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

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers 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 a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

The RSW waiver renewal will make the following changes:

Revisions and updates to several performance measures
Addition of new provider type for Client training & Wellness Education
Remove the reserve capacity
Increase in capacity
Addition of Institutes for Mental Disease (IMD) and Inpatient Behavioral Health Agencies to eligible locations ALTSA will pay for retainer payments

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 §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*):

Residential Support Waiver

C. Type of Request: renewal

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**

Draft ID: **WA.027.02.00**

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

Regular Waiver

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

01/01/24

PRA Disclosure Statement

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

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

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

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

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 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 §1915(a)(1)(a) of the Act and described in Appendix I**
- ☐ **Waiver(s) authorized under §1915(b) of the Act.**

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

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

- ☐ **§1915(b)(1) (mandated enrollment to managed care)**
- ☐ **§1915(b)(2) (central broker)**
- ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
- ☐ **§1915(b)(4) (selective contracting/limit number of providers)**

- ☐ **A program operated under §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 §1915(i) of the Act.**
- ☐ **A program authorized under §1915(j) of the Act.**
- ☐ **A program authorized under §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, the Residential Support Waiver provides supports and services in licensed community residential settings to adults who are eligible for nursing facility level of care and have the need for enhanced residential services. Supports and services include behavioral supports, personal care assistance, and additional supports related to mental health disorders, chemical dependency disorders, traumatic brain injuries and/or cognitive impairments.

The waiver is operated by the State Department of Social and Health Services (DSHS) through the Aging and Long-Term Support Administration (ALTSA). The State determines financial and functional eligibility for services. Residential case management is provided by ALTSA local Home and Community Services (HCS) offices.

The goal of the waiver is to provide residential supports and other services needed by participants to successfully live in the community.

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

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

◉ **Not Applicable**

○ **No**

○ **Yes**

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

◉ **No**

○ **Yes**

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

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §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 5/5/2023.

Public notice of the waiver amendment was filed in the State Register on 5/30/2023. 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 renewal and review period was posted on ALTSA's internet site on 5/30/2023 announcing public review and comment period of 5/30/2023 through 6/30/2023. All notices invited the public to review and comment on the waiver renewal application.

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

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

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

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal

Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

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

7. Contact Person(s)

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

Last Name: Rector

First Name: Bea

Title: Assistant Secretary

Agency: Aging and Long-Term Support Administration

Address: P.O. Box 45600

Address 2:

City: Olympia

State: **Washington**

Zip: 98504-5600

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

Fax: (360) 407-7582

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

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

Last Name: Moua

First Name: Anne

Title: Waiver Program Manager

Agency: DSHS/Aging and Long-Term Support Administration

Address: PO Box 45600

Address 2:

City: Lacey

State: **Washington**

Zip: 98503

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

Fax: (360) 438-8633

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

8. Authorizing Signature

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

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

Signature:

State Medicaid Director or Designee

Submission Date:

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:

Agency:

Address: PO Box 45600

Address 2:

City: Lacey

State: **Washington**

Zip: 98503

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

Fax:

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:

None of the above boxes apply.

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.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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:

DSHS/Aging and Long-Term Support Administration (ALTSA)

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that

division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

Schedule A5 of the Cooperative Agreement delegates the following functions to the operating agency:
-Submission of all necessary application, renewal and amendment materials to CMS in order to secure and maintain approval of all proposed and existing waivers;
-Responsibility for the operation, management, and reporting of allowable Medicaid administrative activities for approved federal waivers; and
-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 statewide level. These results are analyzed and incorporated into a statewide proficiency improvement plan. 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 proficiency improvement plan. The proficiency improvement plan is reviewed and approved for implementation by executive management.

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

Appendix A: Waiver Administration and Operation

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

○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

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

Appendix A: Waiver Administration and Operation

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

○ **Not applicable**

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

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

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

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

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix A: Waiver Administration and Operation

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

The Home and Community Services Division of ALTSA.

Appendix A: Waiver Administration and Operation

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

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

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

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Local Non-State Entity
Participant waiver enrollment	☐	☒	☐
Waiver enrollment managed against approved limits	☐	☒	☐
Waiver expenditures managed against approved levels	☐	☒	☐
Level of care 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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete

the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

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

Where possible, include numerator/denominator.

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

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

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

QA and fiscal proficiency improvement plans are required for areas where required proficiency levels are not achieved or if improvement is not evident based upon previous proficiency improvement plans. Proficiency improvement plans include how individual problems are corrected as they are discovered. Some issues, such as health and safety, require immediate action. Regions are required to develop and submit to the QA unit a Proficiency Improvement Plan (PIP) within 30 days of receiving their final report. Proficiency improvement plans are individualized and evaluated prior to approval to ensure that the plan will effectively address areas of needed improvement.

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

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design

methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	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:

Additional criteria:
1. Meets NFLOC and is currently residing at a state mental hospital or the psychiatric unit of a hospital, or has a history of failed placements or denials of appropriate placements, or is imminently in danger of losing a current placement due to problematic behaviors; and
2. Has been assessed as medically and psychiatrically stable; and
3. Has a history of frequent or protracted psychiatric hospitalizations, or a history of an inability to remain medically or behaviorally stable for more than six months and within the last year has exhibited behaviors such as self-endangerment, aggression, intrusiveness, intractable psychiatric symptoms, problematic medication management, sexual inappropriateness, or elopement; and
4. Due to the protracted nature of behavior and clinical complexity, has no other placement options as evidenced by having been unsuccessful in finding community placement by otherwise qualified community providers; and
5. Has behavioral or clinical complexity that requires the level of supplementary or specialized staffing available only in the qualified community settings provided through this waiver; and
6. Requires caregiving staff with specific training in providing personal care, supervision and behavioral supports to adults with challenging behaviors.

Individual resides in an institution at time of referral and will receive ongoing waiver services in community-based setting.

Absent the waiver, the alternative institution where the individual would receive needed services would be a NF.

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:

There is no maximum age limit. Persons with disabilities may continue to participate in the waiver beyond the age of 64 as specified in the above chart. A bug in the web based application will not allow the submission of the waiver if this section is 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	3799
Year 2	4255
Year 3	4766
Year 4	5337
Year 5	5978

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:

Each waiver year, slots will be filled as eligible participants choose to enroll in the waiver.

An individual may self-refer or be referred by the treatment team with the person's consent. The individual is then assessed for functional and financial eligibility. If a waiver slot is not available, the applicant will be placed on a waiting list based on the date eligibility was determined.

Once the maximum number of unduplicated participants is reached in each waiver year, no additional participants will be enrolled and a waiting list will be developed. At the beginning of each new waiver year in which there is unused waiver capacity, participants will be prioritized for enrollment, based on the following criteria:
1. Length of time since the participant requested placement;
2. Continued functional and financial eligibility;
3. Geographical preferences; and
4. Choice of provider, setting, and roommate.

If an applicant declines to take a waiver slot due to the geographic location or for any other reason, the individual will remain on the waiting list if he/she still desires a community residential transition. If the individual wants to remain on the waiting list, he/she will retain current placement on the waiting list.

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)*:

- ◉ **§1634 State**
- ○ **SSI Criteria State**
- ○ **209(b) State**

2. Miller Trust State.

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

- ◉ **No**
- ○ **Yes**

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

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☒ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☐ **Optional state supplement recipients**
- ☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- ○ **100% of the Federal poverty level (FPL)**

○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

☒ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☒ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☒ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

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

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

Specify:

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

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

Specify percentage:

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

Specify dollar amount:

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

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

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

Specify:

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

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

Appendix B: Participant Access and Eligibility

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

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

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

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

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

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

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI 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 §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:

The total personal needs allowance will not exceed 300% of the federal benefit rate, and is the total of:
100% of the federal benefits rate;
Any payee and/or court-ordered guardianship fees;
Any court-ordered guardianship-related costs; plus
An amount for employed individuals equal to the first $65 of the recipient's earned income, plus one-half of any remaining earned income

○ **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 §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:

  The total personal needs allowance will not exceed 300% of the federal benefit rate, and is the total of:
  100% of the federal benefits rate;
  Any payee and/or court-ordered guardianship fees;
  Any court-ordered guardianship-related costs; plus
  An amount for employed individuals equal to the first $65 of the recipient's earned income, plus one-half of any remaining earned income

- ○ **Other**

  Specify:

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

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

  Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified 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 a government agency under contract with the Medicaid agency.**

Specify the entity:

◉ **Other**

Specify:

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

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

In addition to meeting the following minimum qualifications, agency 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 Managers, 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 two years 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 three years of paid 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.

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 2, or Juvenile Rehabilitation Counselor 2 in State service.

Job classification descriptions are available from the operating agency.

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

The level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool is fully specified in WAC 388-106-0355 (eligibility for nursing facility care services).

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

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

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

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

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

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

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

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

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

twice;

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

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

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

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

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

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

(ii) No provider was available to assist; or

(iii) The individual declined assistance with the task.

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

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

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

(c) One-person physical assist provided;

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

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

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

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

These WAC references are available to CMS upon request.

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

- ◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
- ○ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

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

Case managers complete Level of Care evaluations using the automated assessment tool CARE. CARE is used for both initial evaluations and re-evaluations. The re-evaluation process does not differ from the initial evaluation process. Evaluations are completed when an applicant initially applies for long term services and support, annually, and less than annually when a significant change in the participant's condition occurs within the annual plan period. Information about the person's ability to perform Activities of Daily Living and Instrumental Activities of Daily Living, as well as their strengths and preferences is obtained via a face-to-face interview. Evaluators also obtain and verify information by collateral contacts with formal and informal supports including physicians, caregivers, and family.

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:

Reevaluations must be conducted every twelve (12) months or whenever there is a significant change in the participant's condition.

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

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**

Specify the qualifications:

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

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

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

Quality assurance staff monitoring of records includes monitoring for timeliness.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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:
Percent of initial applications with documentation that an assessment was submitted and reviewed for a level of care determination. N=Number of applications received that were submitted and reviewed for a level of care assessment D=Number of applications received

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

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

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: The 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:
Number 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. D=All participants records reviewed who had an eligibility determination.

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 = 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**

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

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

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

Social service supervisors/managers annually monitor worker assessments to ensure LOC accuracy and that a LOC is determined annually or at significant change (approximately 2500 reviews statewide). 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 unit monitors LOC using a statistically valid sample of records statewide on a 12-month review cycle.

Monitoring activities and data provide evidence of use of the CARE application. LOC determinations that are not correctly determined are corrected and correction is verified at second review. Training to address use of the CARE application is developed based on the data: individual, unit, regional or statewide. CARE enforces rules of eligibility. An algorithm in CARE determines LOC based on information entered into the assessment by the participant and case manager. A LOC determination is completed on all applicants for whom there is reasonable indication that services may be needed in the future. If the participant is not eligible for waiver services, the option is not available for the case manager to select/participant to choose and will not print on the service summary (plan of care).
-An intake is completed at the state agency (HCS) within two working days of receiving the request/referral for services; referrals are entered within one working day for applicants discharging from the hospital.
- The case is assigned to a social worker (the primary case manager) within one working day of the intake date.
- A face-to-face contact is made within two working days of receipt of the referral for applicants coming home from the hospital.
- The initial assessment process timeline is 45 days. The assessment must be completed and services authorized (if eligible) within 45 days from the intake date. Annual and significant change assessments must be completed within 30 days of the assessment creation date.

b. Methods for Remediation/Fixing Individual Problems

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

Upon completion of each record review, the case manager is expected to make necessary corrections to individual problems. Problems related to health and safety, provider qualifications and payment require either immediate action or must be completed within 3 working days. If the remediation steps are numerous and cannot be completed within 3 working days, they must be initiated for completion within 3 working days. Individual corrections are verified by either the QA unit or the case management supervisor. The QA unit verifies that required corrections have been made at the individual level within 30 days of the preliminary review and documents the verification in the QA monitoring application. Any items that are not corrected within 30 days are followed up by the QA unit to confirm that they have been corrected at 60 days. If items are not corrected by the 60th day, the QA unit follows up with the region until the items are corrected and reports the date of correction to the HCS management team. Supervisors verify that corrections have been made at the individual level prior to completing the review and also document this activity in the QA monitoring application.

Quality assurance proficiency and follow-up reports document prompt assessment and eligibility determinations, accuracy, and remediation. QA reports may be generated at any time and are reviewed on an ongoing basis at all levels of the system. Corrections are made at 30 days and 60 days as identified.

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

Quality assurance reports and aggregate data are reviewed throughout the year (based on the QA review cycle schedule) by individuals who make decisions on what improvements are needed individually or systemically. Regions are required to develop and submit to the QA unit a Proficiency Improvement Plan (PIP) within 30 days of receiving their final report. The PIP addresses any area where the required proficiency is not met. 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. The region completes a PIP progress report and sends to the QA lead when due with a copy to the QA manager. If the progress report is not received on time, the QA lead follows up with the region. The PIP must be completed by the due date specified on the approved PIP. The HCS management team is notified if a PIP is not completed by the approved due date.

ii. Remediation Data Aggregation

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

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

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 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 case manager or social worker and a signature is obtained stating that the individual understands they have a choice in the type of services received, where the service is provided as well as the right to a fair hearing. The individual signs this form to designate the service choice.

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

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

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

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

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

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

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

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

-WAC 388-271 Limited English proficient services.

-DSHS Administrative Policies

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

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

Appendix C: Participant Services

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

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	**Adult Day Health**		
Other Service	**Adult Family Home Specialized Behavior Support Service**		
Other Service	**Client Support Training & Wellness Education**		
Other Service	**Community Stability Supports**		
Other Service	**Enhanced Residential Services**		
Other Service	**Expanded Community Services**		
Other Service	**Nurse Delegation**		
Other Service	**Skilled Nursing**		
Other Service	**Specialized Medical Equipment and Supplies**		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

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

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

Adult Day Health services are available to participants living in an adult family home, assisted living facility, enhanced adult residential care or enhanced services facility.

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

For individuals living in an enhanced services facility, skilled nursing is provided by facility staff and cannot be duplicated in the Adult Day Health setting.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Center

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Adult Day Health Center

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

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

Other Standard *(specify):*

The Adult Day Health center must have a Core Provider Agreement with the State Medicaid Agency. Minimum staffing requirements for Adult Day Health centers include an administrator, program director, registered nurse, activity coordinator, a physical/occupational therapist or speech therapist, and a social worker. The administrator and program director may be the same person.

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

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

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

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

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

Adult Day Health settings must be fully aligned with the HCB settings requirements outlined in 42 CFR § 441.301.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Adult Family Home Specialized Behavior Support Service

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
02 Round-the-Clock Services	02013 group living, other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Specialized Behavior Support--Adult Family Homes provide 24 hour on site staffing in typical single family homes located in community neighborhoods. The following basic services are provided; personal care, homemaker, chore, and medication oversight. Care must be furnished in a way which fosters the independence of each participant. Routines of care provision and service delivery must be participant-driven to the maximum extent possible, and treat each person with dignity and respect.

Specialized Behavior Support--Adult Family Homes also provide an enhanced staff ratio requiring an additional 6 to 8 hours of staff for each waiver participant served in the home. Staff must participate in training and consultation with behavioral client support training providers and will implement behavioral plans and strategies developed for the client. Recreational opportunities will be specifically designed and provided to meet behavioral challenges of each waiver participant. Staff will implement an individually developed crisis prevention strategy for each waiver participant and provide supervision, safety and security.

