# 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:**
**New Freedom**

**C. Waiver Number:WA.0443**
**Original Base Waiver Number: WA.0443.**

**D. Amendment Number:WA.0443.R04.01**

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

01/01/25

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

## 2. Purpose(s) of Amendment

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

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 ? Waiver Administration | |

| Component of the Approved Waiver and Operation | Subsection(s) |
|---|---|
| ☒ Appendix B ? Participant Access and Eligibility | B-6-c |
| ☐ Appendix C ? Participant Services | |
| ☒ 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*):

New Freedom

**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.0443**
**Waiver Number:WA.0443.R04.01**
**Draft ID: WA.015.04.01**

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

Regular Waiver

**E. Proposed Effective Date of Waiver being Amended: 01/01/25**
**Approved Effective Date of Waiver being Amended: 01/01/25**

**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:

○ **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:

A 1915(b)(4) waiver application has been submitted concurrently with this waiver amendment.

**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.

As an important element of the State's commitment to provide community alternatives to institutional care, New Freedom provides participant directed services to adults who are eligible for nursing facility level of care. The New Freedom waiver offers participants the opportunity for full participant direction. Participants select the services they need, when those services are provided, who will provide the services, and how they will be delivered. Participants have flexibility to plan and purchase goods and services specific to their unique needs and preferences within the participant's budget and waiver rules.

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 at local Home and Community Services (HCS) offices. Ongoing case management is provided by local Area Agencies on Aging (AAA).

The state uses the automated comprehensive assessment tool, CARE, to gather information about the participant's strengths, functional abilities, preferences, and limitations. When the person-centered assessment has been completed, this information is used to compute an individualized monthly budget based on the assessed needs of the waiver participant and valued at the hourly rate for in-home personal care.

New Freedom participants receive assistance from AAA case managers, also known as a Care Consultant for the New Freedom program, to prepare a Participant Centered Spending Plan (PCSP) for the budget allowance which can include a range of choices beyond one-on-one personal care. Care Consultants facilitate planning at the direction of the participant and/or the participant's representative.

Financial Management Services (FMS) are provided to manage the budget allowance and associated responsibilities such as payroll and withholding. FMS contracts with qualified providers to deliver the services identified in the PCSP. The FMS also ensures that expenditures are keeping within the participant's service plan. Financial Management Services are provided through a contract between the FMS entity and ALTSA.

The New Freedom waiver is currently available to individuals residing in King, Pierce, Spokane, Whitman, Stevens, Ferry, and Pend Oreille Counties.

## 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)*:

- [x] **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:*

  Available only in King, Pierce, Spokane, Whitman, Stevens, Ferry, and Pend Oreille Counties

- [ ] **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:

Tribal notice regarding the amendment was published on 7/25/2024.

Public notice of the waiver amendment was filed in the State Register on 8/19/2024.

Individuals were able to submit comments by email, mail, or telephone. 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 (W4A)
- Indian Policy Advisory Committee (IPAC)
- The Service Experience Team (SET)
- State Council on Aging
- HCS Regional Administrators, Deputy Regional Administrators, and Field Services Administration
- Home Care Agencies
- LeadingAge

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:** HCBS Waiver Program Manager

**Agency:** Aging and Long-Term Support Administration

**Address:** PO 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:** Oct 4, 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 B: Evaluation/Reevaluation of Level of Care Quality Improvement: Level of Care - Sub-assurance c:
Number and percent of participants whose eligibility was determined using the appropriate processes and instruments according to the approved description to determine participant level of care.
N = Number of participants whose eligibility was determined using the appropriate processes and instruments according to the approved description to determine participant level of care
D = Total number of participants who had an eligibility determination reviewed

Appendix C: Participant Services Quality Improvement: Qualified Providers - Sub-assurance a:
PM#1
N = Number of waiver service providers with initial contracts meeting licensure &/or certification standards & adhere to other standards prior to furnishing waiver services
D = Waiver service providers with initial contract that require licensure &/or certification
PM#2
N = Number of waiver service providers who continue to meet licensure &/or standards at contract renewal delegated by the State Medicaid Agency & adhere to other standards prior to their furnishing waiver services
D = All waiver service providers that require licensure &/or certification who were required to have contract renewals

## 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:

Aging and Long-Term Support Administration

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:

The State's Medicaid agency, the Health Care Authority, employs oversight methods that cover the full range of responsibilities specified in item A-7, including participant waiver enrollment, waiver enrollment managed against approved limits, waiver expenditures managed against approved levels, level of care 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 and quality assurance and quality improvement activities. The oversight methods include: a Cooperative Agreement between the Medicaid agency, the Health Care Authority (HCA), and the operating agency, the Department of Social and Health Services (DSHS), that expressly details the delegated functions performed by the operating agency; the Medicaid Agency Waiver Management Committee that reviews all functions delegated to the operating agency and includes representatives from within administrations of the operating agency, including Aging and Long Term Supports Administration's (ALTSA) Home and Community Services (HCS), Residential Care Services (RCS), and Adult Protective Services (APS), as well as Developmental Disabilities Administration (DDA) and HCA. The committee meets quarterly 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.

The Medicaid agency assesses the operating agency's performance annually and updates are also provided by the operating agency to the Medicaid agency quarterly.

Oversight methods also include the State Auditor which performs audits of all activities of the operating agency; the operating agency's Quality Assurance programs which systematically oversee all quality control systems, measures and processes; cost report auditing by the Management Services Division (MSD) of ALTSA for residential provider expenditures; rates development, management and oversight for contracted providers by the DDA Rates Unit of MSD; and legislative oversight of all aspects of waiver programs by the Joint Legislative Audit & Review Committee (JLARC).

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.

## 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.:*

Financial Management Services (FMS):
FMS responsibilities include: accessing the monthly benefit from the Department on behalf of the participant; setting up and managing the participant individual accounts; setting up procedures for verifying qualifications and credentials of providers/service vendors (with the exception of personal care individual providers); implementing efficient and timely consumer directed payment systems; facilitating payment for labor, services and other items needed by participants as identified in the PCSP excluding personal care services, processing criminal background checks, verifying completion of required training, developing contracts with vendors, and coordinating with the participant's Care Consultant.

○ **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 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.

☐ **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:

Department of Social and Health Services, Aging and Long-Term Support Administration

## 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 complete on-site 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 on a defined schedule. Monitoring includes provider qualifications, correct execution of waiver contracts and payment accuracy.

FMS agency billings regarding utilization management are reviewed by ALTSA monthly. Contracts and billings are reviewed by ALTSA program management staff annually. Monthly reviews include utilization management, however annual reviews of this includes ensuring that billed services are in accordance with the negotiated contracts. Contracts are reviewed to ensure that services outlined in the contract are delivered by qualified providers to recipients as outlined in their plan of care. The assigned operational and administrative functions are monitored as part of ALTSA's annual QA Monitoring Cycle, which also includes waiver contracts managed by the AAA. This review includes an assessment of performance related to review of participant service plans, utilization management, execution of Medicaid provider agreements, and quality assurance/improvement activities. ALTSA presents the contract monitoring reports to the Medicaid agency at the quarterly waiver management meetings. These reports provide a summary of the AAA on-site contract and fiscal monitoring, including identified trends.

ALTSA presents the contract monitoring reports to the Medicaid agency at the quarterly waiver management meetings. These reports provide a summary of the AAA on-site contract and fiscal monitoring, including identified trends.

## 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 | Contracted Entity | 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:**
**Number and 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):
**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**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and 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):
**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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>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**<br>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 and fiscal proficiency improvement plans (PIPs) are required for areas where required proficiency levels are not achieved or if improvement is not evident based upon previous PIPs. PIPs are evaluated and individualized prior to approval to ensure that the plan will effectively address areas of needed improvement. The FMS and case management entities are required to perform discovery and remediation activities. Training elements of PIPs are coordinated through ALTSA and ALTSA staff are made available to provide training and technical support to FMS and AAA 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 performance plans (PIPs) are required for areas where required proficiency levels are not achieved or if improvement is not evident based upon previous PIPs. PIPs include how individual problems are corrected as they are discovered. Some issues, such as health and safety, require immediate action. Proficiency Improvement Plans are evaluated and individualized prior to approval to ensure that the plan will effectively address areas of needed improvement.

Training elements of PIPs are coordinated through ALTSA and ALTSA staff are made available to provide training and technical support to FMS and AAA staff. Field offices including FMS and AAA staff are required to provide QA with an update within 30 days to report on their progress toward implementing PIPs.

**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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

**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** | | | | | |
| | ☒ | **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 age 64 as specified in the chart. The waiver is available only to persons who wish to direct their services.

**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** | 675 |
| **Year 2** | 675 |
| **Year 3** | 675 |
| **Year 4** | 675 |
| **Year 5** | 675 |

**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 sync 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 in a state-contracted residential facility (e.g., adult family home, assisted living facility), the 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 (FBR)).

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 who is under contract with the operating agency performs an assessment of need. Re-evaluations are performed by the two Area Agencies on Aging or a Federally Recognized Tribe who is 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 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 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.

Training:

HCS and AAAs are required to develop and document a training plan for all new employees, which initially includes training on completing CARE assessment and application. At a minimum, the first five CARE assessments must be reviewed. After this, review of 50% of assessments for the next three months. After 3 months, additional reviews are completed at the supervisor’s discretion based on the worker’s performance. Ongoing, Supervisors are required to identify individual training needs for staff and arrange for the provision of that training.

**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; or
-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; or
-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.

**** The CARE tool is comprised of a built-in algorithm (scoring system) of criteria that automatically places the participant in the one of seventeen classification groups based on the following four characteristics:

(1) Cognitive performance.
(2) Clinical complexity.
(3) Mood/behaviors symptoms.
(4) Activities of daily living (ADLs).

(1) When assessing for cognitive performance, the cognitive performance scale is utilized based on the following criteria:

- Whether a participant is comatose
- The ability of a participant to be understood
- Short-term memory problem
- Total dependence in self-performance of eating.

The selection of this criteria will then determine a scoring of 1 through 6 on the cognitive performance scale. WAC 388-106-0095

(2) When assessing for clinical complexity criteria the algorithm will look for a combination of specific diagnoses or treatments paired with a specific number of points for ADLs that together will place the participant in this category. WAC 388-106-0095

(3) When assessing for mood and behaviors, the algorithm has specific behaviors that are used as criteria, and this also includes the status of that behavior (current, past), frequency, and alterability. If a participant has one or more of these behaviors listed in the assessment and the participant does not qualify for a higher group (clinical complexity, cognitive performance, exceptional criteria), the participant will be placed in this category.
WAC 388-106-0100

(4) When assessing for activities of daily living, the algorithm applies a point value to each self-performance score per activity of daily living in CARE. WAC 388-106-0105
The ADLs assessed include:
- Personal hygiene
- Bed mobility
- Transfers
- Eating
- Toilet Use
- Dressing
- Locomotion in room,
- Locomotion outside of room, and
- Walk in room

(5) Based on these four clinic characteristics, the assessment tool also assesses exceptional care needs of individuals. The CARE tool algorithm has specific criteria, which when selected in combination, will place an individual in an exceptional care classification. This classification is generated by a combination of specific treatment needs in addition to an ADL score that is 22 or greater. WAC 388-106-0110

**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) and obtaining information from the client during the interview, collateral contacts, and medical records (as needed). CARE is used for both initial evaluations and re-evaluations. The re-evaluation process does not differ from the initial evaluation process. Evaluations are completed initially, at annual review, and when a significant change is determined by a report that there has been a change in the client's cognition, ADLs, mood and behaviors, or medical condition that will affect the client's benefit classification. Initial level of care evaluations are completed by HCS case managers. Care Consultants complete annual and significant change reviews. The participant's assigned Care Consultant is responsible for completing re-evaluations. All initial, annual, and significant change evaluations/re-evaluations are conducted by case managers/Care Consultants through a face-to-face, telephonic, or other technology media client interview, for any client. When completing evaluations and re-evaluations, 42 CFR 441.535 will be followed. Telephonic or assessments 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. 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. A home visit would be required if the results appear to be affected based on the use of telephonic or other technology media.

The state will utilize HIPPA-compliant technology platforms and case managers/Care Consultants will conduct assessments in private settings, maintain the participant's privacy at all times, and verify the participant's identify 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 client'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):*

CARE generates an assessment timeliness report that Care Consultants use to identify the need to conduct reevaluations. Care Consultants use these reports to assure the timeliness of annual reviews. In addition to timeliness reports, an automated "tickler" notifies the Care Consultant 40 days in advance of the upcoming reassessment date.

Case management supervisors have a required schedule of record reviews for individual Care Consultants and are responsible for evaluating staff on assessment timeliness. In addition, supervisors use reports produced by CARE to track timeliness of assessments.

Quality 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 at the state level. Written documentation of all evaluation and reevaluations are maintained for a minimum of three years at the local office.

## 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 assessment D = Number of applications received**

**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** |

| **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**<br>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:**
**See Main Optional section**

**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**<br>Confidence Interval =<br>95% Confidence Level<br>Margin of error = +/-5% |
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>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**<br>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 and Care Consultants 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).

Supervisors/managers annually monitor worker records to ensure LOC accuracy and that a LOC is determined annually or at significant change. For new staff, supervisors review the first five 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 staff monitor 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 gathered from the client/representative and entered into the assessment by the case manager or Care Consultant. 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 New Freedom eligible, the option is not available for the participant/case manager to select/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 service specialist (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 initial assessment must be completed and services authorized (if eligible) within 45 days of the intake date. Annual and significant change assessments must be completed 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. Care Consultants are required to take action within 30 days to address all inappropriate LOC determinations identified during the supervisory and QA monitoring, by completing a CARE assessment. The supervisor or QA staff verify that all corrections are made. 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 corrective action. QA roll up reports are reviewed at all levels of the system: case managers and Care Consultants- individual proficiency reports; supervisors - unit reports; HCS Regional Administrators and AAA Directors - regional reports; and ALTSA HQ - 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 ALTSA 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**<br>Specify:<br>Area Agency on Aging | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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/participant's freedom to choose between institutional and home and community-based services. The DSHS 14-225 is explained to the individual by the Care Consultant or social service specialist/case manager and a signature is obtained stating that the individual understands they have a choice in the type of services received and 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/administrative 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 participant receives a signed copy of the DSHS 14-225, and a copy of the form is maintained in the applicant/participant'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 for a minimum of three years in the client record at the state level.

## 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):

The following references govern access to services for participants with Limited English Proficiency (LEP):

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 participants with LEP:

-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 and translators.

-WAC 388-271 Limited English proficient services.

-DSHS Administrative Policies
6.12 Adjustment of Workload for Staff who Provide Translation and Interpretation Services Outside of their Workload
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)

DSHS 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 aide 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 and Interpreter Brokerage contract for Spoken Languages.
4. If the listed contractors cannot meet the need, or there is an emergency, which requires the immediate attention, staff can access the Language Line.
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** | **Personal Assistance Services (PAS)** | | |
| **Other Service** | **Environmental and Vehicle Modifications** | | |
| **Other Service** | **Individual Directed Goods, Services and Supports** | | |
| **Other Service** | **Training and Educational Supports** | | |
| **Other Service** | **Treatment and Health Maintenance** | | |

## 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:**

Personal Care

**Alternate Service Title (if any):**

Personal Assistance Services (PAS)

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 08 Home-Based Services | 08030 personal care |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

Supports involving the labor of another person to help waiver participants carry out everyday activities they are unable to perform independently. The participant has the authority to direct the delivery of personal care. Responsibilities include hiring, terminating, and developing the schedule for the provider.
Services may be provided in the person's home or to access community resources. The scope of Personal Care Assistance Services (PAS) is broader than personal care services provided through the State plan and provides participants with an increased choice of types of qualified providers. PAS includes all of the following elements:
-Direct personal care services which is defined as assistance with activities of daily living, including mobility, bathing, body care, dressing, eating, personal hygiene, medication management, toilet use, and transfer. Assistance with instrumental activities of daily living (i.e. essential shopping, housework, meal preparation and transportation for essential shopping).

-Delegated health related tasks as defined in Washington State Nurse Delegation rule. Providers of direct personal care services may be asked to perform certain delegated tasks. These services differ from Treatment and Health Maintenance services in that they are provided to a participant by an individual or agency caregiver who has been trained by a nurse to provide what would otherwise be a skilled task. Treatment and Health maintenance services are provided by a licensed, skilled professional. Rules regarding Nurse Delegation are listed in WAC 246-840-910 through WAC 246-840-990.

Assistance with other tasks or activities that support independent living and is necessary due to the functional disability, such as homemaking and chore services, that is not available under state plan personal care.

Personal assistance with transportation to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the PCSP. 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 PCSP.

Providers are required to meet training requirements as defined in 388-71-0836 through WAC 388-71-1006. Consumers and their family can access a pool of qualified providers through the Carina Care System (https://www.carinacare.com/) at the implementation of the CDE. Once the implementation of the CDE is complete, the provider type of Individual Provider will be phased out.

Participants have both budget and employment authority. Participants use their budget to purchase services, supports, and items that meet the New Freedom service definitions and have the authority to fully direct all waiver services.

The services under the New Freedom 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 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 | Home Care Agency/ Home Health Agency |
| Individual | Individual Entrepreneurs |
| Agency | Consumer Directed Employer of personal care providers |
| Individual | Individual Provider |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Personal Assistance Services (PAS)**

**Provider Category:**

Agency

**Provider Type:**

Home Care Agency/ Home Health Agency

**Provider Qualifications**

**License** *(specify):*

Home care agency license under chapter 70.127 RCW and WAC 246-335 or Home Health Agency License under Chapter 70.127 RCW

**Certificate** *(specify):*

**Other Standard** *(specify):*

Employees must complete the DSHS background check requirements outlined in WAC 388-71-0510 and the training/certification requirements described in WAC 388-71-0520 and 0523.

