



Region 10  
2201 Sixth Avenue, MS/RX 43  
Seattle, Washington 98121

**JAN 30 2012**

Douglas Porter, Director  
Health Care Authority  
Post Office Box 45502  
Olympia, Washington 98504-5502

**RE: Washington's Home and Community-Based Services (HCBS) Basic Plus (#0409)  
Final Report**

Dear Mr. Porter:

Enclosed is the final report of the Centers for Medicare & Medicaid Services' (CMS) review of the Basic Plus Waiver, control number #0409 that serves individuals age 18 and older, who are developmentally disabled (DD) and who would otherwise require placement in an intermediate care facility for the mentally retarded (ICF/MR) level of care (LOC). Thank you for your assistance throughout this process, and for sending comments on the draft report. The State's responses to CMS' recommendations have been incorporated in the appropriate sections of the final report.

We found the State to be in partial compliance with the six assurance review components. For those areas in which the State is not compliant, please be sure they are corrected at the time of renewal. We have also identified recommendations for program improvements in four of the assurance areas. The State's implementation and successful completion of the mandated Corrective Action Plan (CAP), as well as, its continued participation in the scheduled CMS CAP update calls will remediate a number of the identified issues related to the health and welfare assurance.

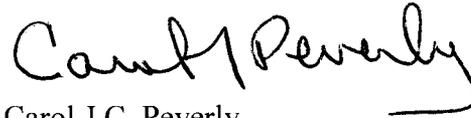
Finally, we would like to remind you to submit a renewal package on this waiver to CMS Central and Regional Offices at least 90 days prior to the expiration of the waiver, March 30, 2012.

Your waiver renewal application should address any issues identified in the final report as necessary for renewal and should incorporate the State's commitments in response to the report. Please note the State must provide CMS with 90 days to review the submitted application. If we do not receive your renewal request 90 days prior to the waiver expiration date we will contact you to discuss termination plans. Should the State choose to abbreviate the 90 day timeline, 42 Code of Federal Regulations (CFR) 441.307 and 42 CFR 431.210 require the State to notify recipients of service 30 days before expiration of the waiver and termination of services. In this instance, we also request that you send CMS the draft beneficiary notification letter 60 days prior to the expiration of the waiver.

**JAN 30 2012**

We would like to express our appreciation to the management and staff of the Division of Developmental Disabilities who provided information for this review. If you have any questions, please contact me, or have your staff contact Wendy Hill Petras at (206) 615-3814.

Sincerely,



Carol J.C. Peverly  
Associate Regional Administrator  
Division of Medicaid and Children's Health  
Operations

cc:

MaryAnne Lindeblad, Assistant Secretary, Aging and Disability Services Administration  
Linda Rolfe, Director, Division of Developmental Disabilities  
Don Clintsman, Assistant Director, Division of Developmental Disabilities  
Dave Langenes, Waiver Requirements Manager, Division of Developmental Disabilities  
Kris Pederson, HCBS Waiver Program Manager, Division of Developmental Disabilities



**U.S. Department of Health and Human Services**

**Centers for Medicare & Medicaid Services**

**Region 10**

**FINAL REPORT**

**Home and Community-Based Services (HCBS) Waiver Review  
Washington State Basic Plus Waiver  
Control #0409  
January 30, 2012**

## BACKGROUND AND DESCRIPTION

The Washington Basic Plus waiver was approved under Section 1915(c) of the Social Security Act (the Act) as a statutory alternative to Medicaid-funded institutional care. The Secretary of Health and Human Services renewed the waiver with an effective date of April 1, 2007. The current effective period is April 1, 2007, through March 31, 2012. The State was granted a waiver of Section 1902(a)(10)(B) of the Act in order to provide home and community-based services (HCBS) to individuals, age 18 or older, who are developmentally disabled (DD), require an intermediate care facility for the mentally retarded (ICF/MR) level of care (LOC), and are at high risk of out of home placement. The waiver currently serves 2,706 individuals, with an average annual cost per participant of \$26,982. The Washington Aging and Disability Services Administration, Division of Developmental Disabilities (DDD) is the Medicaid Agency responsible for administering HCBS DD services in Washington. The Health Care Authority is the single state agency responsible for administering the Medicaid program.

