, and average cost per unit for each service.

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` is calculated by applying an 7% growth in medical expenses, based on the data from 372 Reports for WY 4/1/2016-3/31/2017 through WY 1/1/2021-12/31/2021. The state applied a 7% growth annually from WY3 of the previous waiver year to the next years to establish WY1 estimates. An 7% growth was applied each year thereafter.

The state used WY3 372 Report (1/1/2021 - 12/31/2021), which was the most current available data, to develop estimates for the number of users, average units per user, and average cost per unit for each service.

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:*

Factor G is calculated by applying a 5% growth in nursing facility services costs. The previous WY5 was determined by taking the average Factor G from the 372 reports for WY 4/1/2016-3/31/2017 through WY 1/1/2021-12/31/2021 and using this number for WY1. A 5% growth was applied each year thereafter.

The state used WY3 372 Report (1/1/2021 - 12/31/2021), which was the most current available data, to develop estimates for the number of users, average units per user, and average cost per unit for each service.

The state's derivations of Factors G and G' are utilizing actual paid claims data.

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` is calculated by applying an 5% average growth in medical expenses, based on the data from 372 Reports for WY 4/1/2016-3/31/2017 through WY 1/1/2021-12/31/2021. The state applied a 5% growth annually from WY3 of the previous waiver year to the next years to establish WY1 estimates. A 5% growth was applied each year thereafter.

The state used WY3 372 Report (1/1/2021 - 12/31/2021), which was the most current available data, to develop estimates for the number of users, average units per user, and average cost per unit for each service.

The state's derivations of Factors G and G' are utilizing actual paid claims data.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed*

separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.

Waiver Services	
Adult Day Health	
Adult Day Care	
Client Support Training & Wellness Education	
Community Choice Guiding	
Community Support: Goods and Services	
Environmental Modifications	
Home Delivered Meals	
Skilled Nursing Services	
Specialized Medical Equipment and Supplies	
Transportation	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**8118000.00**
Adult Day Health	Day	1000	132.00	61.50	**8118000.00**	
Adult Day Care Total:						**137088.00**
Adult Day Care	Day	51	128.00	21.00	**137088.00**	
Client Support Training & Wellness Education Total:						**4178151.60**
Client Support Training & Wellness Education	Each	50755	12.00	6.86	**4178151.60**	
Community Choice Guiding Total:						**3172752.00**
Community Choice Guiding	Hour	2003	99.00	16.00	**3172752.00**	
Community Support: Goods and Services Total:						**29652.00**
Community Support: Goods and Services	Each	21	2.00	706.00	**29652.00**	

GRAND TOTAL:	**21320505.81**
Total Estimated Unduplicated Participants:	**56644**
Factor D (Divide total by number of participants):	**376.39**
Average Length of Stay on the Waiver:	271

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Modifications Total:						**2611074.75**
Environmental Modifications	Each	615	1.00	4245.65	**2611074.75**	
Home Delivered Meals Total:						**1525680.00**
Home Delivered Meals	Meal	1304	150.00	7.80	**1525680.00**	
Skilled Nursing Services Total:						**399996.00**
Skilled Nursing Services	Visit	271	36.00	41.00	**399996.00**	
Specialized Medical Equipment and Supplies Total:						**1141092.00**
Specialized Medical Equipment and Supplies	Each	2186	2.00	261.00	**1141092.00**	
Transportation Total:						**7019.46**
Transportation	Trip	3	21.00	111.42	**7019.46**	

GRAND TOTAL:	**21320505.81**
Total Estimated Unduplicated Participants:	**56644**
Factor D (Divide total by number of participants):	**376.39**
Average Length of Stay on the Waiver:	271

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**8605080.00**
Adult Day Health	Day	1060	132.00	61.50	**8605080.00**	
Adult Day Care Total:						**145152.00**
Adult Day Care	Day	54	128.00	21.00	**145152.00**	
Client Support Training & Wellness Education						**4261706.40**

GRAND TOTAL:	**22577789.83**
Total Estimated Unduplicated Participants:	**59476**
Factor D (Divide total by number of participants):	**379.61**
Average Length of Stay on the Waiver:	271

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:						
Client Support Training & Wellness Education	Each	51770	12.00	6.86	4261706.40	
Community Choice Guiding Total:						3522816.00
Community Choice Guiding	Hour	2224	99.00	16.00	3522816.00	
Community Support: Goods and Services Total:						32476.00
Community Support: Goods and Services	Each	23	2.00	706.00	32476.00	
Environmental Modifications Total:						2763918.15
Environmental Modifications	Each	651	1.00	4245.65	2763918.15	
Home Delivered Meals Total:						1618110.00
Home Delivered Meals	Meal	1383	150.00	7.80	1618110.00	
Skilled Nursing Services Total:						420660.00
Skilled Nursing Services	Visit	285	36.00	41.00	420660.00	
Specialized Medical Equipment and Supplies Total:						1198512.00
Specialized Medical Equipment and Supplies	Each	2296	2.00	261.00	1198512.00	
Transportation Total:						9359.28
Transportation	Trip	4	21.00	111.42	9359.28	