All professional staff must have appropriate licensure and certification as outlined in state statute.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Area Agency on Aging

**Frequency of Verification:**

Upon executing/renewing contract
License renewal every two years
Contract compliance monitoring every two years
An initial background check is completed. If there is reasonable cause to suspect that the provider has been arrested or

convicted of a disqualifying crime, a new background check must be completed.

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Personal Assistance Services (PAS)**

**Provider Category:**

Individual

**Provider Type:**

Individual Entrepreneurs

**Provider Qualifications**

**License** *(specify):*

Providers must meet all statutory professional standards and licensing requirements and have a current license to practice in the state.
RN or LPN license under Chapter 18.79 RCW and Chapter 246-840 WAC

**Certificate** *(specify):*

Nursing Assistants Certificate under Chapter 246-841 WAC

**Other Standard** *(specify):*

Individual entrepreneurs are subject to any licensing or local codes relevant to the task they are going to perform. They must also complete the DSHS background check requirements outlined in WAC 388-71-0510 and the pertinent training/certification requirements described in WAC 388-71-0520 and 0523.

All professional staff must have appropriate licensure and certification as outlined in state statute.

Additional requirements, specific to the service provided, are clearly defined in the Participant Spending Plan. For example, the knowledge of sign language or the completion of training specific to the participant may be required.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Area Agency on Aging

**Frequency of Verification:**

An initial background check is completed. If there is reasonable cause to suspect that the provider has been arrested or convicted of a disqualifying crime, the AAA must have the provider complete a new background check.

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Personal Assistance Services (PAS)**

**Provider Category:**

Agency

**Provider Type:**

Consumer Directed Employer of personal care providers

**Provider Qualifications**

**License** *(specify):*

Current Washington state business license and meet qualifications outlined in RCW 74.39A.500

**Certificate** *(specify):*

**Other Standard** *(specify):*

Personal Care Providers of the CDE: must complete the DSHS background check requirements outlined in WAC 388-71-0510 and the training/certification requirements described in WAC 388-71-0520 and 0523.

Personal Care Providers will have the skills and characteristics the participant(as the co-employer)has deemed important to meet their care plan needs.

Individuals who provide transportation must have a valid driver license and meet state requirements for insurance coverage listed in RCW 46.30.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Aging and Long-Term Support Administration, as the operating agency of the Medicaid agency, will complete monitoring of the Consumer Directed Employer.

**Frequency of Verification:**

Annually the Consumer Directed Employer will be monitored by the Aging and Long-Term Support Administration to verify compliance standards.

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Personal Assistance Services (PAS)**

**Provider Category:**

Individual

**Provider Type:**

Individual Provider

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

IPs must complete the DSHS background check requirements outlined in WAC 388-71-0510 and the training/certification requirements described in WAC 388-71-0520 and 0523.

Individuals who provide transportation must have a valid drivers license and meet state requirements for insurance coverage.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Area Agency on Aging

**Frequency of Verification:**

Initially and every two years for background checks. If there is reasonable cause to believe that the provider has been arrested or convicted of a disqualifying crime within the two year cycle, the AAA must have the provider complete a new background check.

## 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 and Vehicle 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):*

These modifications and supports are comprised of environmental or vehicle modifications to a participant's residence or participant-owned vehicle necessary to accommodate the participant's disability and promote functional independence, health, safety and welfare. Environmental modifications may be make to the participant's residence whether it is owned, rented or leased. In the case where the residence is not owned by the participant, the landlord must sign an agreement to allow the modification to be completed by the State's contractor.
Some examples of services are the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, specialized equipment, installation of specialized electric and plumbing systems which are necessary to accommodate needed medical equipment and specialized accessibility and fire safety adaptations.

Examples of vehicle modifications include adaptive vehicle controls related to steering, braking, shifting, signaling and acceleration, lift devices, seat adaptations, hand rails, and door widening.

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.

The services under the New Freedom 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:**

Alterations to the home which are of general utility and not of direct medical or remedial benefit to the waiver participant are excluded. Alterations that add to the total square footage of the home are excluded. Services in this waiver will not duplicate or replace other state plan services. Vehicle modifications are limited to vehicles owned by the participant or the participant's family, when residing with the participant, and demonstrate cost effectiveness when compared to available alternative transportation. Regularly scheduled upkeep and maintenance of a vehicle are excluded with the exception of upkeep/maintentance to the specific vehicle modification.

**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 Entrepreneurs and Businesses |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Environmental and Vehicle Modifications**

**Provider Category:**

Individual

**Provider Type:**

Individual Entrepreneurs and Businesses

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

All providers must possess any valid license or certification or registration required by State or local law. All services shall be provided in accordance with applicable State or local building codes and meet specifications, if applicable, for modification as set by the American National Standards Institute (ANSI). Providers shall possess a current license to do business issued in accordance with the laws of the local jurisdiction and shall demonstrate knowledge in meeting applicable standards of installation, repair and maintenance and where applicable shall also be authorized by the manufacturer to install, repair and maintain such modifications/adaptations. Home modifications must meet life/safety and building codes and be inspected by the appropriate authority when required.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

FMS

**Frequency of Verification:**

Initially upon contracting then every two years for verification of credentials and background checks; monthly checks for Medicaid Exclusion lists, and Social Security Death Master List.

## 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:**

Individual Directed Goods, Services and Supports

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 17 Other Services | 17010 goods and services |
| **Category 2:** | **Sub-Category 2:** |
| 14 Equipment, Technology, and Modifications | 14010 personal emergency response system (PERS) |
| **Category 3:** | **Sub-Category 3:** |
| 06 Home Delivered Meals | 06010 home delivered meals |
| **Category 4:** | **Sub-Category 4:** |
| 08 Home-Based Services | 08060 chore |

**Service Definition** *(Scope):*

Goods, services, and supports are services, equipment or supplies which:
-are not otherwise provided through this waiver or through the Medicaid State Plan;
-will reduce the need for Medicaid services and/or:
-promote inclusion in the community.
These services must address an identified need in the comprehensive assessment and Person Centered Spending Plan (PCSP). Goods, services, equipment, and other supports should allow the waiver participant to function more independently, or increase safety and welfare, or allow the person to perceive, control or communicate with their environment and assist the participant transition into the community from an institutional setting. Some examples of services are environmental supports (e.g., snow removal, heavy cleaning); assistive technology; supplies and equipment; adaptive clothing; special diets; home delivered meals; trained service animals (including purchase, upkeep and general veterinarian services); repairs and maintenance of equipment; equipment and services that reduce the need for on-site supervision in an emergency such as a personal emergency response system; and transportation not provided by personal assistant.

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. This service may only be provided if the participant does not have the funds to purchase the item or service or the item or service is not available through another source.

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

Services in this waiver category will not duplicate or replace other state plan services.
Veterinary care is available only to service animals.
A service animal is defined by the American with Disabilities Act (https://www.ada.gov/topics/service-animals/) as a dog or miniature horse trained to perform a task directly related to a person's disability.
Meals provided as part of these services shall not constitute a full nutritional regimen (3 meals per day).
As a Medicaid funded service, this definition will not cover experimental goods and services.

**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 | Food Service Vendor |
| Individual | Community Vendor |
| Individual | Transportation |
| Individual | Veterinarians |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Individual Directed Goods, Services and Supports**

**Provider Category:**

Individual

**Provider Type:**

Food Service Vendor

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

Meet all state board of health standards for food service under RCW 43.20.050 to promote and protect the health, safety, and well-being of the public and prevent the spread of disease through food. Meals 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 Provider Qualifications**

**Entity Responsible for Verification:**

FMS

**Frequency of Verification:**

Initially upon contracting and then every two years for verification of credentials and background checks; monthly checks of Federal exclusion lists and Social Security Death Master List.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Individual Directed Goods, Services and Supports**

**Provider Category:**

Individual

**Provider Type:**

Community Vendor

**Provider Qualifications**

**License** *(specify):*

Business licensing requirements per Title 308 WAC.

**Certificate** *(specify):*

**Other Standard** *(specify):*

All community vendors are subject to any licensing,(e.g., approved contractor trade license, teaching certificate) or local codes relevant to task they are going to perform and additional requirements clearly defined in the individualized person centered spending plan(e.g. Peer Support for addressing disability related issues, person centered planning, individual budgeting, employing IPs)

Providers must have a current license or certificate if required by state law per RCW 18. A provider must meet all professional standards and/or training requirements per state statutes.

For providers that do not require professional licensing the participant will define qualifications in the spending plan. The PCSP may identify additional qualifications that the person must meet to provide the service.

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

PERS vendor: All PERS equipment vendors must provide equipment approved by the Federal Communications Commission (FCC). The equipment must also meet the Underwriters Laboratories, Incl. (UL) standard, or ETL listed mark on the equipment will be accepted as evidence of the equipment's compliance with such standard.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

FMS

**Frequency of Verification:**

Initially upon contracting then every two years for verification of credentials and background checks; monthly checks for Federal exclusion lists and Social Security Death Master List.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Individual Directed Goods, Services and Supports**

**Provider Category:**

Individual

**Provider Type:**

Transportation

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

For transportation, standards are the same for common carrier transportation of taxi cab, bus, other commercial carrier, or private automobile. Individuals who provide transportation must have a valid driver license and meet state requirements for insurance coverage.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

FMS

**Frequency of Verification:**

Initially upon contracting and then every two years for verification of credentials and background checks; monthly checks for Federal exclusion lists and Social Security Death Master List.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Individual Directed Goods, Services and Supports**

**Provider Category:**

Individual

**Provider Type:**

Veterinarians

**Provider Qualifications**

**License** *(specify):*

Licensed under State Statute Chapter 18.92 RCW, Chap 246.933 WAC

**Certificate** *(specify):*

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

FMS

**Frequency of Verification:**

Initially upon contracting and then every two years for verification of credentials and background checks; monthly checks for Federal exclusion lists and Social Security Death Master List.

## 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:**

Training and Educational Supports

**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):*

Training and educational supports are for the sole benefit of the participant and are provided directly to the participant. Formal and informal care providers may participate in the training with the participant in order to continue to support the participant's goal outside the training environment. This services is beyond the scope of state plan services that are necessary to promote the participant's health and ability to live and participate in the community. This service category includes training or education on participant health issues or personal skill development that improves the participant's own ability to accomplish everyday activities and maintain, slows decline, or improves functioning and adaptive skills. Training and Educational supports will address an identified need in the Participant Centered Spending Plan.

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

The state plan CFC skills acquisition training is specifically for acquiring, maintaining, or enhancing skills specific to ADLs, IADLs, and health related tasks. Under the New Freedom waiver, training and educational supports includes supports that are necessary to promote health and the ability to live and participate in the community, or to maintain or slow the decline of functioning or improve adaptive skills.

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

Waiver services in this category are not within the scope of or applicable to the Individuals with Disabilities Education Act (IDEA).

**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 | Health Care Providers |
| Individual | Community Vendor |
| Agency | Community Colleges |
| Agency | Assistive Technology Professional |

| Provider Category | Provider Type Title |
|---|---|
| Individual | Assistive Technology Professional |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Training and Educational Supports**

**Provider Category:**

Individual

**Provider Type:**

Health Care Providers

**Provider Qualifications**

**License** *(specify):*

Providers must meet all statutory professional standards and licensing requirements and have a current license to practice in the state.
RN or LPN license under Chapter 18.79 RCW and Chapter 246-840 WAC

**Certificate** *(specify):*

Dietician and Nutritionist certificate under Chapter 18.138 RCW

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

FMS

**Frequency of Verification:**

Initially upon contracting and then every two years for verification of credentials and background checks; monthly checks for Federal exclusion lists and Social Security Death Master List.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Training and Educational Supports**

**Provider Category:**

Individual

**Provider Type:**

Community Vendor

**Provider Qualifications**

**License** *(specify):*

Business licensing requirements per Title 308 WAC

**Certificate** *(specify):*

**Other Standard** *(specify):*

Additional requirements are clearly defined in Person Centered Spending Plan. A provider must meet all professional standards and /or training requirements which may be required by state statute. Some of these include:
A Bachelor's degree or higher in Psychology, Social Work, Health or other related field, with experience providing services

to aging or disabled populations or a Bachelor's degree in social work or psychology with experience in the coordination or provision of independent living services; or experience in creating, implementing, and instructing classes and programming for an Adult population.
When the chosen provider was not one in which a degree is required, the provider id bonded and insured.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

FMS

**Frequency of Verification:**

Initially upon contracting and then every two years for verification of credentials and background checks; monthly checks for Federal exclusion lists and Social Security Death Master List.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Training and Educational Supports**

**Provider Category:**

Agency

**Provider Type:**

Community Colleges

**Provider Qualifications**

**License** *(specify):*

Community Colleges are established, described and regulated in Chapter 28B.50.020 RCW.

**Certificate** *(specify):*

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

FMS

**Frequency of Verification:**

Initially upon contracting and then every two years for verification of credentials and background checks; monthly checks for Federal exclusion lists and Social Security Death Master List.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Training and Educational Supports**

**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 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:**

FMS

**Frequency of Verification:**

Initially upon contracting and then every two years for verification of credentials and background checks; monthly checks for Federal exclusion lists and Social Security Death Master List.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Training and Educational Supports**

**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:**

FMS

**Frequency of Verification:**

Initially upon contracting and then every two years for verification of credentials and background checks; monthly checks for Federal exclusion lists and Social Security Death Master List.

## 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:**

Treatment and Health Maintenance

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 11 Other Health and Therapeutic Services | 11130 other therapies |

**Category 2:**

11 Other Health and Therapeutic Services

**Sub-Category 2:**

11070 dental services

**Category 3:**

11 Other Health and Therapeutic Services

**Sub-Category 3:**

11040 nutrition consultation

**Category 4:**

11 Other Health and Therapeutic Services

**Sub-Category 4:**

11050 physician services

**Service Definition** *(Scope):*

Treatment and health maintenance supports are services necessary to promote the participant's health and ability to live and participate in the community. Services are provided for the purpose of preventing further deterioration, improving or maintaining current level of functioning.

Supports and services categorized here include those typically performed or provided by people with specialized skill, certification or licenses. Treatment and health maintenance services must be reasonably related to addressing the participant's needs that arise as a result of their functional limitations and conditions. Services provided under the waiver service are not covered under State Plan services. The services are included in participant's consumer directed plan to augment State Plan services. Service providers must possess the appropriate professional licensing per Title 18 RCW.

The services under the New Freedom 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 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 | Home Health Agency |
| Individual | Licensed health practitioner |
| Individual | Community Vendor |
| Agency | Adult Day Care Centers |
| Agency | Home Care Agencies |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Treatment and Health Maintenance**

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency

**Provider Qualifications**

**License** *(specify):*

Licensed under chapter 70.127 RCW and chapter 246-335 WAC

**Certificate** *(specify):*

**Other Standard** *(specify):*

All professional staff employed by the agency to provide waiver services must meet any applicable statutory licensing and certification requirements.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

FMS

**Frequency of Verification:**

Initially upon contracting and then every two years for verification of credentials and background checks; monthly checks for Federal exclusion lists and Social Security Death Master List.
License renewal every two years
Contract compliance monitoring every two years

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Treatment and Health Maintenance**

**Provider Category:**

Individual

**Provider Type:**

Licensed health practitioner

**Provider Qualifications**

**License** *(specify):*

Providers must meet all statutory professional standards and licensing requirements and have a current license to practice in the state.

**Certificate** *(specify):*

**Other Standard** *(specify):*

Chapter 246-808 Chiropractic
Chapter 246-809 Counselors
Chapter 246-822 Dieticians or nutritionist
Chapter 246-830 Massage Therapist
Chapter 246-836 Naturopathic physicians
Chapter 246-840 Practical and Registered Nurse
Chapter 246-847 Occupational therapist
Chapter 246-863 Pharmacists
Chapter 246-915 Physical therapists
Chapter 246-803- Acupuncture
Chapter 246-817- Dentists
Chapter 246-851- vision
Chapter 246-828- Audiology

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

FMS

**Frequency of Verification:**

Initially upon contracting and then every two years for verification of credentials and background checks; monthly checks for Federal exclusion lists and Social Security Death Master List.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Treatment and Health Maintenance**

**Provider Category:**

Individual

**Provider Type:**

Community Vendor

**Provider Qualifications**

**License** *(specify):*

Business licensing requirements per Title 308 WAC

**Certificate** *(specify):*

**Other Standard** *(specify):*

Community vendors are subject to any licensing or local codes relevant to the task they are going to perform and additional requirements clearly defined in plan of service/spending plan.

For providers that do not require professional licensing the participant will define qualifications in the PCSP. The PCSP may identify additional qualifications that the person must meet to provide the service.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

FMS

**Frequency of Verification:**

Initially upon contracting and then every two years for verification of credentials and background checks; monthly checks for Federal exclusion lists and Social Security Death Master List.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Treatment and Health Maintenance**

**Provider Category:**

Agency

**Provider Type:**

Adult Day Care Centers

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

(1) Minimum staffing requirements for adult day care centers include an administrator/program director, activity coordinator, a consulting registered nurse, and a consulting social worker.

(2) The administrator/program director must have a master's degree and one year of supervisory experience in health or social services (full-time equivalent); or a bachelor's degree in health, social services or a related field, with two years of supervisory experience (full-time equivalent) in a social or health service setting; or a high school diploma or equivalent and four years of experience in a health or social services field, of which two years must be in a supervisory position, and have expertise with the populations served at the center.