The Centers for Medicare & Medicaid Services (CMS) conducted an on-site review of the State's currently approved Basic Plus waiver. The review was comprehensive in scope and addressed the six assurances defined in the *Interim Procedural Guidance (IPG)* protocol, as revised by the interim guidance procedures of 2007. The protocol reflects a national effort to standardize the HCBS waiver reviews, with an emphasis on quality assurance (QA).

Health Insurance Specialists Wendy Hill-Petras, Daphne Hicks, and Susie Cummins of the CMS Seattle Regional Office (RO) conducted the review using the IPG in December 2010. This report follows the protocol in addressing areas assessed in the review process and indicates key findings and recommendations as appropriate. The CMS review focused on statutory requirements under Section 1915(c)(2)(A) of the Act requiring states to assure that:

- Necessary safeguards have been taken to protect clients' health and welfare;
- Necessary safeguards have been taken to assure financial accountability;
- Waiver enrollees meet the appropriate LOC;
- Consumer freedom of choice is assured in selecting available care alternatives; and
- Cost neutrality is maintained relative to the cost of institutional care.

This review focused on the extent to which the policies and procedures have been implemented, and the results of the State's oversight activities. The State provided evidence of how it identified quality related issues and corrective actions taken. The CMS review documented that the State was in partial compliance with federal waiver requirements. A summary of the findings is located in Appendix A.

The purpose of this report is to provide findings of the on-site review and recommend actions which CMS believes will strengthen the State's oversight of the waiver program. The CMS team reviewed its findings with the State staff during the exit interview conducted on December 21, 2010.

## Home and Community-Based Services Waiver Services

### Introduction

Pursuant to Section 1915(c) of the Social Security Act, the Secretary of the Department of Health and Human Services has the authority to waive certain Medicaid statutory requirements to enable a State to provide a broad array of home and community-based services (HCBS) as an alternative to institutionalization. The Centers for Medicare & Medicaid Services (CMS) has the responsibility and authority to approve state HCBS waiver programs.

CMS must assess each home and community-based waiver program in order to determine that State assurances are met. This assessment also serves to inform CMS in its review of the State's request to renew the waiver.

<b>State's Waiver Name:</b>	Basic Plus Waiver (#0409)
<b>Administrative Agency:</b>	Health Care Authority
<b>Operating Agency:</b>	Aging and Disabilities Services Administration (ADSA), Division of Developmental Disabilities (DDD)
<b>State Waiver Contact:</b>	Kris Pederson
<b>Target Population:</b>	Individuals with Developmental Disabilities
<b>Level of Care:</b>	Intermediate Care Facility for the Mentally Retarded (ICF/MR)
<b>Number of Waiver Participants:</b>	2,706
<b>Effective Dates of Waiver:</b>	April 1, 2007, through March 31, 2012
<b>Average Annual Cost:</b>	\$26,982 Per Person
<b>Approved Waiver Services:</b>	Personal Care; Day Habilitation (Community Access and Person-to-Person); Prevocational Services; Supported Employment (Individual Supported Employment and Group Supported Employment); Respite; Behavior Management and Consultation; Staff/Family Consultation and Training; Community Guide; Environmental Accessibility Adaptations; Transportation; Specialized Medical Equipment and Supplies; Skilled Nursing; Adult Family Home; Adult Residential Care; Sexual Deviancy Evaluation; Specialized Psychiatric; Mental Health Stabilization; Occupational Therapy; Physical Therapy; and Speech, Hearing and Language Services.
<b>CMS Contact:</b>	Wendy Hill Petras, (206) 615-3814

## Observations, Findings, and Recommendations

### I. State Conducts Level of Care (LOC) Determinations Consistent with the Need for Institutionalization.

**The State must demonstrate that it implements the process and instrument(s) specified in its approved waiver for evaluating/re-evaluating an applicant's/waiver participant's LOC consistent with care provided in a hospital, nursing facility (NF), or intermediate care facility for the mentally retarded (ICF/MR).**

*Authority: 42 Code of Federal Regulations (CFR) 441.301; 42 CFR 441.302; 42 CFR 441.303; and State Medicaid Manual (SMM) 4442.5.*

**Compliance:** The State demonstrates the assurance but the Centers for Medicare & Medicaid Services (CMS) recommends improvements or request additional information.