The total number of individuals living in the home, who are unrelated to the principal care provider, cannot exceed 6. Separate payment is not made for homemaker or chore services furnished to a participant since these services are integral to and inherent in the provision of this service.

Contracted Specialized Behavior Support--Adult Family Homes must retain a participant's bed when the participant has a short-term stay in a hospital, nursing facility, Institutes for Mental Disease (IMD), or Inpatient Behavioral Health Agencies and is likely to return to the Adult Family Home. The State will compensate the Adult Family Home for up to twenty days when the participant's bed is retained during the participant's absence. The department's Case Manager will determine the timeframes for beginning and ending retainer payments, including whether the stay in the hospital, nursing facility, Institutes for Mental Disease (IMD), or Inpatient Behavioral Health Agencies will be short-term and the participant is likely to return to the Adult Family Home.

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

Payments for Adult Family Home Specialized Behavior Support Services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Family Home

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Family Home Specialized Behavior Support Service

Provider Category:

Agency

Provider Type:

Adult Family Home

Provider Qualifications

License *(specify):*

Licensed under Chapter 388-76 WAC

Certificate *(specify):*

Must be contracted to provide AFH/SBS services.

All caregivers and managers must successfully complete mental health training and any other specialty training required to meet the needs of the population served. Adult Family Home caregivers must receive 10 of their annual required 12 hours of continuing education in a topic area that is relevant to residents served in this waiver.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

At least every 18 months

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Client Support Training & Wellness Education

HCBS Taxonomy:

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

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

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

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assistive Technology Professional
Individual	Assistive Technology Professional
Agency	Adult Day Health Center
Individual	Occupational Therapist
Individual	Human Service Professional
Agency	Home Health Agency
Individual	Board-Certified Music Therapist
Individual	Certified Dietician/Nutritionist
Agency	Chronic Disease Self Management Trainer
Agency	Board-Certified Music Therapist
Agency	Community College
Individual	Pharmacist
Individual	Evidence Based Trainer

Provider Category	Provider Type Title
Individual	Physical Therapist
Individual	Licensed Practical Nurse
Agency	Physical Therapist
Individual	Independent Living Provider
Individual	Registered Nurse
Agency	Community Mental Health Agency
Agency	
Agency	Occupational Therapist
Agency	Centers for Independent Living
Agency	Home Care Agency
Agency	Evidence Based Trainer
Individual	Chronic Disease Self Management Trainer

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Assistive Technology Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A generalist certification

Other Standard *(specify):*

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

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Assistive Technology Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

A generalist certification

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: Masters Degree or Higher in Special Education or Rehab Science
ii. 1000 hours in 6 years

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Adult Day Health Center

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified under Washington Administrative code which defines ADH Center employee requirements. WAC 388-71-0702 through 388-71-0826.

Other Standard *(specify):*

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

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

Employee qualifications are as follows:

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

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

OT License under Chapter 18.59 RCW

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Human Service Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Board-Certified Music Therapist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Certified Dietician/Nutritionist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Dietician and Nutritionist certificate under Chapter 18.138 RCW

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Chronic Disease Self Management Trainer

Provider Qualifications

License *(specify):*

Public Health and Safety providers licensed under Chapter 70 RCW

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Board-Certified Music Therapist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Initial contracting and every two years thereafter

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:

Community College
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Higher Education Institution conducting programs under Chapter 28B.50.020 RCW
Verification of Provider Qualifications
Entity Responsible for Verification:

Area Agency on Aging
Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:

Pharmacist
Provider Qualifications
License *(specify):*

Licensed per Chapter 18.64 RCW and Chapter 246.863 WAC

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Evidence Based Trainer

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

PT license under Chapter 18.74 RCW

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Licensed Practical Nurse

Provider Qualifications

License *(specify):*

Licensed under Chapter 18.79 RCW and Chapter 246-840 WAC

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

PT License under 18.74 RCW

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Independent Living Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Community Mental Health Agency

Provider Qualifications

License *(specify):*

Licensed under Chapter 388-865-0400 WAC

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Provider Qualifications

License *(specify):*

Appropriate license to do business in Washington State.

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

ALTSA

Frequency of Verification:

Upon contract and every two years thereafter.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

Licensed under 18.59 RCW

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Centers for Independent Living

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Client Support Training & Wellness Education

Provider Category:

Agency

Provider Type:

Evidence Based Trainer

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Chronic Disease Self Management Trainer

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Community Stability Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02013 group living, other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Purpose:
The purpose of this service is to fill a gap in services offered to participants with higher nursing needs under the RSW. Services and supports are provided to assist participants to reside in the most integrated setting possible. Care and support services are furnished in a way which fosters the independence of each participant. Routines of care provision and service delivery must be participant-driven to the maximum extent possible and treat each person with dignity and respect.

This residential service offers participants more highly trained staff and a higher level of nursing staff than other RSW services. In addition to providing personal care, staff will be trained to support clients to be successful in the community by implementing strategies that support the participants behavioral challenges and assist with recreational activities of interest to the participant.

Scope:
Services and supports provided are: assistance with the activities of daily living and instrumental activities of daily living; assistance to participate in activities of the person's choice; medication oversight; and behavior supports in the place of residence. These services are provided by a licensed Assisted Living Facility (ALF) and personal care may be furnished in the community or in the workplace. The service requires an on-site licensed nurse 40 hours per week and on-call availability 24 hours a day, and an on-site behavior support clinician 40 hours per week.

ALF staff providing this service must participate in additional training and coordinate with behavior support client training providers and will implement behavioral strategies developed with each participant. Recreational opportunities and group activities will be specifically designed with each participant and provided for more community inclusion, reducing the behavioral challenges of each waiver participant.

Staff will implement individually developed crisis prevention strategies for each waiver participant that aligns with the requirements of the person-centered service planning process as well as the HCBS requirements for provider-owned or controlled settings.

The provider must retain a participant's bed when the participant has a short-term stay in a hospital or nursing facility and is likely to return to the residential facility. The State will compensate the provider for up to twenty days when a participant's bed is retained during the participant's absence. The department's Case Manager will determine the timeframes for beginning and ending retainer payments, including whether the stay in the hospital or nursing facility will be short-term and the participant is likely to return to the residential facility.

The scope of this service is different than Expanded Community services as it adds more staff training and the availability of more nursing staff.

This service does not duplicate coverage under the state plan, including a service that can be provided as an expanded EPSDT service.

All Enhanced Adult Residential Care Facility (EARC) provider type training requirements in the current approved waiver are required, and in addition to those general EARC caregiver training requirements, caregivers providing this service will also receive the following training:
1. De-escalation strategies
2. Crisis Prevention Intervention
3. Challenging Behaviors
4. Behavior Support
5. Therapeutic Options
6. Person-Centered Planning

To ensure duplicate billing does not occur, the ProviderOne system will have a conflict edit that will result if an overlapping service is authorized at the same time as Community Stability Supports.

Contracted Residential Community Stability Supports providers must retain a participant's bed when the participant has a short-term stay in a hospital, nursing facility, Institutes for Mental Disease (IMD), or Inpatient Behavioral Health Agencies and is likely to return to the residential facility. The State will compensate the Residential Community Stability Supports facility for up to twenty days when a participant's bed is retained during the participant's absence. The department's Case Manager will determine the timeframes for beginning and ending

retainer payments, including whether the stay in the hospital, nursing facility, Institutes for Mental Disease (IMD), or Inpatient Behavioral Health Agencies will be short- term and the participant is likely to return to the residential facility.

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

Payments for Community Stability Supports services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement.

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	Enhanced Adult Residential Care Facility

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Stability Supports

Provider Category:

Agency

Provider Type:

Enhanced Adult Residential Care Facility

Provider Qualifications

License *(specify):*

Assisted Living Facilities with a contract to provider EARC services are licensed under Chapter 18.20 RCW and Chapters 388-78A WAC.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Training Requirements:
--First Aid and CPR prior to working with residents
--2 hours of Orientation prior to working with residents
--3 hours of Safety Training prior to working with residents
--70 hours of basic training
--12 hours of Continuing Education annually; in an Enhanced Adult Residential Care facility, caregivers must have at least 6 of the 12 hours of annual Continuing Education in topics related to dementia (WAC 388-110-220)
--Specialty Training if serving residents with special needs

The Provider will coordinate opportunities for staff and participants to receive training that supports each participant's community transition. Training provided shall range from broad behavioral care topics to specific consultation and training related to the needs of the participant.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

At least every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Enhanced Residential Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02013 group living, other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Services and supports are provided to assist participants in residing in the most integrated setting possible. Services and supports provided are: assistance with the activities of daily living and instrumental activities of daily living; community inclusion to participate in activities of the person's choice; social and leisure skill development; oversight and supervision; personal care; medication oversight; and behavior supports. Care and support services are furnished in a way which fosters the independence of each participant. Each person will be treated with dignity and respect.

The increased staffing level in Enhanced Services Facilities requires an on-site licensed nurse 24-hours per day and an on-site mental health professional for at least 8 hours per day. Staff must participate in training and consultation with behavioral client support training providers and will implement behavior plans and strategies developed for each client. Recreational opportunities and individual and group activities will be specifically designed and provided to meet the behavioral challenges of each waiver participant. Staff will implement and individually-develop crisis prevention strategies for each waiver participant and provide supervision, safety, and security. Crisis prevention strategies will align with the requirements of the person-centered service planning process as well as requirements for provider-owned or controlled settings.

The total number of individuals living in the setting, who are unrelated to the principal care provider, cannot exceed 16. Separate payment is not made for homemaker or chore services furnished to a participant, since these services are integral to, and inherent in, the provision of this service.

Contracted Enhanced Services Facilities must retain a participant's bed when the participant has a short-term stay in a hospital, nursing facility, Institutes for Mental Disease (IMD), or Inpatient Behavioral Health Agencies and is likely to return to the Enhanced Services Facility. The State will compensate the Enhanced Services Facility for up to twenty days when the participant's bed is retained during the participant's absence, at a rate of 70% of the daily rate. The Case Manager will determine the timeframes for beginning and ending retainer payments, including whether the stay in the hospital, nursing facility, Institutes for Mental Disease (IMD), or Inpatient Behavioral Health Agencies will be short-term and the participant is likely to return to the Enhanced Services Facility.

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

Payments for Enhanced Services Facilities are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Nurse delegation is not available in ESFs.

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	Enhanced Services Facility

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Enhanced Residential Services

Provider Category:

Agency

Provider Type:

Enhanced Services Facility

Provider Qualifications

License *(specify):*

Licensed under Chapter 388-107 WAC

Certificate *(specify):*

The facility must be contracted to provide this service.

All caregivers, excluding professional licensed nursing staff, must complete a department-approved certified nursing assistant training program or meet the long-term care worker training and certification requirements of Chapter 388-112 WAC.

Other Standard *(specify):*

Professionals providing services in an enhanced services facility must meet specific qualifications:
--Registered Nurse, licensed under Chapter 18.79 RCW and Chapter 246-840 WAC;
--Licensed Practical Nurse, licensed under Chapter 18.79 RCW and Chapter 246-840 WAC;
--Mental health professionals may be a psychiatrist, psychologist, psychiatric nurse, licensed mental health counselor, licensed mental health counselor-associate, licensed marriage and family therapist, licensed marriage and family therapist-associate, licensed independent clinical social worker, licensed independent clinical social worker-associate, licensed advanced social worker, or licensed advanced social worker-associate, and other mental health professionals as may be defined under the authority of Chapter 71.05 RCW;
--Home Care Aide Certified, certified by the Department of Health under Chapter 18.88B RCW; and
--Nursing Assistant Certified, certified by the Department of Health under Chapter 18.88A RCW.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

At least every 18 months

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:

Expanded Community Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
02 Round-the-Clock Services	02013 group living, other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Residential Expanded Community Services consist of personal care services, homemaker, chore, medication oversight (to the extent permitted under State law), and behavior support. These services are provided in the residential setting and personal care may be furnished in the community or in the work place. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes participant choice and maximum dignity and independence, in addition to supervision, safety, and security.

Residential Expanded Community Services include coordination of client training with a Behavior Support provider to support each participant's ability to remain in the community. Residential Expanded Community Service providers collaborate with the Behavior Support provider to develop a plan to respond to identified indicators of potential crises and develop a plan to prevent and respond to crises and meet the needs of the participant.

The state ensures that it has mechanisms in place to ensure that no duplication of payment for these waiver services will occur with any other Medicaid services.

Contracted Residential Expanded Community Service providers must retain a participant's bed when the participant has a short-term stay in a hospital, nursing facility, Institutes for Mental Disease (IMD), or Inpatient Behavioral Health Agencies and is likely to return to the residential facility. The State will compensate the Residential Expanded Community Service facility for up to twenty days when a participant's bed is retained during the participant's absence. The department's Case Manager will determine the timeframes for beginning and ending retainer payments, including whether the stay in the hospital, nursing facility, Institutes for Mental Disease (IMD), or Inpatient Behavioral Health Agencies will be short-term and the participant is likely to return to the residential facility.

Payments for Expanded Community Services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement.

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

Payments for Expanded Community Services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement.

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	Enhanced Adult Residential Care Facility
Agency	Assisted Living Facility
Agency	Adult Family Home

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Expanded Community Services

Provider Category:

Agency

Provider Type:

Enhanced Adult Residential Care Facility

Provider Qualifications

License *(specify):*

Assisted Living Facilities with a contract to provide EARC services are license under Chapter 18.20 RCW and Chapters 388-78A WAC.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Training Requirements:
--First Aid and CPR prior to working with residents
--2 hours of Orientation prior to working with residents
--3 hours of Safety Training prior to working with residents
--70 hours of basic training
--12 hours of Continuing Education annually; in an Enhanced Adult Residential Care facility, caregivers must have at least 6 of the 12 hours of annual Continuing Education in topics related to dementia (WAC 388-110-220)
--Specialty Training if serving residents with special needs

The Provider will coordinate opportunities for staff and participants to receive training that supports each participant's community placement. Training provided shall range from broad behavioral care topics to specific consultation and training related to the needs of the participant.

Must be contracted to provide Expanded Community Services

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

At least every two years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Expanded Community Services

Provider Category:

Agency

Provider Type:

Assisted Living Facility

Provider Qualifications

License *(specify):*

Assisted Living Facility license under Chapter 18.20 RCW and Chapters 388-78A and 388-110 WAC

Certificate *(specify):*

N/A

Other Standard *(specify):*

Training Requirements:
--First Aid and CPR prior to working with residents
--2 hours of Orientation prior to working with residents
--3 hours of Safety Training prior to working with residents
--70 hours of basic training
--12 hours of Continuing Education annually; in an Enhanced Adult Residential Care facility, caregivers must have at least 6 of the 12 hours of annual Continuing Education in topics related to dementia (WAC 388-110-220)
--Specialty Training if serving residents with special needs

The Provider will coordinate opportunities for staff and participants to receive training that supports each participant's community placement. Training provided shall range from broad behavioral care topics to specific consultation and training related to the needs of the participant.

Must be contracted to provide Expanded Community Services

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

At least every two years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Expanded Community Services

Provider Category:

Agency

Provider Type:

Adult Family Home

Provider Qualifications

License *(specify):*

Licensed under Chapter 388-76 WAC

Certificate *(specify):*

Must be contracted to provide AFH services.