Contract requirements for adult day care centers are listed in WAC 388-71-0724 through WAC 388-71-0774.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

FMS

**Frequency of Verification:**

Initially upon contracting and then every two years for verification of credentials and background checks; monthly checks for Federal exclusion lists and Social Security Death Master List.

Annual review per WAC 388-71-0724

Contract compliance monitoring every two years

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Treatment and Health Maintenance**

**Provider Category:**

Agency

**Provider Type:**

Home Care Agencies

**Provider Qualifications**

**License** *(specify):*

licensed under chapter 70.127 RCW

**Certificate** *(specify):*

**Other Standard** *(specify):*

Employees must meet all DSHS background check and training/certification requirements outlined in WAC 388-71-0500 through 05640.

All professional staff must have appropriate licensure and certification as outlined in state staute.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

FMS

**Frequency of Verification:**

Initially upon contracting and then every two years for verification of credentials and background checks; monthly checks for Federal exclusion lists and Social Security Death Master List.

License renewal every two years

Contract compliance monitoring every two years

## 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, contracted Tribal Case Managers, and the contracted case management entity Care Consultants as an administrative activity.

## 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 is responsible for conducting the background check.

The types of positions (e.g., personal assistants, attendants, etc.) for which such investigations must be conducted:
- Personal care provider (agency and individual providers), case manager/Care Consultant, 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

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.

**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 maintains the abuse registry and conducts screenings against the registry.

Personal care providers (agency and individual), case managers/Care Consultants, LPNs, RNs, nursing assistants, certified dieticians, physical therapists, occupational therapists, and all other waiver contractors who have unsupervised access to vulnerable adults must be screened against the abuse registry.

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.

## 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.

A participant may choose a relative/legal guardian to provide the service of personal care except a spouse, married, or legally separated. This waiver is for adults only. Providers, regardless of relationship to the participant, must meet all specified qualifications and must be employed by the CDE. When the participant is unable to supervise providers, Care Consultants are instructed to identify a third party to provide supervision and monitor the best interests of the participant (Long Term Care Manual, Chapter 3). Accountability systems regarding receipt and payment for waiver services provided by non-relative providers are applicable to relative providers.

Payment for services is processed by the Department. DSHS maintains data on the waiver participant including participant 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, rates, and authorization information. An invoice or claim from an authorized provider is the basis for payment of waiver services which have been provided. Each service is shown on an invoice/claim at the end of the service/pay period for which it was authorized. The signed invoice or electronic attestation is verification the service has actually been provided. Claims cannot be made until the day of service delivery or later. Payments are made directly to the service provider.

Payment for services identified in the care plan will be authorized when the following are satisfied:
1. Categorical relatedness and financial eligibility are approved
2. The participant is eligible for nursing facility level of care and is, or likely to be institutionalized
3. The care plan has been approved by the participant and consultant
4. The service provider is qualified
As with providers who are not related to the participant, the CDE may take action to dismiss an individual if the provider's inadequate performance or inability to deliver quality care is jeopardizing the participant's health, safety, or well-being. Examples of circumstances indicating jeopardy to the client could include, without limitation:
(1) Domestic violence or abuse, neglect, abandonment, or exploitation of a minor or vulnerable adult;
(2) Using or being under the influence of alcohol or illegal drugs during working hours;
(3) Other behavior directed toward the client or other persons involved in the client's life that places the client at risk of harm;
(4) A report from the client's health care provider that the client's health is negatively affected by inadequate care;
(5) A complaint from the client or client's representative that the client is not receiving adequate care;
(6) The absence of essential interventions identified in the service plan, such as medications or medical supplies.

○ **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:

Participants who use individual providers of personal care services choose their provider. If a participant chooses a provider who is not enrolled, the participant will refer the potential provider to the CDE for hiring. Any willing and qualified provider has the opportunity to enroll any time. The state maintains an open registry of qualified individual providers. Qualifications are published in WAC and are available to the public via web access and by hard copy upon request.

For all other waiver services, the FMS establishes qualifications and offers the opportunity for any willing provider to demonstrate qualifications and enroll. The FMS continuously seeks to build its pool of waiver service providers in order to offer a wide array of choice to enrollees by actively recruiting and enrolling qualified providers. Waiver service provider enrollment is open and continuous by FMS policy and State requirement.

The FMS Purchasing Specialist assists interested providers by providing written and verbal information regarding qualification requirements, enrollment procedures and other information about the process as needed by the applicant.

## 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:**
**#2 Number and percent of waiver service providers who continue to meet licensure &/or standards at contract renewal delegated by the State Medicaid Agency & adhere to other standards prior to their furnishing waiver services See Main B. Optional for numerator and denominator**

**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**<br>Confidence Interval =<br>95% Confidence level<br>Margin of error = +/-5% |

| | | |
|---|---|---|
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**#1 Number and percent of waiver service providers with initial contracts meeting licensure &/or certification standards & adhere to other standards prior to furnishing waiver services See Main B. Optional for numerator and denominator**

**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**<br>Confidence Interval =<br>95% Confidence level<br>Margin of error = +/-5% |
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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:**
**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 providers that meet all waiver requirements D = Number of providers 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**<br>Confidence |

| | | |
|---|---|---|
| | | Interval =<br>95% Confidence level<br>Margin of error = +/-5% |
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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:**
**Number and percent of waiver service providers that meet training requirements, as delegated by the SMA and in accordance with state requirements and the approved waiver N = Number 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 D = Number of waiver service providers**

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

| **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**<br>Confidence Interval = |
| ☒ **Other**<br>Specify:<br>AAA | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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.

-Nurse delegators are contracted for four years after verification that all requirements are met. To ensure that all contracts are current and up to date, all contracts are renewed at the same time on a four-year cycle. Additionally, a review of licensing requirements is completed annually, and background checks and insurance requirements are verified on all nurse delegators every two years.

- Agency providers are monitored by the Area Agencies on Aging (AAA). A review of provider files is completed annually. Reports are provided to the operating agency (ALTSA) annually.

- Nursing Assistant Certified (NAC), Home Care Aide Certified, and Nursing Assistant Registered (NAR) must complete required training to be able to perform delegated tasks. The State (Department of Health) maintains a registry system which verifies contract status.

- Individual providers must be at least 18 years old, present current state photo ID and social security card and pass name/DOB background check prior to contracting.

- Waiver participants that choose to self-direct their personal care, hire, train and supervise qualified providers are free to terminate the provider's employment and select new providers. Individual and agency providers must meet the requirements outlined in WAC 388-71. Payment is withheld if the IP/agency worker does not complete the required training and/or

certification requirements.

- The QA team monitors a statistically valid sample of provider files/qualifications. Monitoring includes verification that:
- Background checks are completed and passed
- Required training was completed within the timeframes indicated
- Providers subject to licensing or certification are valid at the time of contract renewal and per individual licensing or certification schedule.

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 occur 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.

During participant contacts, care consultants verify with participants that services are being received as outlined in the plan and discuss any issues with services and/or providers. Participants have the right and responsibility to report provider issues to the care consultant who will assist the participant to resolve the issue and to ensure that the provider qualifications are being met.

Reports are provided to the operating agency (ALTSA) annually. 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.

The State monitors the FMS to verify that the FMS is executing provider contracts correctly. Upon completion of each provider file review, the FMS is expected to make necessary corrections. Corrections are verified by either the QA team or the FMS supervisor. The QA team verifies that required corrections have been made at the individual level and documents the verification in the QA monitoring database. 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 database.

The FMS terminates contracts for providers if qualifications are not met.

The FMS provides technical assistance if standards are not met for other provider contracts they manage. Failure to make required changes can lead to contract termination.

**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**<br>Specify:<br>AAA | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| | ☐ **Other**<br>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.

For the New Freedom waiver, waiver participants reside and receive services in their own home.

During the Care Assessment planning process, participant's preferences and goals are reviewed and documented to ensure that the individual has access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. The in-home setting option is identified and documented in the person-centered service plan and are based on the individual's needs, preferences.

During the annual re-evaluation, the same process is followed to ensure the requirements continue to be met.

Description of Residential Settings:

Adult family homes are licensed residential homes that must be in compliance with HCB settings rules. Adult family homes provide HCBS to more than one but not more than eight adults who are not related by blood or marriage to a licensed operator, resident manager, or caregiver, who resides in the home. Adult family homes are single-family homes in residential neighborhoods and are integrated in the surrounding community. This setting is integrated in, and supports full access of participants to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals NOT receiving Medicaid.

Enhanced services facilities are licensed residential settings that provide HCBS to up to sixteen adults and must be in compliance with HCB settings rules. Residents have single rooms and share living and dining spaces. These homes will be located within the community to ensure participants have access, and can participate in, community activities and services. This setting is integrated in, and supports full access of participants to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals NOT receiving Medicaid. Assisted living facilities are community settings that are licensed to provide medication assistance administration, personal care services, intermittent nursing, and limited supervision to seven or more residents, and must be in compliance with HCBS rules.

Assisted living facilities include a private apartment. This setting is integrated in, and supports full access of participants to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals NOT receiving Medicaid. Enhanced Adult Residential Care facilities are community settings that are licensed to provide medication assistance, personal care services, and limited supervision to seven or more residents, and must be in compliance with HCBS rules.

Enhanced Adult Residential Care facilities provide medication administration and intermittent nursing services. These facilities are integrated in, and support full access of participants to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals who are NOT receiving Medicaid services.

Adult family homes (AFH), assisted living facilities (ALF), and enhanced adult residential care (EARC) settings were reviewed by CMS during the approval of Washington's 1915(k) State Plan Amendment and were determined to fully align with HCB settings requirements.

Description of how the settings meet federal HCB Setting requirements:

Adult family homes, enhanced services facilities, assisted living facilities, and enhanced adult residential care facilities are required by WAC or contract to have an Admission Agreement with the participant. The Admission Agreement summarizes the services, provides assurance that resident rights will be adhered to, and describes staffing levels and hours. During the initial licensing and contracting process for new facilities, a review of the Admissions Agreement elements is conducted based on the following criteria:
• An evaluation as to whether the admission agreement is written in a language and manner that can be easily understood by residents and their representatives
• Statements about services, items and activities that are available in the facility and the charges for them
• An evaluation as to whether the admission agreement fully informs each resident of his or her rights (and the facility's rules and policies governing resident conduct) in a language that they understand • An evaluation whether it includes any rules that require

or request the resident give up or limit any rights
• An evaluation about whether the admission agreement restricts or limits visitation in any way or limits the resident's right to self-determination

All policies required in Chapters 388-76, 388-78A, 388-107, and 388-110 WAC must be provided during initial licensing and contracting and then made available thereafter during inspections and investigations. All policies must adhere to the following state and federal requirements:

(i) Integration Waiver participants are encouraged and supported to fully engage in community life and employment opportunities. Participants utilize typical community resources for recreation, medical services, banking, shopping, religious services, and other needs.

(ii) Choice of Services and Providers Participants are offered a choice of settings in which they may receive waiver services. Case managers provide information about licensed and contracted providers available to the individual through the waiver and the individual selects the provider and setting of their choice. Case managers enter the choice into the service plan, assist individuals in locating an appropriate provider of their choice, and facilitate the placement the individual has chosen.

(iii) Rights, Privacy, and Autonomy Washington's legislature has codified its intent that choice, participation, privacy, and the opportunity to engage in religious, political, civic, recreational, and other social activities foster a sense of self-worth and enhance the quality of life for long-term care residents. The Revised Code of Washington (RCW) provides extensive and explicit rights to residents in adult family homes, assisted living facilities, and enhanced adult residential care facilities (Chapter 70.129 RCW). Washington Administrative Code (WAC) requires adult family homes (Chapter 388-76 WAC), assisted living and enhanced adult residential care facilities (Chapter 388-78A WAC), and enhanced services facilities (Chapter 388-107 WAC) to provide a safe, clean, comfortable, and home-like environment. Restraints and seclusion are prohibited in Washington Home and Community-Based residential facilities except for the purposes of medical treatments. Neither seclusion nor restraint may be used for discipline or convenience of the provider.

(iv) Individualization State statute requires that residents who choose to live in adult family homes, assisted living facilities, enhanced adult residential care facilities, and enhanced services facilities be provided with, among others, the right to: choose activities, schedules, and health care consistent with his or her interests; assessments and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident, including unscheduled access to community activities. Participants retain control over their personal resources unless they have chosen not to or have been determined by the courts or the Social Security Administration to be unable to manage their personal resources.

(v) Additional Characteristics

(a) Residents of adult family homes, assisted living facilities, enhanced adult residential care facilities, and enhanced services facilities will receive the protections from evictions outlined in RCW. Title 59 RCW provides protections, including an unlawful entry and detainer action as outlined in Chapter 59.16 RCW, including a process for contesting the eviction. Additionally, adult family homes, assisted living facilities, and enhanced adult residential care facilities are required by RCW 70.129.110 and enhanced services facilities are required by contract and revised WAC 388-107-0280 to give at least 30 days' notice prior to terminating the agreement or transferring/discharging the participant. A provider may give less than 30 calendar days' notice only when a shorter time is necessary to preserve the health and safety of other residents, the participant has an urgent medical need or the participant has not resided in the facility for the prior 30-day period.

(b) Each participant has privacy in his/her bedroom or apartment. Some homes offer single occupancy bedrooms, while others offer double occupancy; participants select the residential setting that best meets his/her preferences from all options available and qualified to meet the needs of the participant and within the participant's available financial resources. Bedroom doors may be locked unless otherwise indicated by an identified need in the treatment plan or prohibited by the fire marshal. Necessary staff will have a readily accessible means of unlocking any locked door in the facility when safety or evacuation needs arise. Participants may have their own possessions in their bedroom and have the right to decorate their room.

(c) Participants have the right to select and control their own schedules and activities, such as events in the community, religious services, shopping, visiting, and other activities of the participant's choosing. Participants will have access to food and water at all times.

(d) Residents in adult family homes, assisted living facilities, enhanced residential care facilities, and enhanced services facilities may have visitors at any time.

(e) All facilities must be physically accessible to the individuals they serve.

Washington State Law provides clear protections for residents. Chapter 49.60 of the Revised Code of Washington (RCW) is the state's law against discrimination, and which created the Washington State Human Rights Commission to develop policies and rules to eliminate and prevent discrimination. Chapter 162-26 in Washington Administrative Code (WAC) identifies unfair practices to include reasonable accommodations, accessibility and service animals. All participant needs, including any special needs, service preferences and requirements, or modifications, are documented in the client's comprehensive assessment and are included in the service plan. Adult family homes are not institutional and do not have the qualities of institutions. If a setting violates an individual's personal rights of privacy, dignity, choice, and respect, the home is cited and must develop a corrective action plan to address the issues.

Adult Day Health settings serve participants funded through Medicaid as well as participants funded through a variety of other sources including private pay. All community members have free access to these services and settings including both Medicaid and non-Medicaid funded participants. During the development of the statewide transition plan, the state ADH Program Manager conducted a systemic assessment of all state regulations corresponding to the HCB settings regulations. In addition, the State conducted site visits of all Adult Day Health Centers. Adult Day Health settings fully aligned with HCB settings requirements outlined in 42 CFR § 441.301.

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. The State Medicaid Agency, HCA, has delegated the operational compliance monitoring activities and responsibilities to ALTSA. HCA provides oversight through waiver management meetings with the operating agency every 6 months where quality monitoring activities are reported and reviewed.

Adult family homes, assisted living facilities, enhanced adult residential care facilities, and enhanced services facilities are licensed through the state Residential Care Services (RCS) Division.

The initial inspection ascertains that all policies of the home or facility are in compliance with state and federal statutes and rules. The subsequent re-inspections determine continued compliance with these requirements. Survey staff interview participants as part of both regular and complaint investigation surveys.

The Residential Care Services (RCS) Division of ALTSA monitors compliance with the HCBS setting requirements. RCS conducts inspections and complaint investigations of all licensed facilities; inspections are conducted every 9-18 months with the average being 12 months. Inspections are unannounced and unpredictable as to when they will occur. If a facility is found not to be in compliance with any of the client’s rights identified in the HCB settings rules, RCS takes an enforcement action against the facility and the facility is required to develop a corrective action plan to address the issue. For repeat violations, RCS may fine the facility or revoke the license.

Facilities are required to follow the RCW and RCS monitors to compliance with the HCBS requirements. The RCW provides the basis for RCS inspections and citations when a facility violates a resident’s rights. The RCW states the resident has the right to choose activities, schedules, and care, interact with members of the community both inside and outside the facility, make choices about aspects for his or her life, and participate in social, religious, and community activities. As part of the inspection process, RCS conducts an environmental tour, conducts resident record reviews, interviews providers/resident managers, interviews staff, observes use of restraints, and conducts comprehensive client and collateral interviews to determine compliance with HCBS settings requirements.

RCS regulates physical plant requirements every year (not just at initial licensing). If a licensed assisted living facility makes changes to their physical plant, the plans must be approved through the construction review process. Once the work is complete, RCS licensors review the work to ensure the changes are safe for residents. It is possible that a code that involves access could be updated but the facility is not required to complete construction to meet the new standard unless it poses a risk to the health and safety of residents.

RCS interviews residents using an inspection tool. Questions were added to the RCS interview tool to elicit resident feedback on whether their rights are being violated. The resident interview tools are completed to elicit input on the resident’s experience and to learn if the resident believes their rights are being honored. Any violation of a resident’s right, identified in the resident interview, is required to be addressed and a corrective action plan completed to ensure ongoing compliance. The tool will be updated periodically to address systemic issues or trends identified in the State’s analyses of licensing investigations and complaint resolutions regarding HCB nature of settings and community integration activities.

The RCS licensure and interview process also includes a determination of whether providers are adhering to the person-centered planning process when Negotiated Care Plans or Negotiated Service Agreements and Admissions Agreements are developed.