Sub-assurance 1: The LOC of enrolled participants is re-evaluated at least annually or as specified in the approved waiver.

The CMS reviewed the following information to assess compliance with the sub-assurance:

- Evidence Package
- Comprehensive Assessment and Reporting Evaluation (CARE) System and Case Management Information System (CMIS)
- Division of Developmental Disabilities (DDD) Assessment Activity Report for October 2010 (Draft)

*Evidence Package.* The State's evidence package documented that 13 percent of the LOC assessments were out of compliance with the reassessment timeframes documented in the approved waiver. During the course of the on-site review, the DDD staff interviewed stated that the percentage was due in part to outliers, but that the State continues to move forward with its remediation efforts. As part of this effort, the State has developed a system of ticklers to alert staff of assessment dates at the Case Resource Manager (CRM) level. At the time of the CMS review, the same tickler system was not readily available to DDD regional management, and the Central Office (CO) management team was compiling monthly assessment due reports and sending them to the regional management. Until the system change can be fully implemented to include notification to regional management, the CO management will continue the current process to assure that the regional care managers are meeting the LOC timeframes. The regional compliance with the sub-assurance is reported to DDD CO management three times a year.

*CARE Tool and CMIS.* During the course of the review, the State provided the CMS team with an overview of the CARE and CMIS system, and granted the team temporary access to the system. The electronic CARE assessment tool is utilized by the CRM to conduct LOC assessments. The CARE tool tracks assessment dates, records the type of assessment (initial, interim or redetermination), documents service episode record (SER) notes that can be categorized, and includes a number of additional assessment tools. The assessment tools include the Minimum Data Set (MDS), the Mini-Mental Status Exam (MMSE), the Centers for

Epidemiological Studies (CESD) - Iowa Depression Scale, the Cognitive Performance Scale, the Zarit-Burder Scale, and the Support Intensity Scale (SIS). The CARE tool houses the CMIS, which includes a tickler system designed to notify the CRM of assessment due dates, tags SERs with codes and provides management reports to assist in identifying trends related to LOC assessments and service plan development. The State reported that the CMIS reports are monitored at least annually by CO management. The CARE tool provides evidence of the State's ability to track reevaluations at the CRM level.

*DDD Assessment Activity Report for October 2010 (Draft).* The DDD Assessment Activity Report provides the Assessment Activity Review Team (AART) and upper management data on all DD assessment activities categorized by HCBS waiver and region. The report is reviewed monthly and provides evidence of the State's ability to monitor that the LOC assessments and reassessments are timely. The following information is documented through the report:

- Number of clients approved to receive waiver services;
- Total number of CRM;
- CRM to client ratios;
- Number of LOC decisions appealed with outcomes (eligible/ineligible/withdrawn);
- Caseload adjustments;
- Number of timely assessments and reassessments completed; and
- Administrative hearing information.

Sub-assurance 2: The State's process and instruments documented in the approved waiver are applied appropriately and according to the approved description to determine participant LOC.

The CMS reviewed the following information to assess compliance with the sub-assurance:

- Joint Requirement Planning (JRP) Team Processes
- SIS Inter-rater Reliability (IRR) Review Procedures (Draft Version 1.7)
- IRR Database
- IRR Activity Report (March 2010 Draft)
- Evidence Package

*JRP Team Processes.* The State employs the DDD JRP team to ensure IRR in the use of the CARE assessment tool. The JRP team members are designated as Washington State's SIS and ICF/MR LOC assessment experts and are responsible for training State CRMs (ongoing and through the DD Academy) and shadow visits for the required IRR reviews. Additionally, the JRPs may develop expertise in different areas of the LOC assessment to assist with the State's training efforts and provide technical assistance. The State utilizes the JRP to assure inter-rater reliability across all CRM assessments.