All caregivers and managers must successfully complete any specialty training required to meet the needs of the population served.

Other Standard *(specify):*

Training requirements:
--First Aid/CPR prior to working with residents
--2 hours of Orientation prior to working with residents
--3 hours of Safety Training prior to working with residents
--70 hours basic training
--12 hours of Continuing Education annually
--Specialty Training if serving a resident with special needs

The Provider will coordinate opportunities for staff and participants to receive training that supports each participant's community placement. Training provided shall range from broad behavioral care topics to specific consultation and training related to the needs of the participant.

Must be contracted to provide Expanded Community Services

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

At least every 18 months

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:

Nurse Delegation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11020 health assessment
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11030 medication assessment and/or management
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Nurse delegation may occur in an adult family home setting. In an adult family home, a registered nurse delegator assesses a client for program suitability; teaches and evaluates competency; supervises the performance of a nursing assistant or certified home care aide. The nursing assistant or certified home care aide has met additional education requirements in order to perform the delegated nursing tasks for the participant. These tasks may include medication administration, blood glucose monitoring, insulin injections, ostomy care, simple wound care, straight catheterization or other tasks determined appropriate by the delegating nurse.

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

Services do not duplicate personal care.

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

Washington State’s Nurse Practice Act prohibits the following tasks from being delegated: injections other than insulin, central lines, sterile procedures, and tasks that require nursing judgment.

Nurse delegation is not available in ESFs.

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	Registered Nurse

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nurse Delegation

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Licensed under Chapter 70.127 RCW and Chapter 246-840 WAC

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nurse Delegation

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

Licensed under Chapter 18.79.040 RCW

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Skilled Nursing

HCBS Taxonomy:

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

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

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

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

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

Licensed under Chapter 18.79 RCW and Chapter 246-840 WAC

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:
Individual
Provider Type:

Licensed Practical Nurse
Provider Qualifications
License *(specify):*

Licensed under Chapter 18.79 RCW and Chapter 246-840 WAC
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

Area Agency on Aging
Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:
Agency
Provider Type:

Home Health Agency
Provider Qualifications
License *(specify):*

Licensed under Chapter 70.127 RCW
Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14032 supplies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Specialized medical equipment and supplies include devices, controls, or appliances, specified in the plan of care, which enable the participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable/non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medical Equipment and Supply Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Medical Equipment and Supply Contractor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must have a Core Provider Agreement with the State Medicaid Agency

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Initial contracting, and every four years thereafter.

Appendix C: Participant Services

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

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

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

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☒ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

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

DSHS/ALTSA or Tribal Case Managers.

Appendix C: Participant Services

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

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

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

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory

investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

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

The types of positions (e.g., personal assistants, attendants, etc.) for which such investigations must be conducted:
- Long Term Care workers, (agency and individual), case manager, LPN, RN, nursing assistant, certified home care aide, certified dietician, physical therapist, occupational therapist, administrators, resident managers, 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 for Long Term Care workers, administrators, and resident managers.

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

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

- ○ **No. The state does not conduct abuse registry screening.**
- ◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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

Personal care providers (agency and individual), case managers, LPNs, RNs, nursing assistants, certified home care aides, certified dieticians, physical therapists, occupational therapists, and all other waiver contractors who have unsupervised access to vulnerable adults.

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

Appendix C: Participant Services

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

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

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

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

- (●) **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

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

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

- (●) **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ( ) **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- ( ) **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

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

- ( ) **Other policy.**

Specify:

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

The state establishes qualifications and offers the opportunity for any willing provider to demonstrate qualifications and enroll. Information is provided through provider organizations, direct contact with potential providers through resource development staff, procurements and mailings. Provider enrollment information and forms are continuously available for provider enrollment via ALTSA's internet website. Providers who meet qualifications and are willing to contract will be contracted to serve waiver participants in the specified geographic areas covered by the waiver. Access problems identified will be addressed through enrollment of additional providers. A competitive procurement process was used to select initially contracted ESF providers.

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

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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:
Percent of waiver service providers who require licensure &/or certification that continue to meet contract standards at time of contract renewal, as delegated by the State Medicaid Agency; N = All contracted waiver providers that require licensure &/or certification that meet contract standards at contract renewal; D = All contracted waiver providers who were required to have contract renewals.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
The number & percent of service providers who require licensure &/or certification who meet standards prior to furnishing waiver services, as delegated by the State Medicaid Agency; N = All waiver service providers who require licensure and/or certification that initially meet contract standards; D = All waiver service providers, with initial contracts, that require licensure and/or certification.

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

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

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

Data Aggregation and Analysis:

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

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

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

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

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

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 = 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:

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:
3. The number and percent of adult day health facilities that have met training requirements, as delegated by the State Medicaid Agency; N = Number of adult day health facilities that met training requirements; D = Number of adult day health facilities reviewed.

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

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

☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 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:

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

Performance Measure:
1. The number and percent of RNs providing Nurse Delegation that have met training requirements, as delegated by the State Medicaid Agency; N = Number of RNs that provide nurse delegation that meet training requirements; D = Number of RNs that provide nurse delegation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ND monitoring tool

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

Data Aggregation and Analysis:

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

Performance Measure:
2. The number and percent of waiver participants who's residential service provider completed required specialty training, as delegated by the State Medicaid Agency; N = Number of waiver participants who's residential service provider completed required specialty training; D = Number of participant files reviewed

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

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

		Confidence Interval = 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:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the

State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

-Contracts for all waiver providers are maintained in a central database. Contract status is updated on a daily basis.
-Residential waiver service providers are monitored by the State every 18 months. Inspection reports, statement of deficiencies, and record reviews are used to verify compliance.
-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 two year cycle.
-Nursing Assistant Certified (NAC) 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.
-Each HCS supervisor monitors the providers. Provider contract and training compliance is also monitored through the DSHS /central contracts database. The QA unit monitors a statistically valid sample of provider files/qualifications. Monitoring includes verification that:
1. Background checks are completed and passed
2. Provider contract is completed and valid
3. Required training was completed within the timeframes indicated
4. Providers subject to licensing or certification are valid at the time of contract renewal and per individual licensing or certification schedule.

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

When a residential waiver service provider does not meet licensing/certification requirements, RCS implements corrective action which may include technical assistance, sanctions, and/or termination. Based upon findings from onsite inspections, areas of non-compliance are evaluated for scope and severity. Enforcement remedies are immediate and based upon real or potential negative impact on residents living in the setting. Trends are discussed at RCS management team meetings and outcomes and actions are discussed and prioritized. On a yearly basis, areas of most frequent citation during that year are evaluated. Identified issues often determine where additional policy clarification is required or training is needed.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

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

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

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.

Specialized Behavior Support (SBS) services are provided by licensed adult family homes holding an AFH contract with a contract sub-code allowing them to provide SBS services. These settings are fully aligned with the HCB settings requirements and the provider, by contract, may provide more specialized services.

Expanded Community Services (ECS) are provided by licensed AFHs, ALFs, and EARCs holding contracts with a contract sub-code allowing them to provide ECS. These settings are fully aligned with the HCB settings requirements and the provider, by contract, may provide more specialized services.

Community Stability Supports (CSS) services are provided by EARCs holding contracts allowing them to provide CSS. These settings are fully aligned with the HCB settings requirements and the provider, by contract, may provide more specialized services.

Initial licensing and contracting of adult family homes, assisted living facilities, enhanced adult residential care facilities, and enhanced services facilities includes the following review:

DESCRIPTION OF ADULT DAY HEALTH:

Adult Day Health (ADH) services are provided in community centers throughout the state and/or through telephonic or other technology media. ADH participants access the service through public and private transportation when attending in-person and are free to choose the services they will receive from among those for which they are eligible. They may choose other community providers to meet their health and therapy needs should they wish to do so. Participants develop and agree to their ADH service plan.

DESCRIPTION OF HOW THE SETTINGS MEET FEDERAL HCB SETTINGS 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 Facilities Management System (FMS). There are many reports in FMS 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 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.

Adult Day Health settings are monitored by Area Agency on Aging (AAA) staff to ensure they continue to meet the HCBS settings requirements. AAA staff perform an on-site review of ADH centers annually to determine adherence to policy, procedures, and state and federal statutes. If the AAA monitor identifies any client rights violation, they would report this to the state Adult Protective Services.

AAAs require ADH centers to make immediate corrective actions when the health and/or safety of clients is in jeopardy or in the case of intentional or unintentional misuse of funds. The AAA monitors for correction within 3 business days of the determination. In the event the ADH center does not bring the corrective actions into compliance, the AAA determines further corrective action and may impose sanctions on the center.

For items that are not health and/or safety related, the AAA monitor requires the subcontractor to take corrective actions. The corrective action plan submitted by the ADH center must include the date when the center will be in full compliance with each documented deficiency. The corrective action plan must be submitted to the AAA for approval within 30 days of the date of final monitoring report.

The AAA reviews the ADH's progress in bringing the corrective actions into compliance within 60 days following the date the ADH projects it will be in full compliance. In the event the ADH does not bring the corrective actions into compliance, the AAA determines further corrective action and may impose sanctions on the ADH.

AAAs submit ADH monitoring reports to ALTSA headquarters and compliance oversight is provided by the Adult Day Health program manager. Reports to HCA are provided as a component of periodic waiver quality reports.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Comprehensive Assessment Reporting Evaluation (CARE) tool

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:
- ☐ **Social Worker**
  Specify qualifications:

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

The above DSHS documents may be obtained from the Operating Agency.

Appendix D: Participant-Centered Planning and Service Delivery

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

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the

services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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

(a) The case manager develops the plan of care along with the participant and their legal representative (if applicable). The participant may include any other person(s) of their choosing including family and other formal and informal supports. The initial plan of care must be completed within 45 days of the date of the referral. The plan of care is updated at least annually and when a significant change occurs. A significant change assessment is a face-to-face interview conducted when there has been a change in the participant's cognition, ADLs, mood and behaviors, or medical condition. Annual and significant change assessments must be completed within 30 days of the assessment creation date.

(b) Case managers conduct assessments using the automated CARE assessment tool. CARE leads the case manager 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, strengths, limitations and caregiver instructions.

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

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

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

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

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

The activities of daily living section of the assessment includes the following areas: toileting, eating, nutritional/oral status, bathing, transfers, dressing, personal hygiene, household tasks, transportation, shopping, housework, and need for environment modifications and/or assistive equipment.

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

(d) CARE auto generates the results of the assessment including all identified needs (including health care, equipment, and environment needs), participant goals, and preferences into a plan of care. The electronic plan of care will show as incomplete until the case manager and participant have finished all mandatory sections of the assessment and addressed all identified needs. A nursing referral may be recommended or required based on certain data elements or combination of data elements (critical indicators) that were selected in the assessment. Potential critical indicators include: unstable/potentially unstable diagnosis, caregiver training required, medication regimen affecting plan of care, nutritional status affecting plan of care, immobility risks affecting plan of care, past or present skin breakdown, and risk of skin breakdown. The plan of care is reviewed with the participant to assure that their goals and preferences are included and that the plan meets their needs. Participant consent is required before the plan of care is considered complete and can be implemented.

(e) During the assessment process, case managers obtain the participant's permission to collect information and coordinate service planning with the participant's primary care provider and other service systems such as mental health and/or alcohol and substance abuse. When considering how care needs are being met, the care plan takes into account

services being received from allied systems. For participants who have very complex needs or who are involved in multiple systems, cross systems case staffing may be employed.

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

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

(g) Care plans are updated annually or when a significant change occurs. Significant change is defined as a reported significant change, for better or worse, in the participant's cognition, mood/behavior, ADL's or medical condition. Annual updates and significant change assessments are completed face-to-face where the participant resides. Interim updates are made as necessary when there are changes in providers, schedules, etc.

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Strategies to mitigate risk are incorporated directly into service planning. The CARE assessment process identifies participant risk factors, and the participant centered approach allows the Case Manager and participant to incorporate strategies to reduce risk directly into the service planning process. This is done in a manner sensitive to the person's preferences, and unique to the needs and circumstances of the participant. Risk assessment screens in the CARE assessment cover common areas of risk such as: mental and physical health, medication use and management, nutrition, behaviors, personal safety, and environment. CARE creates critical indicators based on certain data elements or combination of data elements identified by the case manager and client. These critical indicators require the case manager to address each element based on the level of risk and participant 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.

Responsibilities and measures for reducing risk, may include the following:

Case Managers must address all critical indicators during the service planning process and may include a referral for nursing services, mental health services, legal services, or other needed services to assist the participant in mitigating areas of risk. Case Managers may submit an Exception to Rule (ETR) requests if the daily rate generated by the CARE algorithm does not meet the participant's care needs.

Participants on this waiver have a behavior support team that works in collaboration with them to develop a behavior support plan.

Residential providers are required to have evacuation plans for all residents who cannot independently evacuate. Residential providers are also required to have sufficient staff in the home to meet the needs of each resident.

Residential Care services monitors residential providers. During the regular inspection process, RCS monitors staffing levels and emergency evacuation procedures to ensure all residents can be safely evacuated.

Backup plans and arrangements:
All participants on this waiver live in residential settings which are required to have sufficient staff in the home to meet the needs of each resident. Residential settings are also required to have an evacuation plan and emergency and disaster plan and procedures to meet the needs of each resident during emergencies and disasters.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

ALTSA is an administration within DSHS, the operating agency and determines all client eligibility. The individual case manager is an employee of ALTSA or is employed by a Federally Recognized Tribe, who is under contract with the operating agency. ALTSA or a Tribal case manager are required to use the department's electronic assessment and service planning tool. ALTSA or Federally Recognized Tribal case managers directly authorize all initial service plans and supervisors conduct quality assurance (QA) activities on service plans. ALTSA has direct electronic access to all service plans.

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

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

At the end of each QA review cycle, a final report is generated which includes detailed data on a statewide level. These results are analyzed and incorporated into a statewide Proficiency 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.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☒ **Operating agency**
- ☐ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

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

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

The written Negotiated Care Plan (NCP) describes the residential plan of care and services to be provided to the participant and is negotiated between the residential provider and the participant. The NCP incorporates the assessment and person centered service plan into the negotiated care plan, including elements of behavior support and individual treatment plans. For residents receiving Residential Support Waiver services, the NCP must include these supplemental topics: a written activity plan to support the resident’s needs and provide specifically-designed recreational opportunities to meet the resident’s behavioral challenges; a Behavior Support Plan to prevent crises and maintain community placement (identifies crisis signals, specific interventions, and a crisis response protocol to outline steps for prevention and intervention strategies to divert behaviors or actions that lead to crisis); and a supervision plan to address resident and community safety when the resident is accessing community activities and resources. The NCP is reviewed and updated annually or when a significant change in the participant's condition occurs.

(b) In addition to an annual face-to-face visit, the frequency of contacts is based on the participant's care needs, cognition, emotional, psychiatric, and/or behavioral issues, and his/her support system. At least one additional contact (in-person or by phone) is required. If a significant change occurs, the case manager is required to make a face-to-face contact. When problems/barriers with services or providers are identified, the case manager works with the participant to develop solutions and ensure access to waiver and non-waiver (including health) services and free choice of providers. Back-up plans are reviewed for effectiveness and revised accordingly.

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.

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

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

Additional monitoring and oversight is provided by established quality improvement and management systems described in Appendix G.