In addition to licensing inspections, the licensing staff investigates complaints from residents or the public, including those about possible resident rights violations, and takes action to ensure that rights are not violated. If a setting violates an individual's personal rights of privacy, dignity, choice, and respect, the home/facility is cited, must correct the issue, and develop a corrective action plan to address the prevention of any future occurrence of the issues.

The Residential Care Services division takes complaints regarding potential violations through the Complaint Resolution Unit (CRU). Any participant, advocate, family member, the Ombuds staff, or anyone in the community can call the CRU to identify a potential violation in a facility. Case managers, who visit participants in the facilities, would also call the CRU if they identified a potential violation. The Department has published an EndHarm toll-free phone number in facilities, Home and Community Services Offices, Area Agencies on Aging, and other public areas, and on the website, to inform the public about reporting incidents for vulnerable adults. The EndHarm calls are dispatched to APS or CRU as applicable. All complaints, regardless of the source, are reviewed and investigated by RCS. If there is a violation of the federal or state policies, the provider is notified of the violation. The provider is required to correct the violation and to implement a plan to ensure the practice that led to the violation does not happen again. Depending on the outcome or timeliness of the remediation at time of re-inspection, RCS is authorized to implement progressive enforcement action (including civil fines, stop placements, and license revocation). Facility citation letters are posted on the department’s internet site for the public to review and for informed decision making when a client is choosing a licensed residential setting.

The telephone number to the complaint hotline for RCS, Disability Rights Washington, and the Ombuds is required to be posted in all residential settings. During inspections, RCS confirms that the telephone numbers are posted in a conspicuous location per Washington State Law. Individuals are not required to utilize or notify the State Ombuds program before filing a complaint. If an individual chooses to use the Ombuds program, they may file a formal complaint at any time, regardless of the status of the Ombuds investigation. Licensing staff investigate complaints from residents or the public. In addition to the published phone numbers for EndHarm, complaints may be made through the Governor’s office, state legislators, and the Office of the Secretary of the Department of Social and Health Services.

The Washington State Ombuds program provides resident advocacy support and takes complaints from residents. If the Ombuds person in a facility suspects that a facility is violating a resident’s rights, she or he will either work with the facility to resolve the problem or encourage the client to call the complaint investigation hotline for RCS. The Ombuds volunteers are not mandated reporters by law. They will share concerns with RCS if the resident agrees or is unable to give or deny consent.

The state records all violations and citations in the STARS. There are many reports in STARS that can be used to analyze and trend investigation data to assess for systemic issues. For the analysis of investigations regarding HCB setting requirements, the state is developing a report capturing all relevant citations into a single report that can be run at any time. The report identifies all facilities that were cited for any resident rights violations. Citations can be aggregated for tracking and trending. Data from this report will be analyzed biannually by the HCS Medicaid Unit, and reported annually to the Medicaid Agency, (HCA) or more often as needed.

ALTSA will assess and consider whether settings proposing to utilize secured perimeters and/or delayed egress have the qualities of home and community-based settings and not the qualities of an institution. ALTSA will not include settings within the waiver that impose secured perimeters and /or delayed egress unilaterally for all residents. These modifications must be individually based on an assessed need in the person-centered service plan. ALTSA will utilize site visits, policy reviews and the survey and certification process to determine that a setting proposing to use a secured perimeter and/or delayed egress has policy and practice in place to ensure this modification applies only for a resident who has an identified need in their person-centered service plan. ALTSA requires providers to follow all requirements outlined in 42 CFR §441.301(4(v)(F) prior to making a modification and to ensure that this modification does not limit the movement of residents who do not have an identified need in their person-centered service plan. RCS will cite settings that have restricted or modified client rights without following the person-centered service planning process.

## Appendix D: Participant-Centered Planning and Service Delivery

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

**State Participant-Centered Service Plan Title:**

Person Centered Spending 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/Care Consultant:
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. Case managers from the contracted case management entity also hold the role of "care consultant" for New Freedom participants. The care consultant provides support to the waiver participant and/or representative who direct the development of the Participant Centered Spending Plan (PCSP).

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.

Note: Equivalent social service experience would include the previous classes of caseworker 3 or higher; OR

For Promotion only: A bachelor's degree and three years of experience as a caseworker 3, social worker 1A or B, social worker 2, casework supervisor trainee, casework supervisor, juvenile rehabilitation supervisor 1 or juvenile rehabilitation counselor 2 in state service.

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.

(a) Case managers and Care Consultants provide information about the waiver verbally, through written materials, or through alternative communication modes adapted to participant need. Initial visits are used for review of New Freedom programmatic and financial features. Care Consultants review the allowable uses of the monthly budget, and help participants think about what supports and services will be included in the PCSP. Participants have the authority to determine the level of assistance provided by the Care Consultants beyond the minimum requirement of orientation to the waiver, and development and review of the PCSP.

Care Consultants review the Client's Rights and Responsibilities (DSHS 16-172) form with participants that outlines 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 Long-Term Care Services for Adults" (DSHS 22-619) booklet is given to all new participants at initial assessment. This document outlines Medicaid eligibility and long-term care services available.

(b) PCSP development always includes the participants and their legal representative (if applicable). Participants may include any other individuals of their choice to participate. ALTSA encourages participants to include family and other informal supports as appropriate to the participant'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):

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

The Participant Centered Spending Plan (PCSP) is developed at the direction of the participant. Others involved in the development of the plan include the New Freedom Care Consultant, the participant's legal representative (if applicable), and any others invited by the participant such as family members, and other informal supports. Planning meetings are scheduled by the participant at times and in locations that are convenient for the participant and others they have invited to the meeting.

The PCSP is developed after the participant's service needs have been identified through the comprehensive assessment using the CARE tool. Comprehensive assessments are conducted face-to-face, through telephonic, or other technology media in a time and place convenient to the participant. Comprehensive assessments, annual updates, and significant change assessments could have all or parts of the assessment completed through telephonic or other technology media. When completing assessments, 42 CFR 441.535 will be followed. Telephonic or assessments through other technology media is available for all individuals, and all individuals are provided the opportunity for an in-person assessment in lieu of one preformed telephonically. Initial comprehensive assessments must be completed, and services authorized (if eligible) within 45 days from intake date. Significant change and annual assessments must be completed within 30 days of the assessment creation date. After the comprehensive assessment has been completed, an interim PCSP can be put into place to provide services needed immediately. This plan is developed by the participant, Care Consultant and others and is intended to ensure that needed services such as personal care are put into place without delay. An interim plan can be in place up to 30 days, by which time the final PCSP must be completed.

After the assessment, the care consultant must make at least one additional contact (in-person or by phone) with the client.

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) 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:

Care Consultants conduct annual and significant change assessments using the CARE automated assessment tool. CARE leads the Care Consultant and participant systematically though a series of assessments covering multiple life domains. Assessment items are based on the Minimum Data Set (MDS) and all areas include participant preferences and goals, limitations, health status, and caregiver instructions. The Care Consultants 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. Care Consultants review the health and welfare of participants receiving New Freedom services at each assessment and participant contact. Registered nurses respond to referrals by Care Consultants 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/Care Consultants on follow up recommendations.

Assessment areas include demographics, collateral contacts, formal and informal supports, caregiver status which includes the Zarit burden scale to assess provider burden, behavioral issues, psychosocial and legal issues. Medical assessment includes diagnoses, ability to manage medications, treatments, both skilled and unskilled, mobility and toileting.

CARE assesses indicators of medical risk including number of hospitalizations, skin breakdown, history of routine and preventive medical care, medication regimen and multiple diagnoses.

CARE screens and assessment elements:
-Participant demographics including collateral Contacts, Caregiver Status, Financial eligibility, Employment status and goals.

-Medical and health status: current medications and medication management, diagnoses, treatments (both skilled and unskilled), indicators of risk such as recent hospitalizations, skin problems, pain, lack of preventive care (mammograms, PSA, Colonoscopy, etc.), significant change in self-sufficiency, communication skills and resources, ability to use the

phone, vision, speech, and hearing abilities, mobility and history/risk of falls.

-Psychosocial assessment: MMSE, memory, current or past behavior and successful interventions, depression, suicide risk, sleep patterns, relationships and interests, decision making, client goals, alcohol, tobacco and substance abuse.

-Legal Issues - Any legal matters concerning the participant 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, pending civil or criminal proceedings.

-Activities of Daily Living (ADLs) including toileting, nutritional/oral status, bathing, dressing, personal hygiene, household tasks, transportation, shopping, wood supply if wood is the sole source of heating or cooking, housework, assessing for environment modifications and/or assistive equipment.

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

At the time of the comprehensive CARE assessment, Care Consultants provide and review with all individuals interested in services the Medicaid and Long-Term Care Services for Adults booklet (DSHS 22-619). This booklet outlines the services, resources, and options available through ALTSA including waiver options. This booklet includes several links to information about services and resources for individuals who have internet access. Additional information about the New Freedom waiver is made available to eligible individuals in King, Pierce, Spokane, Whitman, Stevens, Ferry, and Pend Oreille Counties. The New Freedom Care Consultant reviews programmatic and financial features of the waiver. Care Consultants review the allowable uses of the monthly budget, and help participants think about what supports and services will be included in the spending plan.

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

The Care Consultant gathers additional information about the person's needs, preferences, and goals by engaging with the individual and trusted others. Participants then determine the services they will purchase based on their preferences and priorities and develop their service budget accordingly. Care Consultants can guide conversations and help participants clarify desired outcomes and strategies for meeting them. They help identify risks and develop plans for supports related to those risks. Participants will include plans for emergency back-up personal care services. The plans include descriptions of safeguards necessary to reasonably address the individual's health and welfare, and a plan for meeting the emergency needs of the participant. Participant consent is required before the plan of care is implemented. Signatures may be collected electronically. Case manager with 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 a 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) how waiver and other services are coordinated:

The PCSP documents the participant's goals in relation to the needs identified in the CARE assessment and the subsequent services and goods that will be acquired. The plan includes services and goods acquired through sources other than the waiver, with a description of how waiver services are coordinated with non-waiver services. 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) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan:

The PCSP outlines the service(s) to be provided and identifies the provider who will deliver each service or item. Care Consultants review the Participant Service Budget in the web-based portal operated by the Financial Management Service (FMS) at least quarterly to ensure that the participant is receiving the services/goods identified in their PCSP in a timely manner. The Care Consultant provides technical assistance to the participant regarding managing their budget and problem solving as needed.

PCSPs include projected expenditures for each purchase. The FMS ensures that all expenditures are for services identified in the PCSP and that the expense can be covered by funds in the budget. Participants receive quarterly budget reports to monitor spending on their planned services. The FMS is responsible for conducting regular reviews of the participant's budget and expenditures. The FMS system receives a nightly feed of payment data from the State's payment system and compares that data with participant's individual budgets in the portal. As discrepancies are found the financial analyst researches the issue and works with the case manager/Care Consultant and/or ALTSA Program Manager on an ongoing basis to ensure all issues have been resolved.

(g) how and when the plan is updated, including when the participant's needs change:

The PCSP is updated annually, when the participant adds or deletes a service, or when the participant budget changes as the result of a significant change assessment.

The participant may request a new CARE assessment if a significant change occurs in the participant's condition. Significant change is defined as a reported significant change, for better or worse, in the participant's cognition, mood/behavior, ADL's or medical condition. The significant change assessment could have all or parts of the assessment completed through telephonic or other technology media.

A reassessment due to a significant change may result in an increase or decrease in authorized care hours. Because care hours generated through the assessment are converted to the budget amount available for participant direction, a change in hours will result in a change in the budget amount.

## 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 participant 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-Mmaking screen. CARE creates critical indicators based on certain data elements or combination of data elements identified by the care consultant and participant. These critical indicators require the care consultant 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 participant meets any of the following criteria, then 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 the participant'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 participants 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 their personal safety, as identified in the assessment on the Environment screen or in the SER
• Is not always able to supervise their 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.

During development of the PCSP, the participant weighs the cost-benefit of a potential risk, decides what level of risk to assume and develops a plan to manage it. The strategies and steps to address known critical risks are documented in the PCSP and are tied to the plans for backup services that are also documented in the PCSP. In opting for New Freedom consumer directed services, the participant assumes responsibility for contacting the Care Consultant if the participant believes their needs are not being met or safety and well-being are compromised.

Adult Protective Service staff and New Freedom Care Consultants coordinate with each other for participants who experience or are at risk of abuse, abandonment, neglect, self-neglect or exploitation. The comprehensive assessment identifies individuals with challenging behaviors and documents intervention strategies for each behavior. Individual and agency providers must successfully complete DSHS required training in order to provide personal care services.

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(s) 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.

Participants are given free choice of all qualified approved providers of each service included in their PCSP. Care Consultants provide orientation to participants regarding allowable expenditures and advise participants on accessing services and goods identified in the PCSP. The FMS portal provides participants with a full list of contracted and active vendors available in their geographical area. The Care Consultant can also print a copy and provide to the participant as requested.

## 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. ALSTA and Federally recognized Tribal case managers are required to use the Department's electronic assessment and service planning tool. ALTSA and Tribal case managers complete an assessment of need. For participants enrolling in New Freedom, subsequent annual assessments, LOC determinations, and PCSPs are completed by Care Consultants of the contracted case management agency. 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 are reviewed by an ALTSA quality assurance monitoring team on a 12-month cycle. For New Freedom records drawn, the service plan reviewed is the PCSP. ALTSA calculates the sample by drawing a statistically valid sample across the participant population for all waivers. The sample is derived using a confidence level of 95%, a 50% response distribution, and a 5% margin of error.

Quality assurance 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 State Medicaid Agency reviews a sample of PCSPs 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.

Full details regarding the frequency of reviews, review methodology, and roles and responsibilities are outlined in Appendix H.

## 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:*

In the Document Management System (DMS)

## 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) New Freedom Care Consultants have primary responsibility for monitoring the implementation of the PCSP and participant 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. Care Consultants 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 Care Consultant when there are changes in the participant's condition or needs.

Participants are also responsible to contact their Care Consultant when their condition or service needs change. Collateral contacts are encouraged to notify the Care Consultant with any concerns.

(b) All initial, annual, and significant change assessments are conducted by Care Consultants through a face-to-face or telephonic or other technology media client interview, for any participant. Change assessments could have all or parts of the assessment completed through telephonic or other technology media. When completing assessments, 42 CFR 441.535 will be followed. Assessments completed through telephonic or other technology media would be available for all participants, and all participants are provided the opportunity for an in-person assessment in lieu of one preformed telephonically. In addition to the participant contact at the time of assessment, Care Consultants are required to make at least one additional contact (in-person or by phone) during the service plan year. When problems/barriers with services or providers are identified, the care consultant 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. Care Consultant contacts include a discussion with the participant about access to services and service providers including non-waiver services. When needed, Care Consultants initiate contracts with additional providers to provide services identified in the PCSP and to offer choice to the participant. Care Consultants also assist with referrals to non-waiver services and help participants identify providers of non-waiver services such as healthcare providers.

(c) ALTSA's Quality Assurance unit annually monitors, at a statewide level, a representative sample of case managers' files. If problems are identified in individual records, supervisors/case managers/Care Consultants 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 participant 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:**
**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 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**<br>Confidence Interval =<br>95%<br>Confidence level<br>Margin of error = +/-5% |
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>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**<br>Specify: |

**Performance Measure:**
**Number and percent of service plans for waiver participants that address all assessed needs, including health and 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 and 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** *(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**<br>Confidence Interval =<br>95% Confidence level<br>Margin of error = +/-5% |
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | | |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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:**
**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**<br>Confidence Interval =<br>95% Confidence level<br>Margin of error = +/-5% |
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number & percent of participants who experienced a significant change in condition who were given a significant change assessment when warranted and 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**<br>Confidence Interval =<br>95% Confidence level<br>Margin of error = +/-5% |
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>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: |

**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:**
**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):
**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**<br>Confidence Interval =<br>95% Confidence level<br>Margin of error = +/-5% |
| ☐ **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:**
**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 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**<br>Confidence Interval =<br>95%<br>Confidence level<br>Margin of error = +/-5% |
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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:**
**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 =<br><br>95% Confidence level<br>Margin of error = +/-5% |
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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.

HOW THE SERVICE PLAN IS DEVELOPED (BACKGROUND)
The Service Plan is developed after a comprehensive assessment has been completed using the CARE assessment application. The comprehensive assessment is based on information entered into CARE by the participant and ALTSA case manager or New Freedom Care Consultant during the assessment process. CARE tracks identified needs and types of providers (formal or informal) needed to assist with these needs.

The assessment/plan developed in CARE identifies areas such as:
- Formal and informal supports, which hours have been assigned to each and their schedules;
- Participant goals and preferences; and
- Referrals (who will follow through with the referral and when)

HOW DISCOVERY IS DESIGNED AND IMPLEMENTED
ALTSA monitors participant plans of care 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 five assessments are reviewed and then a minimum of 50% of plans are reviewed during the next three months of employment. Errors in assessments 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 ALTSA QA Unit 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 corrective action is required. Care Consultants are required to take action within specified time frames to address all problems identified in service plans during the QA monitoring.
- All participants assessed needs (including health and safety and risk factors) whether or not paid by ALTSA, are documented in the service plan. Needs that will be met formally, other than personal care, are addressed in the service plan.
- 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 QA monitoring data 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 participant's service plan.
- Service plan development is participant directed and plans are completed in required time frame.
- Participants receive services identified in the service plan.
- 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 Care Consultant is expected to make necessary corrections. Corrections are

verified by either the QA team or the consultant's supervisor. The QA team verifies that required corrections have been made at the individual level within 30 days of the preliminary review and documents 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 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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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)

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

(a) the nature of the opportunities afforded to participants:
New Freedom waiver participants have the opportunity to fully direct all waiver services. Participants work within a budget allotment that is calculated based on their comprehensive assessment. Through this allotment, participants plan for and purchase all necessary goods and services to meet their assessed needs. Participants have both budget and employer authority in the New Freedom waiver.