*SIS IRR Review Procedures. Draft Version 1.7.* All CRMs that conduct the CARE assessment are required to complete an initial two week training on the tool through the DD Academy. The CRM is then shadowed on his/her first LOC assessment by a JRP, who completes an individual assessment in addition to the one completed by the CRM. Once the assessment is completed by the CRM, it is sent forward to the JRP for review to establish the level of consistency between

the two assessments. The results (JRP and CRM) of the assessments are entered into the JRP's IRR database to determine the IRR score.

The CRM must have an IRR pass score of at least 87 percent in the SIS section of the CARE assessment to be able to deliver the CARE assessment independently. A score of 80-87 percent results in a provisional pass which requires reassessment with a JRP, and when the CRM score is below 80 percent the CRM must be shadowed for all assessments. Following the initial JRP shadow visit, each CRM is required to have an annual shadow assessment with the JRP to assure continued IRR.

The current JRP process provides evidence of the State's ability to assure IRR regarding whether CRM and JRP assessments agree that the threshold score for LOC was met, but may not collect enough information to determine whether the assessment comprehensively identifies the needs of the waiver participant. As the waiver participant's service plan is generated based on the CARE assessment, it is important that the tool not only meets IRR for LOC, but also that the CRM and JRP assessment both accurately record the needs of the waiver participant. An expansion of the IRR criteria beyond the threshold for LOC, to include an assessment to assure that the CRM was capturing all of the waiver participant's LOC needs, would enhance the current JRP process, and assist the State in identifying additional areas for training.

*IRR Database.* The JRP team utilizes the IRR database to record assessment information from the CRM and JRP initial and annual shadow visits. The reports that the DDD pull from the database are used by the State to assure that the CRM are meeting the required levels for IRR when utilizing the CARE tool. As mentioned above, the database would be enhanced by the expansion of the information collected.

*IRR Activity Report for March 2010.* The State submitted the March 2010 IRR Activity Report as evidence of the State's ability to track IRR of the LOC assessments. The report includes: the estimated IRR reviews to be completed by month; IRRs with passing scores; the pass scores by SIS subscales; and percentage of agreements. The information is broken out by each of the regions and provides sufficient evidence of State's oversight of the IRR process on a statewide level.

*Evidence Package. Performance Measure 1.* The percentage of all LOC assessments that were completed according to state requirements, as specified in the waiver. The State's evidence package reported that nearly 100 percent of the assessments were completed correctly. This information was based on the frequency in which the JRP and CRM score in the shadow visits concurred that a waiver applicant met LOC, resulting in a 100 percent score. CMS is concerned that the 100 percent score does not represent that all components within the CARE assessment were completed with 100 percent accuracy. The State is not currently breaking down the different components of the CARE assessment process to identify which areas inside and outside the SIS would require additional CRM training.

## **CMS Required Recommendations:**

Sub-assurance 1: To assure compliance with LOC timeline requirements, CMS recommends that the State continue its current CO remediation strategy until a tickler system is operational at the Regional Office (RO) management level.

State Response: We are following your recommendation. Case resource managers have electronic reports (tickler system) which identify assessments that have not been completed within 12 months of the last annual assessment. Regional Waiver coordinators now have access to the Assessment Activity Timeliness report. Monthly, regional waiver coordinators review the timeliness report and distribute information to case resource managers to promote completing assessments timely as well as to seek follow up on getting overdue assessments completed. CO Waiver Program Manager will continue to review the assessment activity report to address system issues regarding timely completion of assessments.

Final CMS Response: CMS has no additional recommendations for the sub-assurance.

Sub-assurance 2: CMS strongly recommends that the State adjust the performance measurement for the sub-assurance to identify components of the CARE assessment tool that require additional CRM training. As noted above, an expansion of the IRR criteria beyond the threshold for LOC, to include an assessment to assure that the CRM was capturing all of the waiver participants LOC needs, would enhance the current JRP process, and assist the State in identifying additional areas for training.

State Response: Washington State currently completes annual training for case managers based on findings from annual waiver audits. This includes training on ISP development, policies and procedures. DDD is interested in investigating this recommendation more fully in the future although recognizes additional staffing is required to implement.

Final CMS Response: CMS has no additional recommendations for the sub-assurance.