A more detailed outline of quality assurance monitoring is in Appendix H.

b. Monitoring Safeguards. *Select one:*

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

○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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 for waiver participants that address health and safety risk factors by the provision of waiver services or other means. N=Number of service plans for waiver participants that address health and safety risk factors. D=Number of service plans reviewed

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

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

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 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:

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

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 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:
The number and percent of service plans that address participant goals by the provision of waiver services or other means. N=Number of service plans with participant goals addressed in the service plan. D=Number of participant service plans reviewed

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

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

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 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. Percent of participants who experienced a significant change in condition who were given a significant change assessment when warranted & the service plan was updated N=Number of record reviews with significant change assessments completed & service plans updated when warranted for a significant change in condition D=Number of participant files reviewed that had significant change reported

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

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

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

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

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

Performance Measures

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

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

Performance Measure:
The number and percent of services that were delivered as authorized. N=number of participants who report receiving services as authorized. D=Number of participants surveyed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 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:
The number and percent of participant files where services were authorized in accordance with the type, scope, amount, duration, and frequency specified in the service plan when warranted. N = Number of participant files reviewed with correct MMIS service authorizations when warranted; D = Number of participant files reviewed.

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

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

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

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

Performance Measures

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

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

Performance Measure:
The number and percent of participants who were provided an informed choice of services and providers by the case manager. N = Number of participants with documentation that the CM informed them of their choices related to waiver services and provider types; 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 = 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:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the

State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

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

HOW DISCOVERY IS DESIGNED AND IMPLEMENTED
ALTSA monitors plan of care decisions in several ways:
1. Local Supervisory Discovery Activities
Each year, social service supervisors/managers monitor three records per experienced worker 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 assessment that can lead to an inaccurate plan of care are corrected. Reports for experienced workers can be generated at any time for preliminary action, and annually for statistical analysis.

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

The QA application and CARE reports, (QA monitoring data is current at the time monitoring occurred and CARE management reports are in real time), capture the following:
- Needs identified in CARE are adequately addressed in the participant's plan of care
- Plan of care development is participant directed and plans are completed in required time frame
- Participants receive all of the services identified in the plan of care
- Participants are provided the freedom to choose waiver services, institutional care, and service providers
- Participant's 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 States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

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

Reports and aggregate data are reviewed throughout the year (based on an established review schedule) by individuals who make decisions on what improvements are needed individually or systemically. Regions are required to develop a Proficiency Improvement Plan (PIP) within 30 days of receiving their final report. The PIP addresses 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. The region completes the "Progress Reporting Section" and sends to the QA lead when due with a cc: to the QA manager. If the progress report is not received on time, the QA lead follows up with the region.

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

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

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

Indicate whether Independence Plus designation is requested *(select one):*

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

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

Fair Hearing policies and corresponding State regulations ensure that all persons have the right to apply for long-term care services administered by the department, and all applicants/participants have the right to have their financial and program eligibility determined by the department and the right to appeal any decision made by HCS staff which they perceive as adversely impacting their long-term care services including, but not limited to the denial of services, reduction in the level of services, suspension of services, or termination of services. Fair hearing policy and procedure is outlined in Chapter 26 of the State Long-Term Care Manual. Implementation and tracking of fair hearings is accomplished through an automated database.

All waiver participants sign and receive a copy the "Acknowledgement of Services" form (DSHS 14-225) when they choose to receive a service under a waiver. This form is used to inform participants of their choices regarding waiver and institutional services and of their fair hearing rights.

The case manager informs the applicant/participant verbally AND in writing when HCS approves, denies, reduces, or terminates services and explains the reason(s) for the action or decision in question, including the facts upon which the decision was based. This notice includes language found in Washington Administrative Code that informs the participant they have a right to continued benefits pending the outcome of the administrative hearing if they request a hearing by the effective date of the department's decision or the end of the month in which the effective date occurs. Participants have ninety (90) days from the date they receive the Planned Action Notice to appeal the department's decision.

The applicant/participant must always be informed of the right to a fair hearing and how to make a fair hearing request. A fair hearing request form is included with the Planned Action Notice sent to the participant. The participant is informed that fair hearing requests may be made verbally or in writing. The Case Manager will assist and/or submit a request for a Fair Hearing on behalf of the participant at their request. Planned Action Notices are currently retained in the participant's CARE record. Decisions are kept with the same retention as other client documents.

The case manager documents in the Service Episode Record the date, topic of discussion, that the fair hearing process has been explained, and the participant's decision.

References:
DSHS form 14-225 - Acknowledgement of Services
DSHS Planned Action Notice
Chapter 388-02 WAC and its successors
DSHS hearing rules
Long-Term Care Manual Chapter 26

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

The system is operated by the Department of Social and Health Services (DSHS) through the Aging and Long-Term Support Administration (ALTSA).

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

a) Types of grievances/complaints that participants may register:

Participants may register complaints about anything the Department does or is responsible for that they perceive as affecting them negatively in any way. To protect participant rights, some types of complaints are immediately directed to other formal systems rather than being addressed through the grievance process.

All participants receive the document, "Your Rights and Responsibilities When You Receive Services Offered by Aging and Disability Services Administration". This document informs participants that they have the right to make a complaint and also have the right to separately request a fair hearing. In addition, participants receive a Planned Action Notice informing them of all actions taken by ALTSA. This notice outlines the fair hearing process and offers participants the pamphlet entitled "Your Hearing Rights in a DSHS Case" which explains that an optional opportunity to settle the case before the hearing is available and also explains that if an agreement cannot be reached the right to a fair hearing remains.

Complaints not handled through the grievance process include the following:
--Complaints of abuse, neglect or financial exploitation of a vulnerable adult or child - referred to formal protective systems
--Participant disputes about services that have been denied, reduced, suspended, or terminated - participant is informed of their rights and referred to the fair hearing process
--Complaints about possible Medicaid fraud - referred to the Medicaid Fraud Control Unit

b) Process and timelines for addressing grievances/complaints:

Complaints can be received and addressed at any level of the organization. However, ALTSA always strives to address grievances/complaints at the lowest level possible. Upon receipt at any level, all DSHS employees are required to respond to in-person or telephone complaints within one business day. Written complaints must receive a response within seven business days. Complaints are referred to the case manager for action unless the complainant requests it not be. If the case manager is unable to resolve the complaint, the person is referred to the case manager's supervisor. The supervisor has ten working days from the date of receipt to attempt to resolve the issue. If the person feels their complaint is not resolved, they are referred to the Regional Manager. The Manager has ten working days to seek resolution. If the person continues to feel their complaint is not resolved, they are referred to the state level ALTSA headquarters. ALTSA has ten working days to resolve the complaint and must notify the person in writing of the outcome.

As part of the pre-hearing process, the administrative hearing coordinator is responsible for clarifying the issues that the participant is disputing. If the dispute is in relation to a personality conflict with the case manager, for instance, or a dispute that falls outside of WAC/eligibility, the coordinator informs the participant about their grievance procedure. A case manager, 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 Notice of Action, Exception to Rule that is given to the participant contains the grievance procedure.

c) Mechanisms 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) Management Bulletin H05-018 Policy/Procedure Client Grievance Policy March 2005
(3) DSHS Administrative Policy No. 8.11

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The State requires the following types of critical events or incidents be immediately reported for review and follow up action by an appropriate authority:
• Abandonment
• Abuse (including sexual, physical, mental, personal exploitation, and improper use of restraint)
• Financial exploitation
• Neglect
• Self-neglect

Types of Abuse under RCW 74.34.020
1. Abandonment means action or inaction by a person or entity with a duty of care for a vulnerable adult that leaves the vulnerable person without the means or ability to obtain necessary food, clothing, shelter, or health care.

2. Abuse means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, and personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult which have the following meanings:

a. Sexual abuse means any form of nonconsensual sexual contact including, but not limited to, unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse includes any sexual contact between a staff person, who is not also a resident or client, of a facility or a staff person of a program authorized under Chapter 71A.12 RCW, and a vulnerable adult living in that facility or receiving service from a program authorized under Chapter 71A.12 RCW, whether or not it is consensual.

b. Physical abuse means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to: striking with or without an object, slapping, pinching, choking, kicking, shoving, or prodding.

c. Mental abuse means a willful verbal or nonverbal action that threatens, humiliates, harasses, coerces, intimidates, isolates, unreasonably confines, or punishes a vulnerable adult. Mental abuse may include ridiculing, yelling, or swearing.

d. Personal exploitation means an act of forcing, compelling, or exerting undue influence over a vulnerable adult causing the vulnerable adult to act in a way that is inconsistent with relevant past behavior, or causing the vulnerable adult to perform services for the benefit of another.

e. Improper use of restraint means the inappropriate use of chemical, physical, or mechanical restraints for convenience or discipline or in a manner that: (i) Is inconsistent with federal or state licensing or certification requirements for facilities, hospitals, or programs authorized under chapter 71A.12 RCW; (ii) is not medically authorized; or (iii) otherwise constitutes abuse under this section. Improper use of restraints is considered abuse under Washington law and must be reported immediately.

3. Financial exploitation means the illegal or improper use, control over, or withholding of the property, income, resources, or trust funds of the vulnerable adult by any person or entity for any person's or entity's profit or advantage other than for the vulnerable adult's profit or advantage. "Financial exploitation" includes, but is not limited to:

(a) The use of deception, intimidation, or undue influence by a person or entity in a position of trust and confidence with a vulnerable adult to obtain or use the property, income, resources, or trust funds of the vulnerable adult for the benefit of a person or entity other than the vulnerable adult;

(b) The breach of a fiduciary duty, including, but not limited to, the misuse of a power of attorney, trust, or a guardianship appointment, that results in the unauthorized appropriation, sale, or transfer of the property, income, resources, or trust funds of the vulnerable adult for the benefit of a person or entity other than the vulnerable adult; or

(c) Obtaining or using a vulnerable adult's property, income, resources, or trust funds without lawful authority, by a person or entity who knows or clearly should know that the vulnerable adult lacks the capacity to consent to the release or use of his or her property, income, resources, or trust funds.

4. Neglect means (a) a pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; or (b) an act or omission by a person or entity with a duty of care that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100.

5. Self-neglect means the failure of a vulnerable adult, not living in a facility, to provide for himself or herself the goods and services necessary for the vulnerable adult's physical or mental health, and the absence of which impairs or threatens the vulnerable adult's well-being. This definition may include a vulnerable adult who is receiving services through home health, hospice, or a home care agency, or an individual provider when the neglect is not a result of inaction by that agency or individual provider.

Intake referrals/reports are received in any format used by the referent including email, phone calls, our online reporting site or postal mail and the referrals are then routed to the appropriate investigative body. Referrals for abuse, neglect exploitation or abandonment can be made directly to APS or the CRU through the use of the Regional APS intake line or the RCS Complaint Resolution Unit (CRU) toll free number. The State also provides an End Harm hotline where any type of referral can be made and the referral is routed to the appropriate investigative entity.

Intake reports are first screened for the need for emergency response and the appropriate emergency responder is notified if indicated. Reports are then evaluated for jurisdiction for 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.
Required reporting of allegations involving waiver participants: What, when and to whom:
RCW 74.34.035 Reports (excerpt):

(1) When there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department.

(2) When there is reason to suspect that sexual assault has occurred, mandated reporters shall immediately report to the appropriate law enforcement agency and to the department.

(3) When there is reason to suspect that physical assault has occurred or there is reasonable cause to believe that an act has caused fear of imminent harm:

(a) Mandated reporters shall immediately report to the department; and

(b) Mandated reporters shall immediately report to the appropriate law enforcement agency, except as provided in subsection (4) of this section.

(4) A mandated reporter is not required to report to a law enforcement agency, unless requested by the injured vulnerable adult or his or her legal representative or family member, an incident of physical assault between vulnerable adults that causes minor bodily injury and does not require more than basic first aid, unless:

(a) The injury appears on the back, face, head, neck, chest, breasts, groin, inner thigh, buttock, genital, or anal area;

(b) There is a fracture;

(c) There is a pattern of physical assault between the same vulnerable adults or involving the same vulnerable adults; or

(d) There is an attempt to choke a vulnerable adult.

5. When there is reason to suspect that the death of a vulnerable adult was caused by abuse, neglect, or abandonment by another person, mandated reporters shall, pursuant to RCW 68.50.020, report the death to the medical examiner or coroner having jurisdiction, as well as the department and local law enforcement, in the most expeditious manner possible. A mandated reporter is not relieved from the reporting requirement provisions of this subsection by the existence of a previously signed death certificate. If abuse, neglect, or abandonment caused or contributed to the death of a vulnerable adult, the death is a death caused by unnatural or unlawful means, and the body shall be the jurisdiction of

the coroner or medical examiner pursuant to RCW 68.50.010.

Required reporters of allegations of abuse, abandonment, neglect and financial exploitation:
RCW 74.34.020 Definitions: (14) "Mandated reporter" is an employee of the department; law enforcement officer; social worker; professional school personnel; individual provider; an employee of a facility; an operator of a facility; an employee of a social service, welfare, mental health, adult day health, adult day care, home health, home care, or hospice agency; county coroner or medical examiner; Christian Science practitioner; or health care provider subject to chapter 18.130 RCW. Mandated reporters are informed to call one number, 1-866-END-HARM. Call line operators or intake workers use a decision tree of questions to direct reports immediately to the correct investigative entity. Once received, if the investigative entity determines they do not have jurisdiction, the referral is immediately sent to the correct investigative entity.

Mandated reporters are informed to call one number, 1-866-END-HARM for all types of reports. Call line operators or intake workers use a decision tree of questions to direct reports immediately to the correct investigative entity. Once received, if the investigative entity determines they do not have jurisdiction, the referral is immediately sent to the correct investigative entity.

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.

References:

-Chapter 74.34 RCW: Abuse of Vulnerable Adults statute
-WAC 388-71-0100 through 01280: Adult Protective Services
-HCS Long-Term Care Manual, Chapter 6, policies and procedures of the Adult Protective Services Program

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The following resources illustrate ways that participants, family members, caregivers and/or legal representatives are provided information about protections from mistreatment and told how to report concerns or incidents of abuse, neglect, and exploitation:

Participants receive information at least annually during their annual assessment or more frequently if their situation changes significantly. Every CARE assessment addresses potential abuse, neglect and exploitation. This information is provided by the social worker or case manager verbally and in the 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).

The participant financial eligibility process also includes a review of funds and information on client financial rights.

Other resources available to participants and representatives include:
1. Provider training (e.g., Caregiver Orientation, and Revised Fundamentals of Caregiving and Safety Training);
2. ALTSA and DSHS internet websites;
3. Eldercare Locator (AoA);
4. DSHS End Harm campaign and the activities associated with the annual statewide July Adult Abuse Prevention month.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and

the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Reports of the abuse, abandonment, neglect, financial exploitation or self-neglect of a participant are received by Adult Protective Services by phone, fax, letter, online, 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 timeframe for initiation of each investigation.

Both APS and RCS fall under statute, RCW 74.34. RCW 74.34.063 requires the department to determine jurisdiction and initiate a response to a report no later than 24 hours after knowledge of the report.

Based on the facts and circumstances known at intake, reports are prioritized and assigned for investigation based on the severity and immediacy of actual or potential physical, mental or financial harm to the alleged victim, as follows:

1. High priority when serious or life threatening harm is occurring or appears to be imminent. APS will conduct an unannounced private interview with the alleged victim within 24 hours of receipt of the report.