(b) how participants may take advantage of these opportunities:
Each participant develops a Participant Centered Spending Plan (PCSP) which addresses the needs identified in the comprehensive assessment. The PCSP identifies which goods and services will be purchased to meet the assessed needs and the qualified provider of each good and service.

(c) Process to access participant direction opportunities, the entities that support individuals who direct their services, and the supports that each entity provides:

Care Consultants support participants in developing and implementing the PCSP. The Care Consultant assists the participant in accessing participant direction opportunities by assisting in identifying and locating qualified providers and provides training and support to manage providers. Care Consultants provide orientation to participants about waiver requirements and participant responsibilities; review initial spending plan and subsequent revisions; maintain contact with participants for the first six months, as needed thereafter and at least annually. Optional supports provided by the Care Consultant include training and support to assist participants in developing spending plans; information related to recruiting and supervising individual's providers; and assistance in identifying equipment and services. Care Consultants conduct comprehensive assessments annually and more frequently when significant changes occur. They also complete LOC evaluations. Nursing services are provided through the case management entity.

Financial Management Services (FMS) are provided for all provider tasks related to payment of services, payment of other services and goods, providing participants with flexible mechanisms to expedite preferred purchases, conduct criminal background checks, contracting activities related to providers of waiver services (except for personal care providers) and providing participants with quarterly budget statements. The vendor contracted to provide the FMS is ACES$.

## Appendix E: Participant Direction of Services

### E-1: Overview (2 of 13)

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

○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

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

☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

## Appendix E: Participant Direction of Services

### E-1: Overview (3 of 13)

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

◉ **Waiver is designed to support only individuals who want to direct their services.**

○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

*Specify the criteria*

## Appendix E: Participant Direction of Services

### E-1: Overview (4 of 13)

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

(a) Printed material is available about participant direction through the New Freedom waiver. This material details the rights and responsibilities of New Freedom participants and describes the benefits and challenges, including possible liabilities such as hiring, firing and recruiting providers of personal care and arranging for back up providers, of participant-direction. This material is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction. In addition to printed material, Care Consultants and social service specialists/case managers are available to personally discuss these aspects of participant direction in the New Freedom waiver. This information is also included on the public ALTSA internet site.

(b) Care Consultants and social service specialists/case managers are responsible for furnishing information about participant direction to all interested individuals.

(c) Information about participant direction is furnished timely to allow sufficient time for the participant to weigh the pros and cons of participant direction and obtain additional information if needed.

Information is provided to individuals inquiring about services in King, Pierce, Spokane, Whitman, Stevens, Ferry, and Pend Oreille Counties prior to entrance on the waiver.

Also, at the time of the comprehensive CARE assessment, Care Consultants/social service specialists/case managers inform individuals (and/or representatives) of waivers that are available to them, including the New Freedom waiver, and the services, benefits and responsibilities in each program.

Care Consultants/social service specialist/case managers also provide this information at the request of participants currently enrolled in other waiver programs.

## Appendix E: Participant Direction of Services

### E-1: Overview (5 of 13)

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

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**
Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The participant or their representative acting in conjunction with the Care Consultant direct the development and implementation of the PCSP. Representatives who direct waiver services may not be paid providers of waiver services.

The participant identifies a friend, family member, neighbor, or community resource to act as their representative. Representatives and their contact information are entered in the Department's assessment. Representatives in conjunction with the participant make the following decisions:
-Recruit staff
-Select staff from IP worker registry and refer to CDE for hiring.
-Specify additional staff qualifications based on participant needs and preferences
-Determine staff duties based on needs identified in the Department's assessment
-Notify the Department if the participant's needs are not being met
-Orient and instruct staff in duties
-Evaluate staff performance
-Discharge staff from providing services

At time of assessment, a plan is developed identifying how direction will occur by the representative in order to assure that the representative is functioning in the best interest of the participant. Care planning safeguards to ensure a non-legal representative function in the best interest of the participant may include arrangement for:

-A reliable informal caregiver to identify and report to the Care Consultant when problems with care exist.

-Authorization of more than one provider to ensure there is an additional set of eyes in the participant's home who can provide additional monitoring.

-Other services such as authorization of home delivered meals or adult day care

-More frequent Care Consultant contact with the participant

-Periodic contact with other professionals

## Appendix E: Participant Direction of Services

### E-1: Overview (6 of 13)

**g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

| Waiver Service | Employer Authority | Budget Authority |
|---|---|---|
| **Personal Assistance Services (PAS)** | ☒ | ☒ |
| **Treatment and Health Maintenance** | ☒ | ☒ |
| **Environmental and Vehicle Modifications** | ☒ | ☒ |
| **Individual Directed Goods, Services and Supports** | ☒ | ☒ |
| **Training and Educational Supports** | ☒ | ☒ |

## Appendix E: Participant Direction of Services

### E-1: Overview (7 of 13)

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

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☒ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

## Appendix E: Participant Direction of Services

### E-1: Overview (8 of 13)

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

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

**The waiver service entitled:**

◉ **FMS are provided as an administrative activity.**

**Provide the following information**

**i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

The State Operating Agency and a private financial management agency provide FMS services.

The financial management agency was procured for administrative functions through a standard State of Washington solicitation process in accordance with applicable regulations at 45 CFR §74. A Request for Proposal (RFP) was published nationally and all organizations with capacity to meet all requirements outlined in the RFP were evaluated by a review panel which recommended the successful candidate.

**ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

The FMS entity is paid on a per-participant basis from administrative funds. The per member/per month rate is a flat rate paid to the contracted FMS agency to cover all activities performed for the participant and does not vary according to type of activity performed. The FMS receives payment for each month in which the participant is enrolled in the waiver for any portion of the month. The FMS is required to have an accounting system in place that is capable of performing all required financial transactions and is contractually obligated to use a certified public accountant or an individual with a baccalaureate degree in accounting on staff or under contract to ensure that accounting standards are used. In addition to an annual independent audit, ALTSA provides periodic monitoring of the FMS documentation and accounting systems.

**iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☒ **Other**

*Specify:*

Conducts criminal background checks.

Implements the contracting process for providers of waiver services as applicable (with the exception of individual providers of personal care).

The PM/PM flat rate is structured on a sliding scale which is based on participant enrollment. This was established to ensure the vendor has minimum contract value, regardless of fluctuating enrollment.

Supports furnished when the participant exercises budget authority:

- ☒ **Maintain a separate account for each participant's participant-directed budget**
- ☒ **Track and report participant funds, disbursements and the balance of participant funds**
- ☒ **Process and pay invoices for goods and services approved in the service plan**
- ☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other services and supports**

*Specify:*

Additional functions/activities:

- ☒ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- ☒ **Other**

*Specify:*

Provides participant specific expenditure reports on a quarterly basis as required by the operating agency.

**iv. Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

(a) Aging and Long-Term Support Administration coordinates monitoring FMS performance to ensure that policies and procedures are in place that assure adherence to state and federal regulations, and that practices are in accordance with established contractor performance standards. This includes monthly review of FMS payment data, identification of payment issues, and follow-up to ensure payment corrections are made. Claims submitted by the FMS must correspond with services, amounts, time frames, etc. as authorized in the PCSP. Payment system reports which provide data on participant service use and costs are utilized in monitoring.

The Care Consultant is responsible for verifying expenditure requests are congruent with the PCSP. The FMS generates a quarterly statement of expenditures and balance for review by the participant, Care Consultant, and New Freedom Program Manager. The FMS also has a web-based portal to which the Care Consultant and ALTSA may access at any time.

Both Care Consultants and FMS track and report consumer comments/feedback (excluding comments classified as complaint or allegation which require immediate follow-up per statute) along with routine information about the number of people served in each function and the general patterns of expenditures, by type and benefit category on a quarterly basis. The FMS generates a quarterly statement of expenditures and balance for the participant, Care Consultant and New Freedom Program Manager.

The FMS must maintain records to track all waiver expenditures including time records of people paid to provide supports and receipts for any goods purchased, invoices, and cancelled checks. The records must be maintained for a minimum of five years from the claim date and must be available for audit or review upon request. The FMS must also receive a copy of the recipient's PCSP. Claims submitted by the FMS must correspond with services, amounts, time frames, etc. as authorized in the PCSP.

(b) The participant, Care Consultant, New Freedom Program Manager all have a role in monitoring the performance of the FMS agent.

(c) New Freedom Program Manager monitoring occurs monthly. Utilization and enrollment reports from the New Freedom Care Consultant and FMS include spending plans, costs reports, and narratives regarding challenges and successes of implementation and are provided quarterly.

## Appendix E: Participant Direction of Services

### E-1: Overview (9 of 13)

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

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

*Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*

☐ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

| Participant-Directed Waiver Service | Information and Assistance Provided through this Waiver Service Coverage |
|---|---|
| **Personal Assistance Services (PAS)** | ☐ |
| **Treatment and Health Maintenance** | ☐ |
| **Environmental and Vehicle Modifications** | ☐ |
| **Individual Directed Goods, Services and Supports** | ☐ |
| **Training and Educational Supports** | ☐ |

☒ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

*Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

(a) The types of entities that furnish these supports:
Information and assistance in support of participant direction are furnished by both ALTSA social service specialist/case managers and New Freedom Care Consultants and Financial Management Services.

(b) How the supports are procured and compensated:
The FMS was competitively procured. This service is paid on a fee per client per month basis.

(c) Describe in detail the supports that are furnished for each participant direction opportunity under the waiver:
Care Consultants:
- assist participants to make informed decisions about services and supports that are consistent with their assessed needs and reflect individual circumstances.
- guide and facilitate planning, assist participants in identifying options to carry out the goals of the spending plan, and assist with plan revisions.
- offer orientation and information about waiver requirements, participant responsibilities, and managing the supports and services identified in the plan.
- provide training to waiver participants about participant responsibilities as employers of their individual providers. This training includes information about recruitment, hiring/dismissal, qualifications, duties, scheduling, orientation, supervision, and evaluation. Written information about these topics is also available from ALTSA and is provided to participants who employ individual providers.

The FMS manages contracts with waiver service providers (except for personal care providers). At the direction of the participant, FMS initiates payment for waiver services. The FMS tracks individual budget expenditures and prepares and submits quarterly statements to the participant.

(d) The methods and frequency of assessing the performance of the entities that furnish these supports:
Performance of the case management entity and FMS is evaluated through annual monitoring. Contract monitoring includes a review of a statistically valid sample of participant records and a review of waiver provider contracts and all pertinent FMS and case management records, policies and procedures.

(e) The entity or entities responsible for assessing performance:
Contract monitoring is conducted by staff of the operating agency.

## Appendix E: Participant Direction of Services

### E-1: Overview (10 of 13)

**k. Independent Advocacy** *(select one).*

- (●) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

*Describe the nature of this independent advocacy and how participants may access this advocacy:*

## Appendix E: Participant Direction of Services

### E-1: Overview (11 of 13)

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

The participant or representative, as requested by the participant, will notify the Care Consultant of the participant's desire to terminate New Freedom Waiver services. Case management staff will review all service options with the participant to ensure health and welfare during transition to another service or program. Participants who voluntarily terminate their enrollment in New Freedom are able to transition to services available through the State Plan or another waiver when they meet eligibility standards, ensuring service continuity. The Care Consultant will implement the service plan generated at the comprehensive assessment, or if there is a significant change in the person's condition and will complete a new assessment and service plan. Participants who transition to another waiver or State Plan personal care will be able to continue with the same personal care providers if preferred.

For participants who are no longer eligible for waiver services, case management provides transition supports to promote continuity of services and participant health and welfare. These supports are described in ALTSA's Long-Term Care Manual Chapter 5, and include termination planning with the participant, participant advocacy, technical assistance, referrals for services, and family support.

## Appendix E: Participant Direction of Services

### E-1: Overview (12 of 13)

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

When the Care Consultant in consultation with the participant and/or representative determines that a participant does not have the capabilities to be enrolled or to continue enrollment in a participant directed model of care, the Care Consultant may ask for an involuntary disenrollment.

The Care Consultant will draft a written notice to the participant that documents that one or more of the requirements for involuntary disenrollment/denial of enrollment and forward the notice to the New Freedom Program Manager for approval/denial prior to sending it to the participant. In addition to the disenrollment/denial letter, the Care Consultant will send the New Freedom Program Manager accompanying documentation of what efforts have been made to help the participant to be successful in the program.

The New Freedom Program Manager will notify the Care Consultant responsible for the annual assessment of the outcome of the request for disenrollment/denial within 15 days of receipt. If approved, the Care Consultant will send the disenrollment/denial letter to the participant and include the disenrollment date which will be provided by the New Freedom Program Manager. For involuntary disenrollment, the letter must contain language that the participant will not be losing all long-term care services but will be transferring back to the appropriate waiver or State Plan program.

The Care Consultant will also send the participant a planned action notice (PAN) noting the New Freedom disenrollment and the new State Plan, waiver, or other program that the participant will be receiving. Care Consultant work with all participants to transition from this waiver to another state plan and/or other waiver services. If the participant is not eligible for State Plan or other waiver services, Care Consultant connect participants with other community resources.

Participants who transition to another waiver or State Plan personal care program will be able to continue with the same personal care providers if preferred. Case management staff will implement the service plan generated at the comprehensive assessment, or if there is a significant change in the person's condition, will complete a new assessment and service plan.

WAC 388-106-1475 outlines the requirements for involuntary disenrollment/denial of enrollment.

## Appendix E: Participant Direction of Services

### E-1: Overview (13 of 13)

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

**Table E-1-n**

| | Employer Authority Only | Budget Authority Only or Budget Authority in Combination with Employer Authority |
|---|---|---|
| **Waiver Year** | **Number of Participants** | **Number of Participants** |
| **Year 1** | | 675 |
| **Year 2** | | 675 |
| **Year 3** | | 675 |
| **Year 4** | | 675 |
| **Year 5** | | 675 |

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant Direction (1 of 6)

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

**i. Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both*:

☒ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

The CDE is the agency that supports co-employment.

The standards and qualifications that the state requires of the CDE:
The CDE must meet the following minimum qualifications:
1. The CDE must have at least five years of experience in healthcare or social services, at least three of which must include home care.
2. The CDE must a valid WA business license
3. The CDE must not have been debarred from doing business with any State or federal government agency.
4. The CDE must demonstrated financial stability.

The safeguards in place to ensure that waiver participants maintain control and oversight of the employee.

DSHS has the following safeguards to ensure waiver participants maintain control and oversight of the employee(s):
Requirements of the CDE:
• Must have a commitment to Consumer Engagement and work closely with consumers in design, implementation, and on-going operations through an advisory board, focus groups, or other approved methods.
• Maintain the consumer-centered self-directed care model that allows consumers to choose their Individual Provider (IP) and direct the care they receive. Consumer-centered and self-directed care remains the top priority in the implementation of the CDE solution. Participants must retain authority to select, schedule, supervise, manage, and dismiss their IPs.
• Operations must be responsive to the needs of consumers, families, the IP workforce, AAAs, and DSHS.
• Shall maintain this consumer directed model as a top priority.

Additionally, DSHS:
• Reviewed and approved the full policy and procedure manual for the consumer directed employer vendor. Each policy or procedure was evaluated for compliance with consumer direction, client choice, and maintaining their role as the managing employer.
• During operations DSHS will have robust Quality Assurance Plan with particular emphasis on ensuring contractual obligations are met including performance measures, consumers retain self-direction, and services and payment to IPs are correct.
• Care Consultants are required to have contact with the participant a minimum of twice per year, and more if barriers are identified, which could include provider needs. When problems/barriers with services or providers are identified, the care consultant works with the participant to develop solutions.

State Law:
RCW 74.39A.500 directs DSHS to seek a contractor with “A strong commitment to consumer choice, self-direction, and maximizing consumer autonomy and control over daily decisions.”.

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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

☒ **Recruit staff**

☒ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☐ **Hire staff common law employer**

☐ **Verify staff qualifications**

☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

The state's method of conducting background checks does not vary from that described in Appendix C-2-a.

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☐ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☐ **Discharge staff (common law employer)**

☒ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (2 of 6)

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

**i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☒ **Reallocate funds among services included in the budget**

☒ **Determine the amount paid for services within the state's established limits**

☒ **Substitute service providers**

☒ **Schedule the provision of services**

☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☒ **Identify service providers and refer for provider enrollment**

☒ **Authorize payment for waiver goods and services**

☒ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (3 of 6)

**b. Participant - Budget Authority**

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

The Comprehensive Assessment Reporting Evaluation (CARE) tool is used to capture and classify the needs and resources of waiver participants. The information gathered in CARE is used to determine assistance levels based on the following characteristics: clinical complexity, behavior/mood, cognitive ability, activities of daily living, informal supports. Based upon the combination of these factors, each participant is placed in one of 17 levels of acuity related classification for funding. In New Freedom, these levels are the basis for the determination of the individual budget with payment add-ons, and historical data on costs of units of service, translated into current spending levels for other New Freedom waiver services. The New Freedom participant guidebook explains that the participant budget is determined by the participant's CARE assessment and offers information to the participant about the need to prioritize and select services to create a budget spending plan that does not exceed available resources. This information is publicly available to all interested parties in Washington Administrative Code (WAC).

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (4 of 6)

**b. Participant - Budget Authority**

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

ALTSA case managers/social service specialists inform participants of the budget amount at the time of initial assessment. At the time of annual reassessment or significant change assessment, participants are notified of their budget by New Freedom Care Consultants. Adjustments in the budget amount will occur when the participant's condition or situation changes. Participants who disagree with the outcomes of the CARE assessment have rights to an administrative hearing.