## **II. Service Plans are Responsive to Waiver Participant Needs.**

**The State must demonstrate that it has designed and implemented an adequate system for reviewing the adequacy of service plans for waiver participants.**

*Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.6; and SMM 4442.7 Section 1915(c) Waiver Format, Item Number 13.*

**Compliance:** The State does not fully or substantially demonstrate this assurance, though there is evidence that may be clarified or readily addressed.

Sub-assurance 1: Service plans address all of the participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.

The CMS reviewed the following information to assess compliance with the sub-assurance:

- Evidence Package
- Approved Waiver Application
- Individual Service Plan (ISP) Meeting Survey Database
- Participant Goals
- Necessary Supplemental Accommodation (NSA)
- Employment Services

*Evidence Package. Performance Measure 1(a): The percentage of ISPs conducted for waiver participants that address their assessed health and welfare needs through provision of waiver service or other means.* The State documented a 90 percent compliance rate for the performance measure. To remediate the issue, the State has enhanced the CARE system (September 2009) to add a requirement that all health and welfare needs have been addressed in the ISP before the CARE assessment can be marked as completed. The remediation is tracked by the JRP manager. Compliance has increased by three percent over the previous year.

*Evidence Package. Performance Measure 1(b): The percentage of ISPs conducted for waiver participants that address personal goals.* The data provided by the State, for the 2,015 ISPs reviewed, showed that when the waiver participant identified goals there is a 100 percent compliance rate. However, the information submitted in the evidence package did not provide information on the percentage of the 2,015 reviewed ISPs that contained goals. The measure would be enhanced by the addition of this information.

*Evidence Package. Performance Measure 2: The percentage of ISPs with a monthly waiver service provision or monitoring by a case manager during a break in service.* The State evidence package submission cited a 100 percent compliance rate with this assurance.

*Evidence Package. Performance Measure 3: The percentage of waiver participants' ISPs with critical indicators triggered in the assessment that were addressed in the ISP.* The State evidence package documented a 92 percent compliance rate with this performance measure. This is a two percent improvement over the prior year. The State reported it will continue to train and audit to the requirement that all critical indicators are addressed in the ISP.

*Approved Waiver Application.* The State's current requirement for face-to-face participant or guardian contact is one time per year, during the reassessment. The CRM may contact the participant more frequently, and the CARE tool records the recommended frequency of contact. However, the ongoing monitoring throughout the year may be completed through file review or provider contacts without additional waiver participant or guardian contact. The current contact requirement does not effectively assure that the service(s) provided meets the needs of the waiver participant or that plans are updated when there is a change to the waiver participant's care needs.

*ISP Meeting Survey Database.* The DDD provides each individual (and their family or guardian) assessed with the CARE tool the opportunity to complete a satisfaction survey. The information is collected and analyzed by the Waiver Oversight Committee and State QA Task Force at least annually. The survey results allow the DDD to identify patterns in the CARE assessment process that might require additional staff training or clarification.

*Participant Goals, CMS File Review.* The CARE assessment tool includes a section for waiver participant's goals, but the CMS review of the participant files found that individual goals were inconsistently present in the electronic assessment. The presence of participant goals in the service plan is essential to provide evidence that the service plan is person centered.

*NSA.* The DDD requires each waiver participant to identify an individual to serve as an NSA. The NSA functions as a safeguard to assure that the waiver participant understands all actions taken by the State and is copied on all relevant State documents related to the waiver including the service plan, planned action notices, renewal notifications and fair hearing information. The NSA does not have legal authority to make decisions for the waiver participant. The waiver participant may opt out of the NSA, but all requests to do so are reviewed by the State's attorney general. The NSA functions as an effective resource to assure that the waiver participant has a second set of eyes involved in the administration of his/her waiver services.

*Employment Services.* The staff and advocates interviewed during the CMS on-site visit reported there may be issues with verifying whether employment services adequately meet the waiver participant's goals. The State is aware of these issues and is working to address this through several strategies, including the review of the participant's six month progress report to assure that the participant employment goals are being addressed, an annual review of the contracted counties (alternating between a self assessments and an on-site review), and the monitoring of monthly invoices.