2. Medium priority when harm that is more than minor, but does not appear to be life threatening at this time, has occurred, is on-going, or may occur. APS will conduct an unannounced private interview with the alleged victim within 5 working days of receipt of the report.

3. Low priority when harm that poses a minor risk at this time to health or safety, has occurred, is ongoing, or may occur. APS will conduct an unannounced private interview with the alleged victim within 10 working days of receipt of the report.

Both APS and RCS fall under statute, RCW 74.34. RCW 74.34.063 requires the department to determine jurisdiction and initiate a response to a report no later than 24 hours after knowledge of the report.

On a case-by-case basis, the supervisor or designee may specify a specific response time shorter than the maximum response time designated for the priority level.

APS investigations are completed within 90 days of assignment unless necessary investigation or protective services activity continues. APS supervisors review cases at the 60 day and 90 day marks, and every 30 days after the 90 day mark if the case remains open for necessary protective services activity.

The participant or the participant’s representative is informed of the results of the investigation. For unsubstantiated results the participant/representative receives verbal notification at the end of the investigation. For substantiated results, the participant receives verbal notification (written when requested) at two stages throughout the investigation; (1) when a determination by the investigator to recommend that the allegation be substantiated and (2) when this determination has been reviewed by the regional investigation review team.

RCS investigates licensed or certified residential providers. The complaint investigation response times are 2-days, 10-days, 20-days, 45-days, 90-days, and Quality Reviews. For allegations that involve named individuals that may have perpetrated abuse, neglect, or misappropriation of resident funds response times are 10-days, 20-days, 30-days, and 60-days. All of these categories require an on-site investigation, except for the Quality Review category. In general, the shorter the investigation response timeframe, the more serious the alleged issue. Any report received from a public caller is assigned an on-site investigative response time. RCW 74.39A.060 (5) (b) requires that RCS inform the complainant of the “right to receive a written copy of the investigation report.” RCS provides a copy the investigative report upon request.

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. Intakes, investigations and protective services performed by APS are continuously monitored at state and regional levels.

1. Regional and headquarters program managers conduct on-going audits of case records in the Quality Assurance Monitoring (QAM) 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. Residential Care Services (RCS) and Home and Community Services (HCS) management generate Tracking Incidents for Vulnerable Adults (TIVA) reports to review intakes and investigations by program, type and facility 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.

The Residential Care Services division has a formal quality assurance review process in which a sample of completed facility surveys, inspections, licensing visits, and complaint investigations are reviewed retrospectively on an annual cycle. Headquarters based Social and Health Program Consultants conduct record reviews using the Quality Assurance Monitoring (QAM) application. Proficiency reports are generated utilizing a statewide database. Regional and Headquarters staff use both statewide and regional data to track trends, update policies, and implement training.

Residential Care Services (RCS) management generates Tracking Incidents for Vulnerable Adults (TIVA) reports to review intakes and investigations by program, type, and facility for tracking and trending purposes. Report data is used to monitor required response timelines and to respond to internal and external stakeholder requests for trends in intake types.

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:

◉ **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).

Conditions under which a restraint may be applied:
Physical restraints, mechanical devices used as a restraint and chemical restraints may be used solely to treat a participant's medical symptoms related to behavior that poses a safety or health risk. Restraints may not be used for the purposes of discipline or convenience. The participant has the right to refuse any service or medication at any time, including restraints used for medical purposes.

Identification of a specific and individualized assessed need:
If a restraint is to be used to treat medical symptoms related to behavior, it must be supported by an assessed medical need in the person centered service plan and included in the Negotiated Care Plan which is the plan developed between the participant and the residential provider. The residential provider is required to incorporate the assessment and person centered service plan into the Negotiated Care Plan. The plans must be updated if new needs arise. The Negotiated Care Plan must list all assessed needs for which the participant has chosen to accept care or services and list which care and services the participant has refused. This includes the use of restraints for medical purposes. The participant must agree to and sign the person centered and Negotiated Care Plans.

Informed Consent:
The participant or representative is always included in the development of the person centered care plan and the negotiated care plan. The participant or representative must be made aware of the risks and the right to refuse the restraint. The use of restraints is voluntary and the participant or representative must give informed consent, which is documented in the resident's Negotiated Care Plan.

Positive interventions, supports and less intrusive methods must be employed prior to the use of restraints:
Prior to the use of restraints alternative strategies must be tried. The person centered service plan contains positive and less intrusive interventions that must be employed for any identified behavior including medical symptoms. The participant's negotiated care plan includes strategies, therapeutic interventions, and required staff behavior to address the symptoms for which the restraint is prescribed. The plan addresses a participant's special needs and responses to a participant's refusal of care and the need to reduce tension, agitation or anxiety. The residential provider must document in the negotiated care plan other strategies or modifications used to avoid restraints.

Participants must have an assessed need proportionate to the use of restraints:
The need for a restraint must be assessed by a medical professional. This information must then be incorporated into the participant's negotiated care plan. The conditions under which a restraint may be used must be documented in the participant's care plan and in the medical professional's treatment plan. Documentation must reflect the medical symptom related to behavior for which a restraint is being used, when a restraint may be used, and how the restraint should be used.

Physical restraints or mechanical devices used as a restraint to treat a medical symptom are authorized and monitored under the onsite supervision of a nurse or physician during the time the restraints are applied.

The use of chemical restraints to treat a medical symptom is authorized by a standing physician's order that reflects when and how to use the chemical restraint.

Collection and review of data to measure the ongoing effectiveness of the modification:
The residential waiver service provider must document the use of chemical restraints in the medication log, and must indicate the dosage, when it was given, and whether it was effective. The use of physical restraints and mechanical devices used as a restraint must be reviewed by the supervising medical professional and measured for ongoing effectiveness.

WAC 388-107-0420 requires the enhanced services facility provider document the use of positive interventions and supports before physical restraints are used. If physical restraints are used, the provider must obtain a physician's order within one hour; the physician's order must include treatments to assist in resolving the situation and eliminating the need for the restraint.

Periodic review of restraint usage:
The negotiated care plan must be reviewed at least annually and updated at any time the use of restraint

becomes ineffective, is no longer needed or becomes unsafe.

Restraints may not cause harm:
The use of restraints must be deemed safe and appropriate by the medical professional prescribing and monitoring their use. The participant or representative is informed of any risks and may choose to decline the use of restraints at any time.

Education and training requirements for providers involved in the use of restraints:
All medical professionals involved in prescribing and monitoring restraints must have appropriate licensure and qualifications. In adult family homes, the resident manager and caregivers must have completed all required training which includes safety and orientation, 48 hours of administrative training, 70 hours of basic training and 12 hours per year of continuing education. In enhanced services facilities, the administrator must complete: mental health and dementia specialty training; 12 hours of continuing education per year, with 10 of those being relevant to the facility population; and 3 additional hours of training per quarter that is relevant to the issues, behaviors, or challenges of residents.

Methods for detecting the use of unauthorized restraints:

The Aging and Long-Term Support Administration detects use of restraints 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 licensing rules and related statutes and regulations, and investigation of complaints.

In addition, adult family homes and enhanced services facilities are licensed through the state Residential Care Services Division. The licensing inspection process includes observations and interviews to determine compliance with licensing rules and related statutes and regulations including the use of restraints. In addition to licensing inspections, the licensing staff investigates complaints from residents or the public, including those about possible restraint violations, and takes action to ensure that rights are not violated.

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:

Aging and Long-Term Support Administration is responsible for detecting the unauthorized use of restraints.

Required training for all paid caregivers includes clear instructions that any use of restraint for behavior or convenience is prohibited. 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. Caregivers are among the people that Washington State Law (RCW 74.34) lists as mandatory reporters of suspected abuse.

The Aging and Long-Term Support Administration detects use of restraints through reports received in the Adult Protective Services system, through the CARE assessment process conducted yearly and at significant change, through the grievance process, through quality assurance activities that may include face to face process which includes observations and interviews that determine compliance with licensing rules and related statutes and regulations.

In addition, adult family homes, assisted living facilities, enhanced adult residential care facilities, and enhanced services facilities are licensed through the state Residential Care Services Division. The licensing inspection process includes observations and interviews to determine compliance with licensing rules and related statutes and regulations including the use of restraints. In addition to licensing inspections, the licensing staff investigates complaints from residents or the public, including those about possible restraint violations, and takes action to ensure that rights are not violated.

RCS addresses the use of restraints when necessary during regular licensing visits with the provider. Licensing visits occur at a minimum of every 15 - 18 months. Licensors write statements of deficiencies for any areas of non-compliance found and ensure that a corrective action plan has been created to resolve the issue(s). In addition, as part of the RCS regulatory process, the licensor will call the Complaint Hotline to report any improper use of restraints. Follow up visits with the provider are completed to ensure they are back in compliance within 60 days of the licensing visit.

In addition, RCS Behavioral Health Quality Improvement Specialist staff will also provide technical advice and assistance on specifically identified needs or based on deficiencies found during and after inspections or investigations.

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:

The Aging and Long-Term Support Administration (ALTSA) is responsible for detecting the unauthorized use of restrictive interventions.

Required training for all paid caregivers includes clear instructions that any use of restrictive intervention is prohibited. Mandatory training includes detailed information on types of restrictive interventions that are beyond the obvious use of restraint and seclusion. Training also includes multiple alternatives to restrictive intervention and instructs the caregiver to consult with others involved in the person's care such as family and case managers.

ALTSA detects use of restrictive intervention through reports received by the Complaint Resolution Unit in the Residential Care Services Division, through the CARE assessment process conducted yearly and at significant change, through the grievance process and through quality assurance activities that may include face-to-face interviews of participants and review of complaints.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

ALTSA is responsible for detecting the unauthorized use of restrictive interventions, including seclusion.

Required training for all paid caregivers includes clear instructions that any use of restrictive intervention, including seclusion, is prohibited. Mandatory training includes detailed information on types of restrictive interventions that are beyond the obvious use of restraint and seclusion. Training also includes multiple alternatives to restrictive intervention and instructs the caregiver to consult with others involved in the person's care such as family and case managers.

The Aging and Long-Term Support Administration detects use of restrictive intervention, including seclusion, through reports received in the Adult Protective Services system, through the CARE assessment process conducted yearly and at significant change, through the grievance process and through quality assurance activities that may include face to face interviews of clients and review of complaints. RCS investigates the use of restrictive interventions including seclusion if/when reported as a complaint or as observed during inspections/surveys; these approaches are prohibited practices in licensed and/or certified facility settings.

○ **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.

Adult family home, assisted living facility, and enhanced services facility staff have ongoing responsibility for monitoring participant medication regimes for those participants requiring assistance with or administration of medications. After completing a full assessment of the participant's treatments and medications, the provider is required to develop an individualized plan to provide medication assistance. This assistance is documented in the participant's Negotiated Service Plan and PCSP Plan.

Medication assistance or administration is monitored each time the medication is taken or applied. Medication logs are used to document medication usage.

The licensing inspection tool of adult family homes, assisted living facilities, and enhanced services facilities includes monitoring to WAC which prohibits the use of medications as chemical restraint for discipline and convenience and requires that Negotiated Care Plans, resident assessments, or individual treatment plans include strategies and modifications of the environment and staff behavior to address the symptoms for which the medication is prescribed. Medications are monitored by the prescribing medical practitioner. In addition to licensing surveys which are completed on a 15 - 18 month cycle, the RCS Division investigates reported complaints and concerns involving medications.

Behavior-modifying medications are monitored across Washington State residential care settings by the inspection and complaint inspection processes. RCS staff check to ensure AFHs and ALFs have a documented need for the medications on a negotiated care plan, strategies in place for staff reaction to symptomatic behaviors; the medications must be prescribed, documented and tracked in the medication log.

ESFs also rely on the inspection and complaint investigation processes, with stricter requirements. RCS staff check to ensure ESFs provide de-escalation training for staff, have assessments to include behavioral intervention strategies, crisis-prevention strategies, and a person-centered planning team involving monthly meetings with facility staff, community case managers and the resident. The ESF resident must be free from psychopharmacologic medications used to restrain, discipline, or for the convenience of staff.

Additional monitoring of medications is provided by case management staff responding to assessment triggers who may initiate a nursing referral. The CARE assessment tool has built-in triggers that alert the case manager to the presence of a medication regime that has an effect on participant assessment, service planning and delivery. Nursing referrals may be triggered by:

a. A medication level that is "must be administered to person" and:
-The participant is choking or gagging on medications; or
-The participant is not taking medications as ordered; or

b. The participant is declining assistance with medications and:
-Is not taking medications as ordered; and
-Has greater than one emergency room visit or greater than one hospitalization in the last six months; or

c. The participant's medication regimen is complex and:
-The participant has multiple prescribers; and
-The participant has had greater than one emergency room visit or greater than one hospitalization in the last six months; and
-The participant is not taking medications as ordered.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The CARE Assessment triggers a referral to Nursing Services when certain indicators are identified in the area of medication management. When a referral is indicated, the case manager discusses the situation with the participant and documents the discussion in CARE. If the participant agrees to a referral, documentation includes the date of referral and who is responsible to follow through. A referral is not necessary if the participant states they will discuss the issue with their healthcare provider at the next visit.

Referrals are triggered by:
a. A medication level that is "must be administered to person" and:
-The participant is choking or gagging on medications; or
-The participant is not taking medications as ordered; or

b. The participant is declining assistance with medications and:
-Is not taking medications as ordered; and
-Has greater than one emergency room visit or greater than one hospitalization in the last six months; or

c. The participant's medication regimen is complex and:
-The participant has multiple prescribers; and
-The participant has had greater than one emergency room visit or greater than one hospitalization in the last six months; and
-The participant is not taking medications as ordered.

The RCS Division conducts regular oversight inspections of all adult family homes, assisted living facilities, and enhanced services facilities as part of the license renewal process. These visits occur on a 15 - 18 month cycles. Inspectors monitor that medication assistance or administration is outlined in the participant's Negotiated Care Plan, resident assessment, or Individual Treatment Plan and implemented accordingly. In addition to licensing inspection visits, inspections are also prompted by reports and complaints made to the RCS complaint hot-line or online reporting portal. RCS collects trends, patterns and significant issues identified through licensing inspections and/or calls to the complaint line and online reporting portal. Provider letters are sent to all adult family home, assisted living facilities, and enhanced services facility proprietors addressing these concerns.

The RCS Complaint System tracks broad allegation categories, and staff enter the type(s) of allegation categories in the system based on the report provided and this creates a narrative report for the investigator. If applicable, the report will contain medication management or potentially harmful practices. The information gathered assists investigators in following up with the complaints to determine if failed practice occurred and whether enforcement action(s) is warranted.

RCS employs information gathered through licensing inspections related to medication management and potentially harmful practices by addressing the issues with the provider, writing statements of deficiencies, imposing conditions and/or other enforcement remedies if warranted, and ensuring that the corrective action plans have been resolved through a follow up visit. In addition, as part of the RCS regulatory process, licensors will call the Complaint Hotline during regular licensing visits to report medication management issues and potentially harmful practices. Follow up visit with the provider is completed to ensure they are back in compliance.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

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).