Participants may request an adjustment to the budget through the Exception to Rule (ETR) process. ETR requests are evaluated by determining whether the participant's situation differs from the majority. Managers of statewide HCS programs conduct team review of ETRs weekly and when granting or denying an adjustment to the participant's budget consider whether care needs are exceptional and/or there is an immediate need for a good or service that cannot be purchased within the participant's available budget.

By WAC 388-440-0001 initial ETRs are not subject to a fair hearing. When an ETR is reduced or terminated participants are provided a Planned Action Notice (PAN) which offers participants the opportunity to request a fair hearing.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (5 of 6)

**b. Participant - Budget Authority**

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

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

The participant may make revisions to expenditures when such changes do not substantially alter the plan. Revisions that significantly alter the plan outcomes or redirect substantial budget amounts must be preceded by the review of the Care Consultant to determine if changes in the services plan are required to meet the desired changes chosen by the participant. Substantial alteration of the plan is considered equal or greater than ten percent of the annualized value of the PCSP.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (6 of 6)

**b. Participant - Budget Authority**

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

Each participant's PCSP is tracked by the FMS on a web-based portal similar to an online banking system. When the plan is developed the participant prioritizes needed purchases. When the participant has accumulated the needed funds and approved the purchase to be completed, then the purchase is made, and the balance is readjusted. The FMS will not make payments unless the following conditions have been met:
-the item or service is included in the PCSP.
-the budget balance is sufficient to cover the expenditure.
-the participant has approved the payment.
-appropriate receipts have been provided to the FMS.

The participant receives quarterly reports listing their account balance and expenditures. The participant and the Care Consultant can request a balance at any time for on-going planning purposes. The Care Consultant has access at all times to the web-based portal for this information.

The FMS supplies quarterly reports to each participant which include the account balance. The Care Consultant reviews participants' account balances in the FMS' web based portal for under-utilization and works with the participant to address any service delivery problems that may be contributing to this such as difficulty locating a provider or payment issues.

## 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.

All individuals assessed for this program have fair hearing rights as specified in the Medicaid State Plan. A pamphlet describing the rights and process is included with every Medicaid application and again during the assessment process by the social service specialist. Fair hearing information is also contained in the DSHS document 14-225, Acknowledgment of Services, which the participant signs to indicate understanding of their right to choose between waiver services and institutional care and provides information on their rights to fair hearings.

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/participants have the right to have their financial and program eligibility determined by the Department, the right to appeal any decision which they perceive as adversely impacting the authorization or delivery of LTC services including, but not limited to the denial of services, reduction in the level of services, suspension of services, or termination of service. The fair hearing policy and procedure is outlined in Chapter 1 of the LTC Manual. Implementation and tracking of fair hearings are accomplished through an automated database.

The following steps provide a general outline to describe how the participant, or their legal representative, is informed of the opportunity to request fair hearing and the process used when there is a disagreement:

The New Freedom Care Consultant:
- Informs the participant informally AND in writing of adverse actions through a Planned Action Notice (PAN) when a service is denied, suspended, reduced, or terminated and explains the reason(s) for the action or decision in question, including the facts upon which the decision was based. The PAN provides a minimum of 10-day notice before any action is taken by the Department. PANs are currently retained in the participant's record. Decisions are kept with the same retention schedule as other participant documents.

- Attempts to resolve the issue when a participant does not agree with the decision/action are taken. This includes exploring alternatives such as an Exception to Rule (ETRs), when appropriate, or the availability of other programs or services, including services or assistance which may be offered by other community social service agencies. This is the initial step in the voluntary pre-hearing process.

- Asks the participant if they want to request a fair hearing when the issue cannot be resolved.

- Advises, and may assist, the applicant/participant to complete a request for fair hearing when the participant chooses to make a formal request and submits it to the Office of Administrative Hearings. Fair hearing requests may be made verbally, as well as in any written format. When received, the Office of Administrative Hearings must be contacted to formalize the request. This may be done by the social service specialist/case manager/Care Consultant, the Fair Hearing Coordinator (FHC), or any representative of the Department who receives the fair hearing request from the participant.

- Notifies the local Fair Hearing Coordinator of the participant's fair hearing issue.

- Informs the participant of eligibility for continued benefits, pending the outcome of the fair hearing. The decision about eligibility for continued benefits is determined with the Fair Hearing Coordinator.

- Notifies the participant that benefits must be repaid if the outcome of the fair hearing finds in favor of the Department. The participant has the choice of whether to receive continued benefits pending the outcome of the fair hearing.

- Documents in the Service Episode Record (SER) the date, topic of discussion, that the fair hearing process has been explained, and the participant's decision.

## 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 Aging and Long-Term Support Administration.

**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 is responsible for that they perceive as negatively affecting them 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. Participants are informed of and sign the Rights and Responsibilities form which explains that a participant has the right to file for a fair hearing whether or not they have filed a complaint.

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, the Department always strives to address grievances or complaints at the lowest level possible. Upon receipt at any level, all DSHS employees are required to acknowledge or respond to telephone, or in-person complaints within 48 hours. Written complaints must receive a response within seven (7) business days. Complaints are referred to the Care Consultant for action unless the complainant requests it not be. If the Care Consultant is unable to resolve the complaint, the person is referred to the Care Consultant's supervisor. The supervisor has 10 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 Administrator (RA)/AAA Director. The RA/AAA Director has 10 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 10 working days to resolve the complaint and must notify the person in writing of the outcome.

As part of the pre-hearing process, the Fair Hearing Coordinator is responsible for clarifying the issues that the participant is disputing. If the dispute is in relation to a personality conflict with the Care Consultant, for instance, or a dispute that falls outside of WAC/eligibility, the coordinator informs the participant about their grievance procedure. A Care Consultant, supervisor, etc. may also inform the participant about the agency's grievance procedure. If the issue is the denial of an Exception to Rule request, the Planned Action Notice that is given to the participant 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 participant; 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) 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 and mental)
• Exploitation
• Financial exploitation
• Neglect
• Self-neglect

Intake reports are first screened by ALTSA staff for the need for emergency response and the appropriate emergency responder is notified if indicated within 24 hours. Reports are then evaluated for jurisdiction either Adult Protective Services (APS) or the Complaint Resolution Unit (CRU), whether the intake will result in a full investigation and if so the time frame for the investigation. Reports are then prioritized and assigned for investigation as described in G 1-d.

All intakes reported to APS and CRU are logged into the TIVA system. This system is used by the investigative entities to capture the investigative work and to allow ALTSA and DDA to track and trend critical incidents by type, provider, program and participant. The system allows for the investigator to indicate when other entities have been notified of the alleged incident such as law enforcement.

There is a data link between TIVA and CARE, the case management system, which provides an electronic message to the primary case manager/social services specialist/Care Consultant when a participant on their caseload has been identified as a victim of an alleged APS or CRU intake. This allows the case manager/social services specialist/Care Consultant to collaborate as needed with the investigator to ensure the participant's health and welfare continues to be met. Similarly, when the investigation of the alleged event has been completed the case manager/social services specialist/Care Consultant receives an electronic notice along with a summary of the investigative report.

Types of Abuse under RCW 74.34
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 exploitation of 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, 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, online reporting 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, as these are the entities responsible for screening the need for emergency response. 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, 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: 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 Care Consultant verbally and in ALTSA publication, “Medicaid and Options for Long-Term Care Services for Adults” which is provided during the assessment.

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's 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 Basic Training 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.

Reports of the abuse, abandonment, neglect, financial exploitation or self-neglect of a participant are received by Adult Protective Services (APS) by phone, fax, letter, or in-person.

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 time frame 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 five (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. If a case remains in “investigating” or “investigation pending” status 90 days after intake, APS supervisors review the case at least every 30 days thereafter for the duration of the case.

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 reviewing authority.

Other relevant parties to the investigation are also informed of the investigation results based on the following timelines:
For programs regulated under Residential Care Services (RCS):
• Any substantiated failed practice is communicated through a statement of deficiency to the provider within 10 working days of completion of data collection.
• A complainant is contacted with the results of the investigation upon completion of the investigation. An Investigation Summary Report is mailed to the complainant within 15 working days of the last day of data collection.
• RCS must report to Local Law Enforcement (LLE) immediately (per statute) and the Medicaid Fraud Unit (MCFU) (per policy) whenever there is reason to suspect that criminal mistreatment or criminal neglect has occurred. There are multiple points in time when a referral could be made:
- When onsite and the investigation indicates criminal mistreatment or criminal neglect has occurred
- During the writing of the Statement of Deficiencies (SOD), where managers or staff notice a pattern to the areas of citation that create a picture of criminal neglect.
- During enforcement activities.
• In cases where only RCS is assigned to investigate and new information leads to a need to coordinate the investigation with APS, the investigator will:
- Consult with the RCS Field Manager (FM).
- RCS FM will contact CRU and make a report.
- RCS investigator will collaborate with APS.
• For failed practice that involves a licensed or credentialed professional, and there is reason to suspect professional

standards were violated, the investigator can make a referral to the Department of Health (DOH):
- During the writing of the Statement of Deficiencies (SOD), where managers or staff notice a pattern to the areas of citation that create a picture professional standard violations.
- During enforcement activities.

Licensing and regulatory authorities are notified as follows:

• AAA/HCS case manager/social services specialist/Care Coordinator (operating agency and contracted provider) receive notification via CARE tickler that an APS investigation has been initiated and the finding when the APS investigation is closed. This happens automatically through an interface between the APS Tracking Incidents of Vulnerable Adults 2 (TIVA2) system and CARE. APS coordinates with the AAA/HCS case manager/social service specialist/Care Coordinator throughout the investigation.
• APS sends referrals local law enforcement immediately upon having reason to believe that the incident may be criminal (RCW 74.34.063),
• APS sends referrals to the DOH during intake when it is known that the alleged perpetrator is licensed through RCW 18.130, or other licensing authorities under RCW 18, either at intake or when it is discovered during the course of an investigation.
• APS sends referrals to the Medicaid Fraud Control Unit (MFCU) whenever Medicaid provider fraud is suspected or when resident abuse, neglect, or financial exploitation in residential care facilities receiving Medicaid funds is suspected. This occurs at intake or during the course of an investigation.
• APS sends referrals immediately upon knowledge to the Department of Children, Youth and Families, Child Protective Services, whenever child abuse or neglect is suspected.
• APS sends referrals to RCS if the report contains incidents of provider practice in RCS licensed/certified facilities/programs. In cases where APS and RCS are both involved, coordination/collaboration occurs throughout the course of an investigation.
• APS coordinates/collaborates with federally recognized Tribes when a Tribal member is the subject of an APS investigation. Information is exchanged with the Tribe per the local Memorandum of Understanding with that Tribe, or in compliance with RCW 74.34.095 and RCW 74.34.067(8).

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. The intakes, investigations and protective services performed by APS are continuously monitored at both the state and the regional levels. For example:

1. Regional supervisors and program managers conduct on-going audits of case records in the Quality Assurance Monitoring (QAS) application. Proficiency reports are generated utilizing a statewide database.

2. Regional and headquarter program managers routinely analyze regional data to track, monitor and evaluate implementation of program activities. Reports are generated from a statewide database.

3. Program performance is routinely reported to the Governor (Results Washington).

4. Home and Community Services (HCS) management generate Tracking Incidents for Vulnerable Adults (TIVA) reports to review intakes and investigations by program, type for tracking and trending purposes.

5. Report data is used to develop statewide internal and external training(s) on the recognition and prevention of abuse, neglect and exploitation.

Information and findings are communicated to the Medicaid agency via the quarterly Medicaid Agency Waiver Management Committee.

## 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, environmental), 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.

Clients who choose to self-direct their personal care have the authority to hire and fire at any time providing an additional protection.

○ **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 Care Consultants.

ALTSA 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 participants and review of complaints.

Participants who choose to self-direct their personal care have the authority to hire and dismiss at any time.

○ **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 seclusion.

Required training for all paid caregivers includes clear instructions that any use of seclusion is prohibited. Mandatory training includes detailed information on types of seclusion. Training also includes multiple alternatives to seclusion and instructs the caregiver to consult with others involved in the person's care such as family and Care Consultants.

ALTSA detects use of 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 and through quality assurance activities that may include face-to-face interviews of clients and review of complaints.

Participants who choose to self-direct their personal care have the authority to hire and dismiss at any time.

○ **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:**
**#4 Number and percent of participants that are informed of how to identify and where to report abuse, neglect, and exploitation. N = Number of participants who received information on 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**<br>Confidence Interval =<br>95% Confidence level<br>Margin of error = +/-5% |
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**#5 Number and percent of APS investigations completed within mandatory timeframes. N = Number of APS investigations completed within mandatory timeframes D = Number of APS investigations**

**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**<br>Confidence Interval = |
| ☐ **Other** | ☒ **Annually** | ☐ **Stratified** |

| | | |
|---|---|---|
| Specify: | | Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**#1 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 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** |

| **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**<br>Specify: |

**Performance Measure:**
**#3 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, 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**<br>Confidence Interval =<br>95% Confidence level<br>Margin of error = +/-5% |
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | | |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**#2 Number and percent of critical incidents, by type, where follow-up action was taken, when warranted. N = Number of critical incidents, by type, where action was taken, when warranted D = Number of critical incidents investigated requiring follow-up action**

**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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>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**<br>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):
**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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>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**<br>Confidence Interval =<br>95% Confidence level<br>Margin of error = +/-5% |
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**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:**
**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**<br>Confidence Interval =<br>95%<br>Confidence level<br>Margin of error = +/-5% |
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>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**<br>Specify: |

**Performance Measure:**
**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 at the time of 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**<br>Confidence Interval =<br>95% Confidence level<br>Margin of error = +/-5% |
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | | |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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 (APS), Residential Care Services (RCS), and Children's Protective Services (CPS) for allegations of abuse, neglect, abandonment or exploitation.

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.

APS 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 their own cases; APS supervisor/manager access reports about their 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 Care Consultant documents and addresses health/safety interventions for waiver participants such as: PERS (Personal Emergency Response system), evacuation in an emergency, minimum consultant contacts, 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 participant falls, drug/alcohol assessments, depression screening, caregiver burnout, suicide risk, and other high risk indicators.

HCS/AAA nursing services RNs respond to referrals by Care Consultants based on nursing indicators identified in CARE. Nurses document nursing service activities in CARE and collaborate with Care Consultants 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.

APS reports are reviewed by individuals at each level (investigator, supervisor/manager, 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.

RCW 74.34.300 allows the State to conduct vulnerable adult fatality reviews.

Each HCS/AAA record reviewed during the supervisory and quality assurance review cycle is checked to determine if a mandatory referral to APS should have been made. If appropriate, the HCS/AAA case manager/social service specialist or New Freedom Care Consultant is expected to make necessary corrections. Corrections are verified by either the 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 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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

**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.

The 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 (RSW - #1086), and New Freedom waiver (#0443).

The design of the New Freedom, COPES, and Residential Support waivers are similar in 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 provision of personal care and/or wrap around services that support the delivery of personal care.
b. Participant Safeguards--All three waivers follow the same participant safeguards outlined in this waiver.
c. Quality Management--The information below outlines the ALTSA quality management approach which is the same for all waivers.

The quality management approach is the same across waivers:
a. A methodology for discovering information: The state draws a statistically valid sample of waiver participant records across the three waivers and adds participant records to strategy the sample for individual waivers.
b. The 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 by ALTSA HQ.
c. Process for identifying and analyzing trends/patterns: The QA monitoring application generates reports that allow 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 measures 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 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**<br>Specify:<br>AAA Care Consultant, FMS | ☐ **Other**<br>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:

The QA 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 (COPES WA.0049, New Freedom WA.0443 and Residential Support Waiver WA.1086) operated by the ALTSA. This is based on a 5 % 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 a .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. Results are posted on the ALTSA internet page.

Decisions for action are made based on analysis of the data and determination of priorities. A Headquarters PIP is developed. The PIP may include statewide training initiatives, policy and/or procedural changes and identification of further quality improvement activities/projects.

The State Unit on Aging (SUA) is responsible for oversight of AAA 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 measure the effectiveness of assessment, care planning and interventions and recommends performance improvements.
Adult Protective Services (APS) investigates and makes official findings on any accusations of abuse, abandonment, neglect, self-neglect, or exploitation of a vulnerable adult in any setting. Local and statewide reports are available and reviewed by APS headquarters managers and field managers.

AAA and HCS 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 to ensure 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 (PIPs).

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: Health Care Authority (HCA), the Developmental Disabilities Administration (DDA)and ALTSA. The committee meets at least quarterly to review all functions delegated to the operating agency, current QA 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 PIP, 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.

Financial Management Services (FMS) complete internal monitoring and quality control procedures for all participants. The ALTSA QA team reviews FMS tracking of participant enrollment, budgets, timely completion of authorization for services, participant contacts, and access to waiver goods and services. FMS also provide complaint/Grievance summary report and annual satisfaction survey summaries directed to participants’, and other vendors.

ALTSA HQ New Freedom Program Manager is responsible for oversight of FMS operations including implementation and compliance with contract requirements, state and federal laws and regulations, policies and procedures; approval and oversight of fee for service rates, billing for services provided, and review of utilization reports.