GRAND TOTAL:	22577789.83
Total Estimated Unduplicated Participants:	59476
Factor D (Divide total by number of participants):	379.61
Average Length of Stay on the Waiver:	271

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**9124632.00**
Adult Day Health	Day	1124	132.00	61.50	**9124632.00**	
Adult Day Care Total:						**153216.00**
Adult Day Care	Day	57	128.00	21.00	**153216.00**	
Client Support Training & Wellness Education Total:						**4346907.60**
Client Support Training & Wellness Education	Each	52805	12.00	6.86	**4346907.60**	
Community Choice Guiding Total:						**3909312.00**
Community Choice Guiding	Hour	2468	99.00	16.00	**3909312.00**	
Community Support: Goods and Services Total:						**33888.00**
Community Support: Goods and Services	Each	24	2.00	706.00	**33888.00**	
Environmental Modifications Total:						**2933744.15**
Environmental Modifications	Each	691	1.00	4245.65	**2933744.15**	
Home Delivered Meals Total:						**1715220.00**
Home Delivered Meals	Meal	1466	150.00	7.80	**1715220.00**	
Skilled Nursing Services Total:						**441324.00**
Skilled Nursing Services	Visit	299	36.00	41.00	**441324.00**	
Specialized Medical Equipment and Supplies Total:						**1258020.00**
Specialized Medical Equipment and Supplies	Each	2410	2.00	261.00	**1258020.00**	
Transportation Total:						**9359.28**
Transportation	Trip	4	21.00	111.42	**9359.28**	

GRAND TOTAL:	**23925623.03**
Total Estimated Unduplicated Participants:	**62450**
Factor D (Divide total by number of participants):	**383.12**
Average Length of Stay on the Waiver:	271

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg.*

Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Adult Day Health Total:						***9668538.00***
Adult Day Health	*Day*	*1191*	*132.00*	*61.50*	***9668538.00***	
Adult Day Care Total:						***163968.00***
Adult Day Care	*Day*	*61*	*128.00*	*21.00*	***163968.00***	
Client Support Training & Wellness Education Total:						***4433837.52***
Client Support Training & Wellness Education	*Each*	*53861*	*12.00*	*6.86*	***4433837.52***	
Community Choice Guiding Total:						***4340160.00***
Community Choice Guiding	*Hour*	*2740*	*99.00*	*16.00*	***4340160.00***	
Community Support: Goods and Services Total:						***36712.00***
Community Support: Goods and Services	*Each*	*26*	*2.00*	*706.00*	***36712.00***	
Environmental Modifications Total:						***3107815.80***
Environmental Modifications	*Each*	*732*	*1.00*	*4245.65*	***3107815.80***	
Home Delivered Meals Total:						***1818180.00***
Home Delivered Meals	*Meal*	*1554*	*150.00*	*7.80*	***1818180.00***	
Skilled Nursing Services Total:						***463464.00***
Skilled Nursing Services	*Visit*	*314*	*36.00*	*41.00*	***463464.00***	
Specialized Medical Equipment and Supplies Total:						***1321182.00***
Specialized Medical Equipment and Supplies	*Each*	*2531*	*2.00*	*261.00*	***1321182.00***	
Transportation Total:						***9359.28***
Transportation	*Trip*	*4*	*21.00*	*111.42*	***9359.28***	

GRAND TOTAL:	***25363216.60***
Total Estimated Unduplicated Participants:	***65573***
Factor D (Divide total by number of participants):	***386.79***
Average Length of Stay on the Waiver:	*271*

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**10244916.00**
Adult Day Health	Day	1262	132.00	61.50	**10244916.00**	
Adult Day Care Total:						**172032.00**
Adult Day Care	Day	64	128.00	21.00	**172032.00**	
Client Support Training & Wellness Education Total:						**4522578.48**
Client Support Training & Wellness Education	Each	54939	12.00	6.86	**4522578.48**	
Community Choice Guiding Total:						**4816944.00**
Community Choice Guiding	Hour	3041	99.00	16.00	**4816944.00**	
Community Support: Goods and Services Total:						**38124.00**
Community Support: Goods and Services	Each	27	2.00	706.00	**38124.00**	
Environmental Modifications Total:						**3294624.40**
Environmental Modifications	Each	776	1.00	4245.65	**3294624.40**	
Home Delivered Meals Total:						**1926990.00**
Home Delivered Meals	Meal	1647	150.00	7.80	**1926990.00**	
Skilled Nursing Services Total:						**487080.00**
Skilled Nursing Services	Visit	330	36.00	41.00	**487080.00**	
Specialized Medical Equipment and Supplies Total:						**1386954.00**
Specialized					**1386954.00**	

GRAND TOTAL:	**26901941.98**
Total Estimated Unduplicated Participants:	**68851**
Factor D (Divide total by number of participants):	**390.73**
Average Length of Stay on the Waiver:	271

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medical Equipment and Supplies	Each	2657	2.00	261.00		
Transportation Total:						**11699.10**
Transportation	Trip	5	21.00	111.42	**11699.10**	

GRAND TOTAL:	**26901941.98**
Total Estimated Unduplicated Participants:	**68851**
Factor D (Divide total by number of participants):	**390.73**
Average Length of Stay on the Waiver:	271