Chapters 246-888 and 388-107 WAC provide guidance to residents and providers in community-based care settings on medication assistance and administration. Self-administration with assistance means assistance with legend drugs and controlled substances rendered by a non-practitioner to an individual residing in a community-based care setting or an in-home care setting. It includes reminding or coaching the individual to take their medication, handing the medication container to the individual, opening the medication container, using an enabler, or placing the medication in the hand of the individual/resident. The individual/resident must be able to put the medication into his or her mouth or apply or instill the medication. The individual/resident does not necessarily need to state the name of the medication, intended effects, side effects, or other details, but must be aware that he/she is receiving medications. Assistance may be provided with prefilled insulin syringes. Assistance is limited to handing the prefilled insulin syringe to an individual/resident. Assistance with the administration of any other intravenous and/or injectable medication is specifically excluded. The individual/resident retains the right to refuse medication. Self-administration with assistance shall occur immediately prior to the ingestion or application of a medication.

Independent self-administration occurs when an individual/resident is independently able to directly apply a legend drug or controlled substance by ingestion, inhalation, injection or other means.

If an individual/resident is not able to physically ingest or apply a medication independently or with assistance, then the medication must be administered to the individual/resident by a person legally authorized to do so (e.g., physician, nurse, pharmacist). All laws and regulations applicable to medication administration apply. If an individual/resident cannot safely self-administer medication or self-administer with assistance and/or cannot indicate awareness that he or she is taking a medication, then the medication must be administered to the individual/resident by a person legally authorized to do so.

For adult family homes, WAC 246-840-910 describes the conditions under which a licensed registered nurse may delegate specific nursing care tasks to nursing assistants who meet certain requirements and provide care to individuals in a community-based care setting, including adult family homes: A licensed registered nurse may delegate specific nursing care tasks to nursing assistants who meet certain requirements and provide care to individuals in a community-based care setting.

Before delegating a nursing task in an adult family home, the registered nurse delegator must determine that it is appropriate to delegate based on the following criteria:

1. Determine that the setting allows delegation because it is a community-based care setting or an in-home care setting.

2. Assess the patient's nursing care needs and determine that the patient is in a stable and predictable condition.

3. Determine that the task to be delegated is within the delegating nurse's area of responsibility.

4. Determine that the task to be delegated can be properly and safely performed by the nursing assistant. The registered nurse delegator shall assess the potential risk of harm for the individual patient. Potential harm may include, but is not limited to, infection, hemorrhage, hypoxemia, nerve damage, physical injury, or psychological distress.

5. Analyze the complexity of the nursing task and determine the required training or additional training needed by the nursing assistant to competently accomplish the task. The registered nurse delegator shall consider the psychomotor and cognitive skills required to perform the nursing task. More complex tasks may require additional training and supervision for the nursing assistant. The registered nurse delegator must identify and facilitate any additional training of the nursing assistant that is needed prior to delegation. The registered nurse delegator must ensure that the task to be delegated can be properly and safely performed by the nursing assistant.

6. Assess the level of interaction required, considering language or cultural diversity that may affect communication or the ability to accomplish the task to be delegated, as well as methods to facilitate the interaction.

7. Verify that the nursing assistant or home care aide:

a. Is currently registered or certified as a nursing assistant, or certified as a home care aide in Washington state and is in good standing without restriction;
b. As required in WAC 246-841-405 (2)(a), nursing assistants registered must complete both the basic caregiver training and core delegation training before performing any delegated task;
c. Has a certificate of completion issued by the department of social and health services indicating completion of the required core nurse delegation training; and
d. Is willing to perform the task in the absence of direct or immediate nurse supervision and accept responsibility for their actions.

8. Assess the ability of the nursing assistant to competently perform the delegated nursing task in the absence of direct or immediate nurse supervision to ensure that the nursing task can be properly and safely performed by the nursing assistant.

9. If the registered nurse delegator determines delegation is appropriate, the nurse must:

a. Discuss the delegation process with the patient or authorized representative, including the level of training of the nursing assistant delivering care.
b. Obtain patient consent. The patient, or authorized representative, must give written, informed consent to the delegation process under Chapter 7.70 RCW. Documented verbal consent of patient or authorized representative may be acceptable if written consent is obtained within thirty days; electronic consent is an acceptable format.
c. Written consent is only necessary at the initial use of the nurse delegation process for each patient and is not necessary for task additions or changes or if a different nurse or nursing assistant will be participating in the process.

10. Document in the patient's record the rationale for delegating or not delegating nursing tasks.

11. Provide specific, written delegation instructions to the nursing assistant with a copy maintained in the patient's record that include:

a. The rationale for delegating the nursing task;
b. That the delegated nursing task is specific to one patient and is not transferable to another patient;
c. That the delegated nursing task is specific to one nursing assistant and is not transferable to another nursing assistant;
d. The nature of the condition requiring treatment and purpose of the delegated nursing task;
e. A clear description of the procedure or steps to follow to perform the task;
f. The predictable outcomes of the nursing task and how to effectively deal with them;
g. The risks of the treatment;
h. The interactions of prescribed medications;
i. How to observe and report side effects, complications, or unexpected outcomes and appropriate actions to deal with them, including specific parameters for notifying the registered nurse delegator, health care provider, or emergency services;
j. The action to take in situations where medications and/or treatments and/or procedures are altered by health care provider orders, including:
(i) How to notify the registered nurse delegator of the change;
(ii) The process the registered nurse delegator will use to obtain verification from the health care provider of the change in the medical order; and
(iii) The process to notify the nursing assistant of whether administration of the medication or performance of the procedure and/or treatment is delegated or not;
k. How to document the task in the patient's record;
l. Document what teaching was done and that a return demonstration, or other method for verification of competency, was correctly done; and
m. A plan of nursing supervision describing how frequently the registered nurse will supervise the performance of the delegated task by the nursing assistant and reevaluate the delegated nursing task. Supervision shall occur at least every ninety days.

12. The administration of medications may be delegated at the discretion of the registered nurse delegator but

never by injection (by intramuscular, intradermal, subcutaneous, intraosseous, intravenous, or otherwise). The registered nurse delegator must provide written parameters specific to an individual patient which includes guidelines for the nursing assistant to follow in the decision-making process to administer a medication and the procedure to follow for such administration.

13. Delegation requires the registered nurse delegator teach the nursing assistant how to perform the task, including return demonstration or other method of verification of competency as determined by the registered nurse delegator.

14. The registered nurse delegator is accountable and responsible for the delegated nursing task. The registered nurse delegator must monitor the performance of the task(s) to assure compliance to established standards of practice, policies and procedures and to ensure appropriate documentation of the task(s).

15. The registered nurse delegator must evaluate the patient's responses to the delegated nursing care and to any modification of the nursing components of the patient's plan of care.

16. The registered nurse delegator must supervise and evaluate the performance of the nursing assistant, including direct observation or other method of verification of competency of the nursing assistant to perform the delegated nursing task. The registered nurse delegator must also reevaluate the patient's condition, the care provided to the patient, the capability of the nursing assistant, the outcome of the task, and any problems.

17. The registered nurse delegator must ensure safe and effective services are provided. Reevaluation and documentation must occur at least every ninety days. Frequency of supervision is at the discretion of the registered nurse delegator.

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:

Medication errors are reported to the Complaint Resolution Unit.

(b) Specify the types of medication errors that providers are required to *record:*

All medication errors are to be recorded.

(c) Specify the types of medication errors that providers must *report* to the state:

Medication errors which may be the result of neglect are to be reported.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The RCS Division conducts regular oversight inspections of all adult family homes and enhanced services facilities as part of the license renewal process. These visits occur on 15-18 month cycles. Inspectors monitor that medication assistance or administration is outlined in the participant's Negotiated Care Plan, assessment, or Individual Treatment Plan and implemented accordingly. In addition to licensing inspection visits, inspections are also prompted by reports and complaints made to the RCS complaint hot-line. RCS collects trends, patterns and significant issues identified through licensing inspections and/or calls to the complaint line. Provider letters are sent to all adult family home and enhanced services facility proprietors addressing these concerns.

The RCS Complaint System tracks broad allegation categories, and staff enter the type(s) of allegation categories in the system based on the report provided and this creates a narrative report for the investigator. If applicable, the report will contain medication management or potentially harmful practices. The information gathered assists investigators in following up with the complaints to determine if failed practice occurred and whether enforcement action(s) is warranted.

RCS employs information gathered through licensing inspections related to medication errors by addressing the issues with the provider, writing statements of deficiencies, imposing conditions and/or other enforcement remedies if warranted, and ensuring that the corrective action plans have been resolved through a follow up visit. In addition, as part of the RCS regulatory process, licensors will call the Complaint Hotline during regular licensing visits to report medication management issues and potentially harmful practices. Follow up visit with the provider is completed to ensure they are back in compliance.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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:
#2. The number and percent of critical incidents, by type, where follow-up action was taken when warranted N = Number of critical incidents, by type, where action was taken when warranted D = Number of (critical) incidents investigated requiring action

Data Source (Select one):

Other
If 'Other' is selected, specify:
Administrative data

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

Data Aggregation and Analysis:

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

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

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 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:
#7. The number and percent of critical incidents that were correctly reported to CRU (for residential). N = Number of records reviewed where a referral for CRU was required and not completed; D = Number of records reviewed where a CRU complaint was correctly reported.

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

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

(check each that applies):		
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 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**

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

Performance Measure:
#6. The number and percent of Residential Care Services (RCS) investigations completed within mandatory timeframes. N = Number of CRU investigations completed within mandatory timeframes; D = Number of CRU investigations.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
#4. The number and percent of participants informed of how to identify and where to report abuse, neglect, and exploitation. N=Number of participants 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** Confidence Interval = 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:
#3. The number and percent of critical incidents that were properly reported to Adult Protective Services (APS) N = Number of records reviewed where a referral for APS was warranted and completed 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 = 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**

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

Performance Measure:
#1. The number and percent of deaths investigated where appropriate follow-up action was taken when warranted. N = Number of deaths investigated where appropriate follow-up action was taken when warranted D = Number of deaths investigated

Data Source (Select one):
Other
If 'Other' is selected, specify:
APS Fatality Review data

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

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

Data Aggregation and Analysis:

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

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:
Percent of critical incident trends where systemic interventions were implemented
N=Number of critical incident trends where systemic interventions were implemented
D=Number of critical incident trends

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
Percent of participant records reviewed with no instances of the use of seclusion or restraints D=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, 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 = 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:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
The number and percent of 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 warranted in the assessment. D=Number of participant files reviewed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 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:
The number and percent of participants who received information about the importance of receiving the flu vaccine at the time of annual assessment: N = Number of participants who received information about the importance of receiving the flu vaccine during their annual assessment; D = Number of participants records reviewed who had an annual assessment.

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 = 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**

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

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, complaint resolution unit, residential care services and children's protective services for allegations of abuse, neglect, abandonment or exploitation.

The case manager documents and addresses health/safety interventions for waiver participants such as: evacuation in an emergency, minimum case management contacts, case management, environmental modifications, client training, skin observation protocol, nursing referral indicators from triggered referral screens, assistance obtaining durable medical equipment, cognitive deficits, person(s) responsible for supervising caregivers, screen to document client falls, drug/alcohol assessments, depression screening, caregiver burnout, suicide risk, and other high risk indicators.

HCS nursing services RNs respond to referrals by HCS case managers based on nursing indicators identified in CARE. Nurses document nursing services activities in CARE and collaborate with case managers on follow up recommendations.

RCS performs multiple levels of ongoing quality assurance related to complaint investigations for licensed residential providers. Investigative protocols have been developed for each licensed setting, and the protocols function as a tool to ensure that RCS staff are consistently and thoroughly investigating allegations of abuse and neglect in all licensed settings. All RCS staff and managers have been trained on the use of the protocols. The protocols and other informational resources that have been developed are intended to prospectively influence the quality of on-site investigative work.

RCS has also launched a formal semi-annual quality assurance review process in which a sample of completed investigations is reviewed retrospectively. Multiple objective criteria are used to determine if all elements of a thorough investigation are demonstrated through a random sample of completed investigations. Managers conduct this formal review process for work done in another field unit, so that objectivity is maintained. The process also includes a panel of Headquarters' reviewers who review the same sample of investigations, and then comparisons are made between findings. The protocols, operational principles and procedures, and the results of regional QA work are posted on a unique RCS web-site titled "Q-sure". This web-site is accessible to all RCS staff.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

Each HCS record reviewed during the supervisory and quality assurance review cycle is checked to determine if a mandatory referral to the Complaint Resolution Unit should have been made. If appropriate, the HCS case manager 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 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 ongoing case management training, policy review/revision/development, and other areas as needed.

Reports available from the new TIVA (Tracking Incidents for Vulnerable Adults) system will allow RCS and HCS management to review the intakes and investigations by program, by allegation type, and by provider for tracking and trending purposes. The analysis of this data is used to develop policy and/or program modifications that are necessary to impact changes to any undesired trends and to create/modify training for both case managers and the community on protection of vulnerable adults including how to recognize and prevent instances or reoccurrences of abuse, neglect and exploitation.

Based on data analysis and monitoring, training and/or mentoring is provided by local and regional offices. "Dear Provider" letters are issued by ALTSA policy as guidance to residential providers based on trend areas such as: use of restraints, medication errors, problems with participant's funds, or certain types of abuse, neglect, or exploitation incidents.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

This quality management strategy encompasses the following Medicaid programs and waivers: State Plan Medicaid Personal Care, Roads to Community Living (Money Follows the Person), Community Options Program Entry System waiver (COPES - #0049), New Freedom waiver (#0443), and Residential Support Waiver.

The design of the New Freedom, COPES, and the Residential Support waiver are all similar in that all three are designed to ensure each waiver encompasses all requirements and assurances required by CMS. This is evidenced by the following components throughout the waiver application appendices:
a. Participant services- all waivers offer similar services to participants to remain in the community with the focus on the provision of personal care and/or provide wrap around services that support the delivery of personal care.
b. Participant Safeguards- All three waivers follow the same participant safeguards outlined throughout this waiver.
c. Quality Management. The information below outlines ALTSA quality management approach which is the same for all waivers.

The quality management approach is the same across waivers:
a. Methodology for discovering information: The state draws a statistically valid sample of waiver participant records across the three waivers, and adds participant records in order to stratify the sample for individual waivers.

b. Manner in which individual issues are remedied: The state continues to remediate all QA issues at an individual level. Remediation actions and timelines are recorded and tracked via the QA monitoring application. For all issues in which the state does not meet the 86% compliance, the state conducts a quality improvement project initiated at ALTSA HQ.

c. Process for identifying and analyzing trends/patterns: The QA monitoring application generates reports that allows patterns/trends to be tracked at both the individual office and statewide level. The state analyzes these trends/patterns annually and publishes a Quality Assurance annual report.

d. Majority of the performance indicators are the same: The majority of performance measures associated with CMS assurances are the same. In addition the state does a focused review on the FMS for the New Freedom waiver only.

The provider network is the same across the waiver programs. All provider types within the three waivers are required to meet the same training and background check requirements and become licensed or certified if required.

Provider oversight is the same across the waivers. The same agencies conduct oversight monitoring on the same time frame and using the same tools.