ALTSA monitors AAA to verify that Care Consultants are:
• Assisting the participant to develop a PCSP that identifies a range of services/goods that will provide them the level of support and flexibility they desire within their budget resources
• Making contact with the participant at least quarterly to make any changes that may be needed to the PCSP
• Completing a new functional assessment when there is an identified significant change with the participant care needs that would warrant a reassessment in CARE or when budget changes occur
• Assisting and training participants, as requested, in recruiting, screening, hiring, training, scheduling, communicating expectations, and monitoring IP work functions
• Responding to complaints received from a constituent. ALTSA is notified if a complaint cannot be resolved or is reoccurring
• Reviewing and responding to Quality Assurance tracking reports that include the number of days from authorization/enrollment (service begin date) to completion of the PCSP, and receipt of care services

• Developing and implementing an internal quality assurance plan
ALTSA monitors FMS to verify that FMS is:
• Managing all financial and contract matters on behalf of the participant
• Executing and managing contracts with qualified waiver providers
• Establishing payment processes associated with the PCSP
• Developing policies and procedures that address the philosophy of participant directed services.
• Providing individual service budget reports quarterly to Participants

The consolidated evidence report will be submitted to CMS in WY3 (WY4 for COPES and RS). In New Freedom WY4 an evidence report will be submitted that includes evidence for any assurances not met in the consolidated report; the individual activities in instances of abuse, neglect, and/or exploitation related to NF specifically; and a reporting of all of the performance measures unique to New Freedom.
The performance measures (PM) that are unique to the NF waiver include:
C. a. #1 Number and percent of individual providers (IPs) who meet certification requirements initially, as delegated by the State Medicaid Agency.
N = Number of IPs who require certification that met certification requirements initially
D = Number of initial IP records reviewed, that require certification

#2 Number and percent of individual providers (IPs) that continue to meet certification requirements, as delegated by the SMA
N = Number of IPs that require certification and continue to meet certification requirements
D = Number of IP records reviewed that continue to require certification

#3 Number and percent of home care agency providers that meet licensing requirements prior to furnishing services, as delegated by the State Medicaid Agency N = Number of home care agency providers that meet licensing requirements prior to furnishing services D = Number of home care agencies with initial contracts

#4 Number and percent of home care agency (HCA) providers that continue to meet licensing requirements at time of contract renewal, as delegated by the SMA N = Number of home care agency providers that meet licensing requirements at the time of contract renewal D = Number of home care agency providers that had contracts renewed
C. b. Number and percent of non-licensed/non-certified individual providers (IPs) that meet waiver requirements prior to providing waiver services, as delegated by the SMA. N = Number of contracted IPs that meet all waiver requirements D = Number of IP records reviewed
C. c. #1 Number and percent of home care agency providers that meet training requirements, as delegated by the SMA N = Number of home care agency providers that meet training requirements, as delegated by the State Medicaid Agency D = Number of home care agency providers
#2 Number and percent of individual providers (IPs) providing services that meet training requirements, as delegated by the SMA. N = IPs that meet training requirements D = IPs provider files reviewed

**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).*

*Methods to ensure integrity of payments, including (a) requirements concerning the independent audit of provider agencies:*

*Home Care Agencies 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.*

*The CDE is required to have an annual independent financial audit and provide the results to the state.*

*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.*

*The FMS obtains an annual independent audit.*

*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:*

*Records retained by the FMS provide the necessary documentation to ensure the integrity of payment made for waiver services. The case records at the case management entity contain the participant's eligibility documents, spending plan and other information regarding the participant's needs. The FMS agency is required to maintain documentation that the provider qualifications have been verified and that expenditures are in accordance with the spending plan. Source documentation is required for all expenditures, along with monthly accounting of expenditures and monthly accounting of participant account balances. The documentation must be maintained a minimum of five years from the claim date and must be available for audit or review upon request.*

*Several audits of these records are conducted to ensure the integrity of provider billings:*

*The ALTSA QA team annual review includes:*

*A statistically valid sample from the total population of individuals on all 1915c waivers (New Freedom, COPES, and the RSW) operated by ALTSA, to determine whether ALTSA only paid for services which the participant agreed to, for which no other funding sources were available, whether the services were allowable, and paid to a qualified provider. This sample 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).*

*This review ensures the rate paid for the goods and services was the amount negotiated and authorized by the participant:*
*• All records for participants who died to determine whether payment authorizations were terminated appropriately.*

*Included in the annual review, the Quality Assurance Unit completes a review of the FMS vendor for participants on this waiver.*

*In addition, the QA unit completes a quarterly review of New Freedom participant accounts in the FMS, and this includes 100% of the participant accounts.*

*The ALTSA State Unit on Aging reviews:*
*ALTSA program staff complete a monthly reconciliation review of the per member/per month invoice from the vendor compared to the caseload report to ensure the integrity of the payment to the FMS vendor. If an error is identified, the vendor will return a corrected invoice prior to ALTSA making payment to the FMS vendor.*

*Annually, the New Freedom Program Manager monitors the FMS vendor contract to ensure contract compliance. The monitoring activities include of review of FMS vendor contracts to ensure compliance with required qualifications.*

*All AAA's receive an onsite financial review based on a three (3) year cycle in which all 13 AAA's are monitored. The order AAAs are monitored is based on an annual risk assessment process. In addition, fiscal staff review and approve AAA*

*budgets, review all invoices monthly, and review results of the State Auditor's Office audits annually.*

*AAA's are responsible for contract monitoring of agency personal care providers. The AAA is required to complete a risk assessment on the agency provider which determines the type and frequency of the monitoring conducted. Types of reviews include:*
*• On-site comprehensive review: used when the risk is high, at provider's location and examines financial and programmatic records and allows direct observation of operations.*
*• Focused review: used when the risk level is moderate. Does not require on-site review. Intended to detect and address issues and establish follow-up.*
*• Desk review: used when risk is low, a review of financial records and performance reports*

*ALTSA's oversight of reviews by the AAA:*

*All home care agency personal care provider monitoring reports must be sent to ALTSA.*

*Care Consultant review of waiver services:*
*To ensure participants do not over-pay services, an invoice or quote must always be submitted to the Care Consultant prior to service authorization. In addition, this ensures that all waiver payments are represented in the client-centered care plan prior to purchase. The negotiated rate per service is reviewed between the care consultant and the participant prior to requesting purchases and compared against the overall budget to ensure budget is allocated appropriately. The Care Consultant confirms with the participant that the item was received.*

*Payment Review Program:*

*DSHS launched the Payment Review Program in 1999 to employ new technology to assist with the regular DSHS review of Medicaid billings for accuracy. The focus of the Payment Review Program is to identify and prevent billing and payment errors. Originally, PRP only looked at claims through the MMIS. The Health Care Authority continues to run the PRP after moving out of DSHS and still includes DSHS social service payments. PRP employs algorithms to detect patterns and occurrences that may indicate problem billings. The PRP uses an extensive internal algorithm development and review process. To keep providers informed about finalized algorithms, the Payment Review Program has posted the algorithm descriptions on the HCA Internet site. Teams of HCA, ALTSA, and DDA clinical, program and policy experts rigorously review all data analysis results from PRP reports to ensure accuracy.*

*The Payment Review program pulls two separate reports that identify 100% of waiver participants who either had an HCBS claim while a participant was in an institution (nursing facility or hospital) or where there were claims after the participant died.*

*ALTSA and the Health Care Authority conduct a Medicaid services verification survey monthly to confirm with the participant whether they received the personal care hours, goods, and/or services for which the department paid. To ensure a valid sample, HCA sends 300 ALTSA surveys monthly. ALTSA QA staff follow-up on all responses in which a participant states they did not receive a service.*

*c) the agency responsible for conducting financial audits.*

*ALTSA is responsible for conducting the financial reviews and program integrity. 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.*

## *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***<br>*Confidence Interval =*<br>*95% Confidence level*<br>*Margin of error = +/-5%* |
| ☐ ***Other***<br>*Specify:* | ☒ ***Annually*** | ☐ ***Stratified***<br>*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:***
***#6 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 claims 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***<br>*Confidence Interval =*<br>*95% Confidence level*<br>*Margin of error = +/-5%* |
| ☐ ***Other***<br>*Specify:* | ☒ ***Annually*** | ☐ ***Stratified***<br>*Describe Group:* |
| | ☐ ***Continuously and Ongoing*** | ☐ ***Other***<br>*Specify:* |
| | ☐ ***Other***<br>*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***<br>*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***<br>*Specify:* |

***Performance Measure:***
***#1 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***<br>*Confidence Interval =* |
| ☐ ***Other***<br>*Specify:* | ☒ ***Annually*** | ☐ ***Stratified***<br>*Describe Group:* |
| | ☐ ***Continuously and Ongoing*** | ☐ ***Other***<br>*Specify:* |
| | ☐ ***Other***<br>*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***<br>*Specify:* | ☒ ***Annually*** |
| | ☐ ***Continuously and Ongoing*** |
| | ☐ ***Other***<br>*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***<br>*Confidence Interval =* |

| | | |
|---|---|---|
| | | *95% Confidence level Margin of error = +/-5%* |
| ☐ ***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 Number and percent of paid claims with proper supporting documentation to support***

***the services rendered. N = Number of claims with documentation to support services rendered 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***<br>*Confidence Interval =*<br>*95% Confidence level*<br>*Margin of error = +/-5%* |
| ☐ ***Other***<br>*Specify:* | ☒ ***Annually*** | ☐ ***Stratified***<br>*Describe Group:* |
| | ☐ ***Continuously and Ongoing*** | ☐ ***Other***<br>*Specify:* |
| | ☐ ***Other***<br>*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***<br>*Specify:* | ☒ ***Annually*** |
| | ☐ ***Continuously and Ongoing*** |
| | ☐ ***Other***<br>*Specify:* |

***Performance Measure:***
***#5 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, 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***<br>*Confidence Interval =*<br>*95% Confidence level*<br>*Margin of error = +/-5%* |
| ☐ ***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:* |

***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:***
***Number and percent of claims paid at the published rate N = Number of paid claims at the published rate 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 =* |
| ☐ ***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***<br>*Specify:* | ☒ ***Annually*** |
| | ☐ ***Continuously and Ongoing*** |
| | ☐ ***Other***<br>*Specify:* |

***Performance Measure:***
***Number and percent of claims paid at the rate specified in the waiver application. N = Number of claims paid at the published rate 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***<br>*Confidence Interval =*<br>*95% Confidence level*<br>*Margin of error = +/- 5%* |
| ☐ ***Other***<br>*Specify:* | ☒ ***Annually*** | ☐ ***Stratified***<br>*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.*

*Billings and payments to the FMS are reviewed regularly. Monthly enrollment lists are reconciled against monthly budget authorizations for each enrolled participant. Discrepancies between enrollment lists and budget authorizations are reviewed individually by the New Freedom program manager. Payment to the FMS is not made by the Department until any discrepancies have been reconciled. Payment adjustments are documented in the Department's Agency Financial Reporting System (AFRS).*

***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.*

*Billings and payments to the FMS are reviewed regularly. Monthly enrollment lists are reconciled against monthly budget authorizations for each enrolled participant. Discrepancies between enrollment lists and budget authorizations are reviewed individually by the New Freedom program manager. Payment to the FMS is not made by the Department until any discrepancies have been reconciled. Payment adjustments are documented in the Department's Agency Financial Reporting System (AFRS).*

***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***<br>*Specify:* | ☒ ***Annually*** |
| | ☐ ***Continuously and Ongoing*** |
| | ☐ ***Other***<br>*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 Washington State Legislature determines the rates for the following providers:*
*- CDE of personal care providers*
*- Transportation provided by Individual Providers of personal care*
*- Adult Day services*
*- Home Care Agencies*
*- Nurse Delegators*
*- Skilled Nursing providers*
*- Food Service Vendors (Home Delivered Meals)*
*- Personal Emergency Response System (PERS)*

*The waiver participant determines the rates for the following:*
*- Individual Entrepreneurs*
*- Transportation*
*- Veterinarians*
*- Health Care Providers*
*- Community Colleges*
*- Licensed Health Practitioner*
*- Environmental and Vehicle Modifications*
*- Other service that may be accessed through Individual Directed Goods, Services, and Supports*
*- Community Service Vendor*

*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.*

*Individual Providers of the CDE and Home Care Agency Providers:*
*Personal care rates are based on a per hour unit and is determined by a rate setting board and approved by the State legislature. The rate includes wages, L & I, vacation pay, mileage reimbursement, comprehensive medical, training, and seniority pay. For individual providers who have completed the home care aide certification, the hourly rate also includes a certification differential payment. Due to the agency parity law [RCW 74.39A.310(1)(a)(v)] the home care agency vendor rates are equivalent to that of the individual provider rate.*

*The rate methodology for IP mileage is based upon the IRS mileage rate.*

*Individual providers working prior to the full CDE implementation:*
*RCW 41.56.026 establishes collective bargaining rights for individual providers of personal care. The rate for personal care provided by individual providers is based on a per hour unit and is determined by the State legislature, based on negotiations between the Governor's Office and the union representing Individual Providers. The collective bargaining agreement is negotiated every two years and is subject to funding by the state legislature. If changes are made within the bargaining agreement that affect the rate methodology, a waiver amendment will be submitted.*

*Adult Day Services rates:*
*Adult Day Health providers are reimbursed at 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://www.dshs.wa.gov/altsa/management-services-division/office-rates-management. 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.*

*Two rates were then developed for King County and Metropolitan Areas. Payment will not exceed the prevailing charges in the locality for comparable services under comparable conditions. Since the initial rate development, the daily rates have been changed by an overall percentage each time the legislature mandates a change.*

*Rates for Nurse Delegators and Skilled Nursing services are set by legislative appropriation. Rate adjustments must be approved by the legislature and included in the enacted state budget.*

*AAAs negotiate rates within the range published by ALTSA for Food Service Vendors (Home Delivered Meals) 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 may include periodic market surveys, cost analysis and price comparison. These procedures are followed when rate adjustments are made.*

*Individual Entrepreneurs, Transportation (other than provided by an Individual personal care provider), Veterinarians, Health Care Providers, Community Colleges, Licensed Health Practitioner, Community Vendor, Environmental and Vehicle Modifications, services within Individual Directed Goods, Services and Supports:*
*New Freedom is a self-directed and budget-based waiver which enables participants to manage their services within their allocated budget and to select providers best able to address their assessed needs. Participants have the ability to do comparison shopping and select the provider based on rate and other factors that are important to the participant such as location, references, specialized expertise, and ease of access. Participants either negotiate an agreed upon contractual rate or accept the customary rate charged by the provider. Payment will not exceed the prevailing charges in the locality for comparable services under comparable conditions.*

*OPPORTUNITY FOR PUBLIC COMMENT IN THE RATE DETERMINATION PROCESS:*
*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.*

*Public notice of the waiver amendment was filed in the State Register on 5/28/2024. Individuals were able to submit comments by email, mail, or telephone. The State Register notice was available 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.*

*In addition, the Notice of draft amendment and review period was posted on ALTSA's internet site: https://www.dshs.wa.gov/altsa/hcbs-new-freedom-draft-waiver-amendment*

*No public comments or questions were received based upon any of these actions. Therefore, no related modifications were made to the renewal.*

*CHANGES TO RATES:*
*Personal Care Providers:*
*The rate setting board reviews the rates every two years for personal care providers of the Consumer Directed Employer.*

*Agency Providers:*
*Due to the agency parity law [RCW 74.39A.310(1)(a)(v)] the home care agency vendor rates are equivalent to that of personal care providers through the CDE.*

*Adult Day Services, Nurse Delegators, Skilled Nursing providers, Food Service Vendors (Home Delivered Meals):*
*Rate changes (both increases and decreases) to these services are determined through legislative action and appropriation. Data and information is provided to the legislature upon request by Management Services Division.*

*Individual Entrepreneurs, Transportation (other than provided by an Individual personal care provider), Veterinarians, Health Care Providers, Community Colleges, Licensed Health Practitioner, Environmental and Vehicle Modification vendor, Individual Directed Goods, Services and Supports:*
*New Freedom is a self-directed and budget-based waiver which enables participants to manage their services within their allocated budget and to select providers best able to address their assessed needs. Participants have the ability to do comparison shopping and select the provider based on rate and other factors that are important to the participant such as location, references, specialized expertise, and ease of access. When a provider changes the rates they charge, participants either re-negotiate an agreed upon contractual rate, agree to the rate change or seek a different provider best suited to their needs and budget allocation for that service.*

*ADDITIONAL RATE INFORMATION:*
*All rate changes will be made consistent with the methodology described in this section.*
*Rates for personal care providers of the CDE, Individual providers working prior to the full CDE implementation, transportation provided by personal care providers of the CDE, Adult Day services, Home Care Agencies, Nurse Delegators, Skilled Nursing providers, Food Service Vendors (Home Delivered Meals) 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, and can be found at: https://www.dshs.wa.gov/altsa/management-services-division/office-rates-management*

*Rate changes are determined through legislative action and appropriation. Rates may be reviewed annually during the 5-year period or sooner if rates are not sufficient to meet economy, efficiency, or quality of care to enlist enough providers.*

*Any service rate 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.*

*Waiver participants are informed by the Care Consultant about all payment rates prior to authorizing service expenditures. In addition, rates for Individual Providers and Agency Providers of personal care are publicly available on the ALTSA internet web site.*

*The participant's individual budget is based on the CARE classification assigned to the client through the assessment process. The budget limit for assessment classification is determined by ALTSA. Participants are able to submit an exception to rule request via the care consultant if they need additional funds to address their assessed needs.*

***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:*

*Payments for waiver services are processed by the fiscal management agency with the exception of personal care services. The participant data is associated with the provider name, provider payment identification number, waiver service begin and end dates, rates and authorization information that is based on the client's spending plan. The FMS agency is reimbursed for waiver services using the state's MMIS.*

*Payments for all personal care providers are authorized and processed by DSHS/AAA staff using the State's MMIS. The payment system maintains data associated with the participant and their personal care provider including names, identifying number, service begin/end dates, unit rate, amount paid, date paid, and service name.*