All waiver services are included in the consolidated reporting. There are three Performance Measures that are unique to the Residential Support Waiver. They are:
• The number and percent of waiver participants who's residential service provider completed required specialty training, as delegated by the State Medicaid Agency.
• The number and percent of Residential Care Services (RCS) investigations completed within mandatory timeframes
• The number and percent of critical incidents that should have been reported to CRU (for residential).
• The percent of residential provider rates changed in the waiver that adhere to the rate developed in accordance with the waiver’s approved rate methodology.

Ongoing discovery and remediation is facilitated by regular reporting and communications among the ALTSA Home and Community Services (HCS) Quality Assurance (QA) unit, Home and Community Programs, State Unit on Aging, State regional offices, and other stakeholders including service providers and agencies. As delegated by the Health Care Authority (the single State Medicaid Agency), ALTSA is the operating entity responsible for conducting quality monitoring reviews, trending, prioritizing and determining system improvements based on the data analysis and remediation information from the ongoing quality improvement strategies. These processes are supported by the integral role of other waiver partners in providing data, which may also include data analysis, trending and the formulation of recommendations for system improvements. These partners include Residential

Care Services, waiver service providers, Adult Protective Services, Social Service Payment System, Provider One, the Health Care Authority, Behavioral Health and Service Integration Administration, Developmental Disabilities Administration, Department of Health, and participants. Regular reporting and communication among waiver partners facilitates ongoing discovery and remediation.

ALTSA analyzes and trends data received from quality assurance and quality improvement activities and waiver partners. The analysis includes monitoring reviews of all HCS field offices statewide, and year-to-year comparisons of statewide proficiencies. When data analysis identifies areas needing improvement, ALTSA and waiver partners develop proficiency improvement plans. These plans are prioritized and changes are implemented based on ALTSA strategic goals, stakeholder input, and available resources.

A Proficiency Improvement Plan (PIP) outlines a process for addressing items that do not meet proficiency. Both HCS Headquarters (HQ) and the Regions are responsible for developing and implementing a PIP. The Regions complete a PIP for any QA question where the Region does not meet expected proficiency. The QA unit reviews each PIP to ensure it is completed. A HQ PIP plan is completed for any QA question that does not meet the expected statewide proficiency. The PIP plan 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 HCS Regional Administrators, and is available through the HCS intranet site for staff review and discussion.

The annual QA Audit Report and HQ PIPs developed as a result of this process are reviewed and approved by the State Medicaid Agency through the Medicaid Agency Waiver Oversight Committee. This committee meets, at a minimum, on a quarterly basis and discusses administration and oversight issues. All performance measure activities and findings are discussed and addressed in detail with the oversight committee. The state Medicaid agency provides feedback and recommendations regarding waiver activities. Plans are also shared with stakeholders for review and recommendations.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The QA monitoring application is an integral part of the discovery process and integrates the CMS quality framework and assurances. Data/reports produced from the QA application and CARE are key components of the overall quality management strategy and are used for quality assurance/quality improvement activities and remediation.

After implementation of system improvements, the QA findings are reviewed to determine statewide trends and the impact of the past system improvements. Where needed, feedback from the Regional staff is sought to determine the effectiveness of the system improvements and to identify further modifications which may be required to effectuate a positive change. The roles and responsibilities of the various groups involved in the processes for monitoring and assessing system design changes are described below:

Quality Assurance Unit
The 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 the three state regional areas 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, Residential Support Waiver WA.1086)operated by the Aging and Long-Term Support Administration. This is based on a five percent margin of error, a 95% confidence level, and a response distribution of 50%. The state then stratifies the sample for each specific waiver by drawing a minimum number of records for each waiver. The stratification standards the state uses for minimum sampling is 8% margin of error, 95% confidence level (with .7 distribution assumption).
-Completing an initial review statewide.
-Meeting with the local management team, QA Program Manager, 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/case management entity, unit, and/or worker level.

The QA unit verifies that corrections have been made to all items within 30 days of the area receiving the regional final report and that health and safety concerns are corrected immediately. The QA unit reviews and approves HCS local Proficiency Improvement Plans (PIPs) 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), in addition to participant record reviews.

Upon completion of the 12-month review cycle, statewide systemic data is analyzed for trends and patterns by managers, the HCS Chronic Care, Well Being and Performance Improvement Unit and executive management staff. The Chronic Care, Well Being and Performance Improvement Unit conducts research into methods of improvement and training which are also incorporated into quality improvement activities. Decisions for action are made based on analysis of the data and determination of priorities. A Headquarters PIP is developed. The PIP may include statewide training initiatives, policy and/or procedural changes and identification of further quality improvement activities/projects.

State Unit on Aging (SUA)
The SUA is responsible for oversight of Area Agency on Aging operations. The oversight duties include monitoring implementation and compliance with contract requirements, state and federal laws and regulations, policies and procedures;

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.

The Chronic Care, Well Being and Performance Improvement Unit measures the effectiveness of assessment, care

planning and interventions and recommends performance improvements.

Residential Care Services Division:
Adult family homes and enhanced services facilities are licensed through the state Residential Care Services Division. The Residential Care Services (RCS) Division conducts inspections of adult family homes and enhanced services facilities at least every 18 months to ensure they meet licensing requirements and are in compliance with all state laws and rules. The RCS determines that all rights are respected and preserved through the licensing inspection process, which includes observations and interviews that determine compliance with licensing rules and related statutes and regulations. 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 provider is cited and must develop a corrective action plan to address the issues. The Complaint Resolution Unit (CRU) in RCS investigates licensed residential providers. The CRU receives reports of abuse, abandonment, neglect, or financial exploitation by phone, fax, letter, or in-person. RCS may take enforcement actions based on the findings from licensing inspections and complaint investigations. Enforcement actions range from civil fines to license revocation to referral of criminal allegations to law enforcement.

The Adult Protective Services (APS) Unit investigates and makes official findings on any accusations of abuse, neglect or exploitation of a vulnerable adult when the alleged perpetrator is from outside of the home or is not affiliated with the home.

Home and Community Services Field Supervisors are responsible for monitoring participant records for each of their staff every year. All supervisory reviews are required to be completed in the QA Monitoring Tool. The QA Unit Manager at HCS Headquarters, as well as the field office management staff and individual workers, can see the results of the supervisory reviews. The monitoring is conducted to ensure the quality of assessments and service plans and 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.

The Waiver Management Committee ensures regular opportunities for discussion and waiver oversight between the state Medicaid agency and the operating agency. The committee includes representatives from administrations within the operating agency: the Developmental Disabilities Administration (DDA), Aging and Long-Term Support Administration (ALTSA), and the Behavioral Health and Service Integration Administration (BHSIA). The committee meets at least quarterly to review all functions delegated to the operating agency, current quality assurance activities and performance, pending waiver activity (e.g. amendments, renewals, etc.), potential waiver and rule changes and quality improvement activities.

The State's targeted standards for systems improvement include reviewing the proficiency of every QA question to ensure that proficiency is obtained. Any QA question that has not met proficiency requires a proficiency improvement plan, as described earlier in this document. The entire quality assurance and quality improvement process is reviewed at least annually to ensure quality issues are identified and addressed, and that system improvements are implemented and evaluated.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Improvement Strategy is evaluated and adjusted prior to the beginning of each yearly review cycle, at each waiver renewal, and when appropriate at waiver amendments. Workgroups consisting of ALTSA HQ program managers, HCS Supervisors, Joint Requirement Planners, 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 quality improvement strategy is reviewed and approved by the ALTSA executive management team and the Medicaid Agency Waiver Management Committee, which is overseen by the Health Care Authority (the single Medicaid State Agency).

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ◉ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

a) Requirements concerning the independent audit of provider agencies:

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 subcontractors who expend more than $750,000 in federal assistance in a year.

If the subcontractor is a for-profit organization, it may be a subrecipient, but it will not fall under the OMB CIRCULAR A-133 requirements for a federal single or program-specific audit. In this unique case, the for-profit is monitored annually as follows:
1. By performing a desk review of the vendor's annual audit,
2. By on-site monitoring and completion of the monitoring worksheet.
3. Review of subcontractor's relevant cost information when contract is renewed.
The State Auditor's Office conducts the periodic independent audit of the waiver program as required by the single audit act.

b) 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:

Fiscal Review: Comparison of a sample of contractor billing reports to contractor maintained documentation of work performed. A review of individual employee time records is part of this responsibility. The minimum sample size is 5% of current authorizations. The monitoring activity verifies that work billed for was performed, that the contractor is maintaining documentation of work performed and that employees are paid for work performed.

An abbreviated review consists of a review of complaints and review of any items where compliance was not met during the full review. The abbreviated review must be expanded to a full review when a subcontractor exhibits significant problems that are not corrected as required by corrective action.

Payment Review Program (PRP):
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 PRP is to identify and prevent billing and payment errors. Originally, PRP only looked at claims through the MMIS. Social Service billings were added to PRP in 2002. The Health Care Authority continues to run the PRP after moving out of DSHS and still includes DSHS billings. 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 PRP 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.

Full monitoring of other waiver service contractors includes a comparison of contractor billings to contractor-maintained documentation of work performed. Verification that the work was performed should also be obtained from the client if possible. The minimum sample size for short term or one time services such as environmental modifications, specialized medical equipment is 5% of the total clients the contractor served in the previous two years. The minimum sample size for services that are generally ongoing such as skilled nursing or PERS is 5% of current authorizations. Monitoring includes review of individual files where they exist for services such as skilled nursing, client training, adult day care, home delivered meals and home health aide services.

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).

The Aging and Long-Term Support Administration is responsible for conducting the financial review program. 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 States quality improvement strategy, provide information in the following fields to detail the States 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:

1. The number and percent of participants with correct authorizations. N = Number of participants with correct authorizations 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 =* *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:
3. The number and percent of claims paid only when a participant is eligible to receive the service. N = number of claims paid for eligible participants 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***	☐ ***Weekly***	☐ ***100% Review***

Agency		
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *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:*

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

Performance Measure:
4. The number and percent of waiver service claims paid to a qualified provider. N = Number of claims paid to a qualified provider 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*** *Confidence Interval =* *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. The number and percent of participants who died and whose authorizations were terminated appropriately. N = Number of participants who died and whose authorizations were terminated appropriately D = Number of participants who died.

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

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

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

Data Aggregation and Analysis:

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

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

Performance Measure:
The number and percent of claims coded and paid using the published rate. N=Number of claims coded and paid using 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 =* *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***

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

Performance Measure:
Number and percent of claims paid at the published rate. N=Number of claims paid at the published rate D=Number of records reviewed

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

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

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

Data Aggregation and Analysis:

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

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

The Aging and Long-Term Support Administration review of authorizations against service plans is a proxy for claims review. Payment authorizations are generated by the case manager upon completion of the approved service plan, and then entered into the State's MMIS for payment. The DSHS payment system prevents fraudulent claims from being paid through the electronic system's enforcement edits. In order to make a payment claim against an authorization, qualified providers must have an authorization number. In addition to this protection, the payment system prevents payment of claims greater than the payment authorization.

The record review is the same review described in Appendix H b.i.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method for addressing individual problems as they are discovered. Include information*

regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Upon completion of each record review, the case manager is expected to make necessary corrections. Corrections are verified by either the ALTSA QA unit or the case management supervisor. Reports and aggregate data are reviewed at all levels by individuals that make decisions on what improvements are needed individually or systemically. Regions are required to develop proficiency improvement plans to address any area where required proficiency was not met. Draft plans are reviewed by ALTSA prior to approval and implementation. Progress reports are generated and reviewed. Statewide systemic issues are addressed in on-going case management training, policy review/revision/development, and other areas as needed.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

ENTITY RESPONSIBLE FOR RATE DETERMINATION:
The Office of Rates Management manages the rates for residential settings. The legislature determines the rates for enhanced services facilities, assisted living facilities, and enhanced adult residential care facilities and approves the collectively bargained rates for adult family homes.

The Department follows the federal guidelines found in 42 U.S.C. § 1396a(a)(30)(A) ("Section 30(A)") when establishing rates. The Office of Rates Management (ORM), within Management Services Division, is the office of DSHS that handles long-term care rates. ORM holds workgroups, conducts stakeholder meetings, involves program managers, and provides this information as well as data to the Legislature as requested. Funding for the rates is authorized by the state legislature.

RATE METHODOLOGY:
Enhanced Services Facility:
The ESF rate consists of staffing, admin, and capital costs. The FY13 Medicaid weighted average daily rate for Medicaid funded residents of licensed assisted living facilities was used as the base rate for Enhanced Service Facilities. Additional costs were established from the Bureau of Labor Statistics Occupational Employment Statistics May 2014 wage data and the required number of RNs, LPNs, mental health professionals, Certified Nursing Assistants, ARNPs, and Psychiatrists. The total rate received by the facility also includes a capital component that is derived from the 2011 Nursing home cost report data. Medicaid residents are required to pay all room and board costs; the state pays only for allowable Medicaid services. The room and board portion of the rate is paid directly to the provider by the waiver participant.

Adult Family Homes with Specialized Behavior Support or Expanded Community Services Contract sub-codes:
Under the current rate setting methodology, each Medicaid-eligible resident is assigned to one of the 17 CARE Classifications based on an assessment of the resident using the CARE assessment tool. The daily reimbursement rate for AFH services varies based on this classification as well as the geographic area where the services are provided. Based on the funds allocated by the Legislature for these services, the Department determines the daily reimbursement rates for each CARE Classification and each geographic area. Changes to these rates are based on negotiations between the Governor's Office and the union representing Adult Family Homes and approved by the State legislature. An additional per day unit is determined by the State legislature, based on negotiations between the Governor's Office and the union representing AFH owners. Medicaid residents are required to pay all room and board costs; the state pays only for allowable Medicaid services. The room and board portion of the rate is paid directly to the provider by the waiver participant.

Assisted living facilities, and enhanced adult residential care facilities with ECS Contract sub-codes:
Under the current rate setting methodology, each Medicaid-eligible resident is assigned to one of the 17 CARE Classifications based on an assessment of the resident using the CARE assessment tool. The daily reimbursement rate for EARC and AL services varies based on this classification as well as the geographic area where the services are provided. Based on the funds allocated by the Legislature for these services, the Department determines the daily reimbursement rates for each CARE Classification and each geographic area. An additional per day unit for ECS services is determined by the State legislature. Medicaid residents are required to pay all room and board costs; the state pays only for allowable Medicaid services. The room and board portion of the rate is paid directly to the provider by the waiver participant.

Retainer Payment Rates:
Retainer payments for adult family homes, assisted living facilities, enhanced adult residential care facilities, and enhanced services facilities are made for days 1 through 7 at 70% of the total daily rate. Payment for days 8 through 20 vary between settings based either on legislative appropriations or negotiations between the Governor's Office and the union representing AFH owners.

Adult Day Health rates:
Providers are reimbursed at a flat fee, per-day-per-client rate for all services rendered based on geographic area. Adult Day Health rates are based on legislative appropriation and determined based on multiple cost centers. 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. Three rates were then developed for King County, Metropolitan Service Areas and Non-Metropolitan Service Areas. Payment will not exceed

the prevailing charges in the locality for comparable services under comparable conditions.

All other Waiver services:
DSHS and AAAs negotiate rates within ranges published by ALTSA for each service based on legislative appropriation. Payment cannot exceed 1) the prevailing charges in the locality for comparable services under comparable circumstances, or 2) the rates charged by the AAA for comparable services funded by other sources. The AAA must have written procedures for determining rates that are reasonable and consistent with market rates. Acceptable methods for determining reasonable rates include periodic market surveys, cost analysis and price comparison.