*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:*

*Payment for services identified in the spending plan will be authorized when the following are satisfied:*
*1. Categorical relatedness and financial eligibility are approved.*
*2. The participant is eligible for nursing facility level of care and is, or likely to be institutionalized.*
*3. The individual spending plan has been signed by the participant and consultant.*
*4. The service provider is qualified.*
*5. The participant verifies that service was provided.*

*EVV is not part of the pre-payment review 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:*

*(a) The waiver services that are not paid through an approved MMIS system:*

*The Medicaid agency has the ability to make payments directly to the provider. This waiver uses an FMS agency for payment to all service providers listed in this waiver, other than personal care providers.*

*(b) The process of making such payments and the entity that processes payments:*

*When items or services are identified in participant's care plan, and the participant decides they need an item or service, an invoice or quote is turned in to care consultant who reviews the invoice/quote and supporting documentation and approves the item in the FMS portal. The FMS generates a purchase request form (PRF) that is signed by the participant and goes to the vendor. The FMS will then process the request and purchase the item request and record the information to the correct waiver category. The FMS is responsible for developing contracts with vendors and processing payments in the MMIS. Payments are not made until the participant verifies the service was provided.*

*(c) how the audit trail is maintained for all state and federal funds outside of the MMIS:*

*The FMS agency is paid through the MMIS system for all authorizations made to service providers, which provides a direct link between the MMIS system and claiming FFP.*

*Billings and payments to the FMS are reviewed regularly by the New Freedom. Monthly enrollment lists are reconciled against monthly budget authorizations for each enrolled participant. Discrepancies between enrollment lists and budget authorizations are reviewed individually by the New Freedom program manager. Payment to the FMS is not made by the Department until any discrepancies have been reconciled. Payment adjustments are documented in the Department's Agency Financial Reporting System (AFRS).*

*Annually, the Quality Assurance unit completes a review of the FMS for clients on this waiver.*

*(d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64*

*The client must meet functional and financial eligibility for services, and the need must be documented in the plan. The FMS vendor will not make payment to any waiver provider until all components outlined above have been completed. The FMS billings and payments are reviewed regularly to ensure the funding is attributed to the correct reporting 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:*

*The contracted Financial Management Services agency is a limited fiscal agent and makes payments directly to providers of each waiver service with the exception of personal care provided by personal care providers employed by the CDE or home care agency providers paid under Personal Assistance Services. This includes services paid under the following waiver services:*
*- Individual Directed Goods, Services and Services*
*- Environmental and Vehicle Modifications*
*- Training and Educational Supports*
*- Treatment and Health Maintenance*

*Payments for personal care providers are authorized and processed by DSHS/AAA staff using the State's payment system. The payment system maintains data associated with the participant and their personal care provider including names, identifying number, service begin/end dates, unit rate, amount paid, date paid, and service name.*

*Functions the FMS performs in paying waiver services:*
*The FMS is responsible for developing contracts with vendors, implementing efficient and timely consumer directed payment systems and facilitating payment for labor, services and other items needed by participants as identified in the PCSP.*

*Methods to oversee the operations of the FMS:*

*ALTSA Headquarters staff review billings and payments to the FMS regularly. Monthly enrollment lists are reconciled against monthly budget authorizations for each enrolled participant. Discrepancies between enrollment lists and budget authorizations are reviewed individually by the New Freedom program manager. Payment to the FMS is not made by the Department until any discrepancies have been reconciled. Payment adjustments are documented in the Department's Agency Financial Reporting System (AFRS).*

*ALTSA QA team is responsible for oversight of FMS operations including implementation and compliance with contract requirements, state and federal laws and regulations, policies and procedures; approval and oversight of fee for service rates, billing for services provided, review of remediation (corrective action) plans; and review of utilization reports submitted by the FMS.*

*ALTSA monitors FMS to verify that FMS is:*
*- Managing all financial and contract matters on behalf of the participant.*
*- Executing and managing contracts with qualified waiver providers.*
*- Establishing payment processes associated with the PCSP.*
*- Developing policies and procedures that address the philosophy of participant directed services.*
*- Providing individual service budget reports monthly to care consultants and quarterly to participants.*
*- Ensuring access to the online web portal for Care Consultants.*

*Information on becoming a contracted Medicaid provider and billing the operating agency directly is available through the local Area Agency on Aging.*

☐ ***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:*

*Community Colleges are used for Training and Educational Supports*

## 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:*

- ○ ***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:*

## *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 | 29591.29 | 14728.85 | 44320.14 | 46830.29 | 10605.98 | 57436.27 | 13116.13 |
| 2 | 30806.93 | 17232.75 | 48039.68 | 52918.23 | 12302.93 | 65221.16 | 17181.48 |
| 3 | 32131.50 | 20162.32 | 52293.82 | 59797.60 | 14271.40 | 74069.00 | 21775.18 |
| 4 | 33485.24 | 23589.92 | 57075.16 | 67571.28 | 16554.83 | 84126.11 | 27050.95 |
| 5 | 35045.18 | 27600.20 | 62645.38 | 76355.55 | 19203.60 | 95559.15 | 32913.77 |

## 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* | *675* | *675* |
| *Year 2* | *675* | *675* |
| *Year 3* | *675* | *675* |
| *Year 4* | *675* | *675* |
| *Year 5* | *675* | *675* |

## *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 computed by summing the total enrolled days for participants receiving any waiver service and then dividing by the number of unduplicated participants. Using the 372 Reports, the state added the average length of stay for the last three (3) years per 372 Reports (1/1/2020 - 12/31/2020, 1/1/2021 - 12/31/2021, and 1/1/2022 - 12/31/2022) and divided by three (3).*

## *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:*

*Factor D :*
*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 1/1/2019 – 12/31/2019 through WY 1/1/2022-12/31/2022.*

*The unduplicated participant count is based on the WY5 (1/1/2024 – 12/31/2024) unduplicated participant estimate was used for WY1 (1/1/2025 – 12/31/2025), because there cannot be a reduction of participants per the MOE requirements.*

*The state used WY3 372 Report (1/1/2022 - 12/31/2022), 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 17% growth in medical expenses, based on the data from 372 Reports for WY 1/1/2019-12/31/2019 through WY 1/1/2022-12/31/2022. The state applied a 17% growth annually from WY3 of the previous waiver year to the next years to establish WY1 estimates. An 17% growth was applied each year thereafter.*

*The state used WY3 372 Report (1/1/2022 - 12/31/2022), 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.*

*Factor D' was calculated with the following methodology:*
*Factor D' for WY5 (1/1/2019-12/31/2019) is $5,911.71.*
*Factor D' for WY1 (1/1/2020-12/31/2020) is $5,421.58.*
*Factor D' for WY2 (1/1/2021-12/31/2021) is $7,065.82.*
*Factor D' for WY3 (1/1/2022-12/31/2022) is $9,196.26.*

*The increase from WY5 (1/1/2019-12/31/2019) to WY1 (1/1/2020-12/31/2020) is -8.3%.*
*The increase from WY1(1/1/2020-12/31/2020) to WY2 (1/1/2021-12/31/2021) is 30.3%.*
*The increase from WY2 (1/1/2021-12/31/2021) to WY3 (1/1/2022-12/31/2022) is 30.1%.*

*-8.3% + 30.3% + 30.1% = 52.1%*

*52.1%/3 = 17.4% average growth rate*

*The state rounded to 17%, for a 17% growth rate to trend forward. The renewal application has been updated to reflect D' trending forward with a 17% growth rate.*

***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 13% growth in nursing facility services costs. The 13% growth was determined by taking the average Factor G from the 372 reports for WY 1/1/2019-12/31/2019 through WY 1/1/2022-12/31/2022. A 13% growth was applied to WYs 3-5 to determine the WY 1 Factor G.*

*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 a 13% average growth in medical expenses, based on the data from 372 Reports for WY 1/1/2019-12/31/2019 through WY 1/1/2022-12/31/2022. The state applied a 13% growth annually from WY3 of the previous waiver year to the next years to establish WY1 estimates. A 13% growth was applied each year thereafter.*

*The state's derivations of Factors G and G' are utilizing actual paid claims data.*

*Factor G' was calculated with the following methodology:*
*Factor G' for WY5 (1/1/2019-12/31/2019) is $4,378.15.*
*Factor G' for WY1 (1/1/2020-12/31/2020) is $5,543.69.*
*Factor G' for WY2 (1/1/2021-12/31/2021) is $5,946.50*
*Factor G' for WY3 (1/1/2022-12/31/2022) is $6,794.80.*

*The increase from WY5 (1/1/2019-12/31/2019) to WY1 (1/1/2020-12/31/2020) is 26.6%.*
*The increase from WY1(1/1/2020-12/31/2020) to WY2 (1/1/2021-12/31/2021) is 7.3%.*
*The increase from WY2 (1/1/2021-12/31/2021) to WY3 (1/1/2022-12/31/2022) is 14.3%.*

*26.6% + 7.3% + 14.3% = 48.2%*

*48.2%/3 = 16.1% average growth rate*

*The state rounded this down to 16%, for a 16% growth rate to trend forward.*

## *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* | |
|---|---|
| *Personal Assistance Services (PAS)* | |
| *Environmental and Vehicle Modifications* | |
| *Individual Directed Goods, Services and Supports* | |
| *Training and Educational Supports* | |
| *Treatment and Health Maintenance* | |

## *Appendix J: Cost Neutrality Demonstration*

### *J-2: Derivation of Estimates (5 of 9)*

***d. Estimate of Factor D.***

***ii. Concurrent section 1915(b)/section 1915(c) waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).*** *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. If applicable, check the capitation box next to that service. 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 | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| **Personal Assistance Services (PAS) Total:** | | | | | | | **18369226.20** |
| Personal Assistance Services (PAS) | ☐ | hour | 445 | 1126.00 | 36.66 | **18369226.20** | |
| **Environmental and Vehicle Modifications Total:** | | | | | | | **90748.00** |
| Environmental and Vehicle Modifications | ☐ | Job | 14 | 1.40 | 4630.00 | **90748.00** | |
| **Individual Directed Goods, Services and Supports Total:** | | | | | | | **919555.20** |
| Individual Directed Goods, Services and Supports | ☐ | each | 288 | 15.00 | 212.86 | **919555.20** | |
| **Training and Educational Supports Total:** | | | | | | | **15044.70** |
| Training and Educational Supports | ☐ | each | 11 | 3.00 | 455.90 | **15044.70** | |
| **Treatment and Health Maintenance Total:** | | | | | | | **579546.24** |
| Treatment and Health Maintenance | ☐ | each | 217 | 13.00 | 205.44 | **579546.24** | |

| | |
|---|---|
| **GRAND TOTAL:** | **19974120.34** |
| Total: Services included in capitation: | |
| Total: Services not included in capitation: | 19974120.34 |
| **Total Estimated Unduplicated Participants:** | **675** |
| **Factor D (Divide total by number of participants):** | **29591.29** |
| Services included in capitation: | |
| Services not included in capitation: | 29591.29 |
| **Average Length of Stay on the Waiver:** | 189 |

# *Appendix J: Cost Neutrality Demonstration*

## *J-2: Derivation of Estimates (6 of 9)*

***d. Estimate of Factor D.***

***ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.*** *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. If applicable, check the capitation box next to that service. 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 | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| **Personal Assistance Services (PAS) Total:** | | | | | | | **19112251.08** |
| Personal Assistance Services (PAS) | ☐ | hour | 463 | 1126.00 | 36.66 | **19112251.08** | |
| **Environmental and Vehicle Modifications Total:** | | | | | | | **90748.00** |
| Environmental and Vehicle Modifications | ☐ | job | 14 | 1.40 | 4630.00 | **90748.00** | |
| **Individual Directed Goods, Services and Supports Total:** | | | | | | | **977027.40** |
| Individual Directed Goods, Services and Supports | ☐ | each | 306 | 15.00 | 212.86 | **977027.40** | |
| **Training and Educational Supports Total:** | | | | | | | **16412.40** |
| Training and Educational Supports | ☐ | each | 12 | 3.00 | 455.90 | **16412.40** | |
| **Treatment and Health Maintenance Total:** | | | | | | | **598241.28** |
| Treatment and Health Maintenance | ☐ | each | 224 | 13.00 | 205.44 | **598241.28** | |

| | |
|---|---|
| **GRAND TOTAL:** | **20794680.16** |
| Total: Services included in capitation: | |
| Total: Services not included in capitation: | 20794680.16 |
| **Total Estimated Unduplicated Participants:** | **675** |
| **Factor D (Divide total by number of participants):** | **30806.93** |
| Services included in capitation: | |
| Services not included in capitation: | 30806.93 |
| **Average Length of Stay on the Waiver:** | 189 |

## *Appendix J: Cost Neutrality Demonstration*

### *J-2: Derivation of Estimates (7 of 9)*

***d. Estimate of Factor D.***

***ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.*** *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. If applicable, check the capitation box next to that service. 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 | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| **Personal Assistance Services (PAS) Total:** | | | | | | | **19855275.96** |
| Personal Assistance Services (PAS) | ☐ | hour | 481 | 1126.00 | 36.66 | **19855275.96** | |
| **Environmental and Vehicle Modifications Total:** | | | | | | | **90748.00** |
| Environmental and Vehicle Modifications | ☐ | job | 14 | 1.40 | 4630.00 | **90748.00** | |
| **Individual Directed Goods, Services and Supports Total:** | | | | | | | **1103466.24** |
| Individual Directed Goods, Services and Supports | ☐ | each | 324 | 16.00 | 212.86 | **1103466.24** | |
| **Training and Educational Supports Total:** | | | | | | | **22339.10** |
| Training and Educational Supports | ☐ | each | 14 | 3.50 | 455.90 | **22339.10** | |
| **Treatment and Health Maintenance Total:** | | | | | | | **616936.32** |
| Treatment and Health Maintenance | ☐ | each | 231 | 13.00 | 205.44 | **616936.32** | |

| | |
|---|---|
| **GRAND TOTAL:** | **21688765.62** |
| Total: Services included in capitation: | |
| Total: Services not included in capitation: | 21688765.62 |
| **Total Estimated Unduplicated Participants:** | **675** |
| **Factor D (Divide total by number of participants):** | **32131.50** |
| Services included in capitation: | |
| Services not included in capitation: | 32131.50 |
| **Average Length of Stay on the Waiver:** | 189 |

## *Appendix J: Cost Neutrality Demonstration*

### *J-2: Derivation of Estimates (8 of 9)*

***d. Estimate of Factor D.***

***ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.*** *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. If applicable, check the capitation box next to that service. 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 | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| **Personal Assistance Services (PAS) Total:** | | | | | | | **20680859.16** |
| Personal Assistance Services (PAS) | ☐ | hour | 501 | 1126.00 | 36.66 | **20680859.16** | |
| **Environmental and Vehicle Modifications Total:** | | | | | | | **90748.00** |
| Environmental and Vehicle Modifications | ☐ | job | 14 | 1.40 | 4630.00 | **90748.00** | |
| **Individual Directed Goods, Services and Supports Total:** | | | | | | | **1168175.68** |
| Individual Directed Goods, Services and Supports | ☐ | each | 343 | 16.00 | 212.86 | **1168175.68** | |
| **Training and Educational Supports Total:** | | | | | | | **27126.05** |
| Training and Educational Supports | ☐ | each | 17 | 3.50 | 455.90 | **27126.05** | |
| **Treatment and Health Maintenance Total:** | | | | | | | **635631.36** |
| Treatment and Health Maintenance | ☐ | each | 238 | 13.00 | 205.44 | **635631.36** | |

| | |
|---|---|
| **GRAND TOTAL:** | **22602540.25** |
| Total: Services included in capitation: | |
| Total: Services not included in capitation: | 22602540.25 |
| **Total Estimated Unduplicated Participants:** | **675** |
| **Factor D (Divide total by number of participants):** | **33485.24** |
| Services included in capitation: | |
| Services not included in capitation: | 33485.24 |
| **Average Length of Stay on the Waiver:** | 189 |

# *Appendix J: Cost Neutrality Demonstration*

## *J-2: Derivation of Estimates (9 of 9)*

***d. Estimate of Factor D.***

***ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.*** *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. If applicable, check the capitation box next to that service. 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 | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| **Personal Assistance Services (PAS) Total:** | | | | | | | **21506442.36** |
| Personal Assistance Services (PAS) | ☐ | hour | 521 | 1126.00 | 36.66 | **21506442.36** | |
| **Environmental and Vehicle Modifications Total:** | | | | | | | **90748.00** |
| Environmental and Vehicle Modifications | ☐ | job | 14 | 1.40 | 4630.00 | **90748.00** | |
| **Individual Directed Goods, Services and Supports Total:** | | | | | | | **1317177.68** |
| Individual Directed Goods, Services and Supports | ☐ | each | 364 | 17.00 | 212.86 | **1317177.68** | |
| **Training and Educational Supports Total:** | | | | | | | **36472.00** |
| Training and Educational Supports | ☐ | each | 20 | 4.00 | 455.90 | **36472.00** | |
| **Treatment and Health Maintenance Total:** | | | | | | | **704659.20** |
| Treatment and Health Maintenance | ☐ | each | 245 | 14.00 | 205.44 | **704659.20** | |

| | |
|---|---|
| **GRAND TOTAL:** | **23655499.24** |
| Total: Services included in capitation: | |
| Total: Services not included in capitation: | 23655499.24 |
| **Total Estimated Unduplicated Participants:** | **675** |
| **Factor D (Divide total by number of participants):** | **35045.18** |
| Services included in capitation: | |
| Services not included in capitation: | 35045.18 |
| **Average Length of Stay on the Waiver:** | 189 |