In addition, waiver service definitions and provider qualifications are all standardized. This too helps to ensure that rates are comparable across the state as DSHS or the AAAs are negotiating rates for identical services with providers that meet the same qualifications.

The Administrative Procedure Act, Chapter 34.05 RCW, is followed when soliciting public comments on rate determination methods. Changes to rates that are made by the legislature in the biennial and supplemental budget process are part of public hearings on budget and policy legislation. Rates are posted on public web sites.

CHANGES TO RATES:
Adult Family Homes:
RCW 41.56.029 establishes collective bargaining rights for owners of AFHs that receive payments from Medicaid. The Adult Family Home Council is recognized as the sole and exclusive representative for providers of AFH care services who receive payments from Medicaid and State-funded long-term care programs. The scope of bargaining includes matters that pertain to economic compensation, such as: manner and rate of subsidy and reimbursement, including tiered reimbursement; health and welfare benefits; professional development and training; labor management committees; grievance procedures; and other economic matters. The collective bargaining agreement is negotiated every two years and is subject to funding by the state legislature.

All other waiver services:
Rate changes (both increases and decreases) to all other waiver services are determined through legislative action and appropriation. Data and information is provided to the legislature upon request by Management Services Division.

All rate changes will be made consistent with the methodology described in this section and will be reflected in the published fee schedule based upon the state fiscal year July 1 through June 30. The fee schedule is updated at least annually to reflect any rate changes resulting from legislative action or collective bargaining. Some published rates may be exceeded through an exception process.

Some waiver rates are ranges rather than a flat rate. These are reflected in the Estimate of Factor D tables in J-2(d) as blended, weighted average.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Washington utilizes the Medicaid Management Information System (MMIS) to process claims. The MMIS maintains data on waiver recipients including recipient name, birth date, social security number and case number. The recipient data is associated with the provider name, provider payment identification number, waiver service begin and end dates, unit rate, authorized service charge code, amount paid, date paid, etc.

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.

Aging and Long-Term Support Administration (ALTSA) case managers authorize waiver service payments for recipients meeting financial and service eligibility factors electronically through CARE.
Information on the electronic form is used to update the MMIS and all payment authorizations are recorded in the MMIS. CARE is also used to add, change, or terminate service authorizations.

Claims on service authorizations are made electronically in MMIS by the service provider. Authorizations in MMIS are specific to date of service and can be claimed weekly. Payments are made directly to the service provider. Historical records of all payments are maintained.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- (◉) ***No. state or local government agencies do not certify expenditures for waiver services.***
- (○) ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial*

participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

(a) The individual was eligible for Medicaid waiver payment on the date of service;
Aging and Long-Term Support Administration case manager will authorize waiver program services (as listed on the individual service plan) effective on the date all the following program factors constituting Medicaid eligibility for waiver services are satisfied:

(1) Categorical relatedness and financial eligibility are approved.
(2) The assessed applicant/recipient is eligible for nursing facility level care and is, or likely to be, institutionalized.
(3) The individual service plan is developed and approved by the Aging and Long-Term Support Administration contracted case manager.
(4) The recipient has approved the service plan.
(5) The provider is qualified for payment.
(6) The provider contract procedures are completed.

(b) The service was included in the participant's approved service plan: The waiver services in the approved plans are not authorized until steps in the description of the mechanism for assuring payments are made only for eligible service recipients are completed. Claims for payments can be made only after Aging and Long-Term Support Administration case managers have authorized the payment in the payment system. The only services authorized are those services listed in the participant's plan of care.

(c) Verification that the services were provided:

1. Verification is obtained during face to face annual and significant change reviews with the recipient/representative.
2. Verification is obtained via quality management record reviews which may include face-to-face contact.
3. Verification may be obtained through the ALTSA client grievance process -- the policy and procedure for this process was updated and disseminated in 2005 (MB H05-018 -- Policy/Procedure)
4. ALTSA client services verification survey

If billing problems are identified via the client, the QA process or the grievance process ALTSA corrects the payment and adjusts the claim for FFP accordingly.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- (●) ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ( ) ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☒ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

◉ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*

○ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***This waiver is a part of a concurrent ?1115/?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 ?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 textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §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 §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

- ☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***
- ☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

  If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-

c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

○ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

◉ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☒ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

(a) the local entity or entities that have the authority to levy taxes or other revenues: County and Municipal Governments

(b) the source(s) of revenue: County and Municipal general fund

(c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c: Funds are directly expended as CPEs.

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:*

Clients living in adult family homes, assisted living facilities, and enhanced services facilities are required to pay for their room and board at a rate set by the State. For clients with insufficient income to meet their room and board obligations, state funding is used to supplement client payments up to the room and board standard amount.

Provider payments for clients are authorized electronically through CARE. The authorization includes the total cost of care for the individual. The room and board amount is sent to the MMIS through an automated feed from the financial eligibility program, ACES. When the MMIS system processes provider payments, the room and board costs are subtracted from the total amount owed for the month billed.

When the State submits FFP, the amount billed is the actual amount paid by the State as reported by the MMIS for the client's care in a residential setting.

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	60426.22	17075.59	77501.81	134561.31	6267.46	140828.77	63326.96
2	63223.51	19124.66	82348.17	161473.58	6518.16	167991.74	85643.57
3	66391.02	21419.62	87810.64	193768.29	6778.89	200547.18	112736.54
4	116409.00	23989.98	140398.98	232521.95	7050.04	239571.99	99173.01
5	74029.60	26868.78	100898.38	279026.34	7332.04	286358.38	185460.00

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	*3799*	*3799*
Year 2	*4255*	*4255*
Year 3	*4766*	*4766*
Year 4	*5337*	*5337*
Year 5	*5978*	*5978*

Appendix J: Cost Neutrality Demonstration

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

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

Average length of stay is determined by adding the ALOS from the 372 reports WY1, WY2, and WY3, and dividing by three to obtain the average ALOS.

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:*

Costs for factor D are based on the actual rates for each waiver service. Factor D participant count is based on projected usage in WY5 of the current waiver, and determining the percentage of use for each service. The state estimates the waiver population growth to be 12% each year. The previous WY5 was determined by taking the participant counts from the 372 reports for WY1617 - WY2121 and using these numbers to get the participant count for WY1. The state used WY3 372 Report, which was the most current available data.

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 12% growth in medical expenses. The previous WY5 was determined by taking the average Factor D' from the 372 reports for WY1617 - WY2121 and using this number for WY1. A 12% growth was applied each year thereafter.

Expenditures for prescription drugs covered under Medicare Part D are removed from the cost data that is retrieved from the State Medicaid Agency's MMIS and therefore not included when calculating the estimates for D`.

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 20% growth in nursing facility services costs. The previous WY5 was determined by taking the average Factor G from the 372 reports for WY1617 - WY2121 and using this number for WY1. An 20% growth was applied each year thereafter.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G` is calculated by applying an 4% average growth in medical expenses based on the 372 reports for WY1617 - WY2121. The previous WY5 was determined by taking the average Factor G' from the 372 reports for WY1617 - WY2121 and using this number for WY1. An 5% growth was applied each year thereafter.

Expenditures for prescription drugs covered under Medicare Part D are removed from the cost data that is retrieved from the State Medicaid Agency's MMIS and therefore not included when calculating the estimates for G`.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Health	
Adult Family Home Specialized Behavior Support Service	
Client Support Training & Wellness Education	
Community Stability Supports	
Enhanced Residential Services	
Expanded Community Services	
Nurse Delegation	
Skilled Nursing	
Specialized Medical Equipment and Supplies	

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Adult Day Health Total:						***1124820.84***
Adult Day Health					***1124820.84***	

GRAND TOTAL:	***229559210.67***
Total Estimated Unduplicated Participants:	***3799***
Factor D (Divide total by number of participants):	***60426.22***
Average Length of Stay on the Waiver:	*259*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	day	121	156.00	59.59		
Adult Family Home Specialized Behavior Support Service Total:						**115055360.55**
Adult Family Home Specialized Behavior Support Service	day	1781	243.00	265.85	**115055360.55**	
Client Support Training & Wellness Education Total:						**22774835.64**
Client Support Training & Wellness Education	hour	3551	58.00	110.58	**22774835.64**	
Community Stability Supports Total:						**23295592.32**
Community Stability Supports	day	364	253.00	252.96	**23295592.32**	
Enhanced Residential Services Total:						**22920615.00**
Enhanced Residential Services	day	177	267.00	485.00	**22920615.00**	
Expanded Community Services Total:						**42623820.00**
Expanded Community Services	day	2853	249.00	60.00	**42623820.00**	
Nurse Delegation Total:						**1733820.00**
Nurse Delegation	1/4 hr	1500	142.00	8.14	**1733820.00**	
Skilled Nursing Total:						**26098.56**
Skilled Nursing	visit	46	16.00	35.46	**26098.56**	
Specialized Medical Equipment and Supplies Total:						**4247.76**
Specialized Medical Equipment and Supplies	each	11	1.00	386.16	**4247.76**	

GRAND TOTAL:	**229559210.67**
Total Estimated Unduplicated Participants:	**3799**
Factor D (Divide total by number of participants):	**60426.22**
Average Length of Stay on the Waiver:	259

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**1199189.16**
Adult Day Health	day	129	156.00	59.59	**1199189.16**	
Adult Family Home Specialized Behavior Support Service Total:						**141477394.50**
Adult Family Home Specialized Behavior Support Service	day	2190	243.00	265.85	**141477394.50**	
Client Support Training & Wellness Education Total:						**25276155.24**
Client Support Training & Wellness Education	hour	3941	58.00	110.58	**25276155.24**	
Community Stability Supports Total:						**25663550.88**
Community Stability Supports	day	401	253.00	252.96	**25663550.88**	
Enhanced Residential Services Total:						**28229910.00**
Enhanced Residential Services	day	218	267.00	485.00	**28229910.00**	
Expanded Community Services Total:						**45178560.00**
Expanded Community Services	day	3024	249.00	60.00	**45178560.00**	
Nurse Delegation Total:						**1959216.60**
Nurse Delegation	1/4 hour	1695	142.00	8.14	**1959216.60**	
Skilled Nursing Total:						**27800.64**
Skilled Nursing	visit	49	16.00	35.46	**27800.64**	
Specialized Medical Equipment and Supplies Total:						**4247.76**

GRAND TOTAL:	**269016024.78**
Total Estimated Unduplicated Participants:	**4255**
Factor D (Divide total by number of participants):	**63223.51**
Average Length of Stay on the Waiver:	259

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies	each	11	1.00	386.16	4247.76	
				GRAND TOTAL:		269016024.78
				Total Estimated Unduplicated Participants:		4255
				Factor D (Divide total by number of participants):		63223.51
				Average Length of Stay on the Waiver:		259

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						1264261.44
Adult Day Health	day	136	156.00	59.59	1264261.44	
Adult Family Home Specialized Behavior Support Service Total:						174036575.70
Adult Family Home Specialized Behavior Support Service	day	2694	243.00	265.85	174036575.70	
Client Support Training & Wellness Education Total:						28059675.00
Client Support Training & Wellness Education	hour	4375	58.00	110.58	28059675.00	
Community Stability Supports Total:						28223506.08
Community Stability Supports	day	441	253.00	252.96	28223506.08	
Enhanced Residential Services Total:						34704660.00
Enhanced Residential Services	day	268	267.00	485.00	34704660.00	
				GRAND TOTAL:		316419613.58
				Total Estimated Unduplicated Participants:		4766
				Factor D (Divide total by number of participants):		66391.02
				Average Length of Stay on the Waiver:		259

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Expanded Community Services Total:						**47882700.00**
Expanded Community Services	day	3205	249.00	60.00	**47882700.00**	
Nurse Delegation Total:						**2214666.08**
Nurse Delegation	1/4 hour	1916	142.00	8.14	**2214666.08**	
Skilled Nursing Total:						**28935.36**
Skilled Nursing	visit	51	16.00	35.46	**28935.36**	
Specialized Medical Equipment and Supplies Total:						**4633.92**
Specialized Medical Equipment and Supplies	each	12	1.00	386.16	**4633.92**	

GRAND TOTAL:	**316419613.58**
Total Estimated Unduplicated Participants:	**4766**
Factor D (Divide total by number of participants):	**66391.02**
Average Length of Stay on the Waiver:	259

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**1347925.80**
Adult Day Health	day	145	156.00	59.59	**1347925.80**	
Adult Family Home Specialized Behavior Support Service Total:						**214089536.70**
Adult Family Home Specialized Behavior Support Service	day	3314	243.00	265.85	**214089536.70**	

GRAND TOTAL:	**621274809.50**
Total Estimated Unduplicated Participants:	**5337**
Factor D (Divide total by number of participants):	**116409.00**
Average Length of Stay on the Waiver:	259

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Client Support Training & Wellness Education Total:						**31144635.84**
Client Support Training & Wellness Education	hour	4856	58.00	110.58	**31144635.84**	
Community Stability Supports Total:						**31039456.80**
Community Stability Supports	day	485	253.00	252.96	**31039456.80**	
Enhanced Residential Services Total:						**42603855.00**
Enhanced Residential Services	day	329	267.00	485.00	**42603855.00**	
Expanded Community Services Total:						**50766120.00**
Expanded Community Services	day	3398	249.00	60.00	**50766120.00**	
Nurse Delegation Total:						**250248020.00**
Nurse Delegation	1/4 hr	2165	14200.00	8.14	**250248020.00**	
Skilled Nursing Total:						**30637.44**
Skilled Nursing	visit	54	16.00	35.46	**30637.44**	
Specialized Medical Equipment and Supplies Total:						**4621.92**
Specialized Medical Equipment and Supplies	each	12	1.00	385.16	**4621.92**	

GRAND TOTAL:	**621274809.50**
Total Estimated Unduplicated Participants:	**5337**
Factor D (Divide total by number of participants):	**116409.00**
Average Length of Stay on the Waiver:	259

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**1422294.12**
Adult Day Health	day	153	156.00	59.59	**1422294.12**	
Adult Family Home Specialized Behavior Support Service Total:						**263315917.80**
Adult Family Home Specialized Behavior Support Service	day	4076	243.00	265.85	**263315917.80**	
Client Support Training & Wellness Education Total:						**34575933.24**
Client Support Training & Wellness Education	hour	5391	58.00	110.58	**34575933.24**	
Community Stability Supports Total:						**34111403.04**
Community Stability Supports	day	533	253.00	252.96	**34111403.04**	
Enhanced Residential Services Total:						**52445475.00**
Enhanced Residential Services	day	405	267.00	485.00	**52445475.00**	
Expanded Community Services Total:						**53813880.00**
Expanded Community Services	day	3602	249.00	60.00	**53813880.00**	
Nurse Delegation Total:						**2827282.48**
Nurse Delegation	1/4 hour	2446	142.00	8.14	**2827282.48**	
Skilled Nursing Total:						**31772.16**
Skilled Nursing	visit	56	16.00	35.46	**31772.16**	
Specialized Medical Equipment and Supplies Total:						**5020.08**
Specialized Medical Equipment and Supplies	each	13	1.00	386.16	**5020.08**	

GRAND TOTAL:	**442548977.92**
Total Estimated Unduplicated Participants:	**5978**
Factor D (Divide total by number of participants):	**74029.60**
Average Length of Stay on the Waiver:	259