Sub-assurance 2: The State monitors service plan development in accordance with its policies and procedures.

The CMS reviewed the following information to assess compliance with the sub-assurance:

- Evidence Package
- DDD Regional Office file Review
- Supervisor File Review

*Evidence Package. Performance Measure 1: The percentage of all waiver ISPs that include emergency planning.* The State's data documented a 99.9 percent compliance rate with this performance measure. To remediate, the State amended the CARE tool in September 2009 to require the emergency planning piece to be completed prior to marking the CARE assessment as complete. In January 2010, the State provided staff training on the policy and system enhancement.

*DDD RO File Review.* Quality Care Coordinators (QCCs) are responsible for reviewing a random sample of seven client files per region, per quarter. A review tool comprised of 24 questions is utilized by the QCC. Upon completion of the file review, the QCC drafts a report detailing the results of the file review and sends it forward to the CO. The information within the report is presented to the Regional Administrator (RA) and QA staff during the management meeting. Any identified trends are provided to the waiver coordinators, who are responsible for

developing trainings to remediate the issue. QCCs work with the CRM on a case-by-case basis to resolve identified issues.

*Supervisor File Review.* The RO supervisors are responsible for the review of one file per CRM each quarter. If trends are identified, training is implemented at the RO level.

Sub-assurance 3: Service plans are updated/ revised at least annually or when warranted by changes in the participant's LOC.

The CMS reviewed the following information to assess compliance with the sub-assurance:

- Evidence Package
- Regional Office File Review: CARE Tool
- Approved Waiver Application

*Evidence Package. Performance Measure 1: The percentage of annual ISPs for waiver participants completed before the end of the twelfth month following the initial assessment.* The State's data documented an 87 percent compliance rate with the performance measure. The delay is tied to the current LOC process which is also showing an 87 percent compliance rate. The State is working to enhance the system, but until that point will continue with the current CO report to RO management identifying upcoming due dates.

*Evidence Package. Performance Measure 3: The percentage of waiver participants and family members responding to the ISP meeting survey who reported knowing what to do if their needs change before the next annual meeting.* The ISP survey was completed by 356 individuals; 94 percent knew what to do and six percent did not know or were unsure. To remediate, the State added a component to its internal training focused on the importance of helping waiver participants understand this portion of service plan development. Additionally, the State has changed its survey process, and is now sending out the survey from its CO with the goal to increase the survey response rate.

*Evidence Package. Performance Measure 10: The percentage of waiver recipients with a critical incident report whose ISP was amended when it should have been amended.* The State's internal monitoring found that the ISP had not been updated in response to an incident report (IR) in 33 percent of the IR case files reviewed for the Basic Plus waiver.

*RO File Review: CARE Tool.* The CARE tool documents all assessments and reassessments, and SERs may capture notes indicating a need for service plan revision. An incident review may also generate a revision to the service plan. The information captured in the CARE database is reviewed during the management review of the client files to determine if the plan is updated as appropriate.

*Approved Waiver Application.* The approved waiver requires the CRM to have a face-to-face contact with the waiver individual once a year for LOC assessments, but the ongoing monitoring requirements may be met through file reviews or provider contacts. The CARE tool documents the required monitoring frequency, but the CRM is not required to make another direct contact

with the waiver participant or their guardian at any other point in the year to check on the sufficiency of the plan's amount, duration and scope of approved service, unless a reassessment is requested. While the CRM may contact the waiver participant several times a year in practice, the annual requirement has the potential to result in unmet needs for some of the waiver participants.

Sub-assurance 4: Services are delivered in accordance with the service plan, including type, scope, amount and frequency specified in the plan of care (POC).

The CMS reviewed the evidence package and approved waiver application to assess compliance with the sub-assurance.

*Evidence Package. Performance Measure 2: The percentage of waiver ISPs with services that are delivered in accordance with the type, scope, amount, duration and frequency as specified in the ISP. The State reported a 99.9 percent compliance rate with the performance measure.*

*Evidence Package. Performance Measure 3: The percentage of waiver ISPs with services that are delivered within 90 days of the ISP effective date or as specified in the ISP. The State reported a 94 percentage compliance rate and will continue with its current monitoring process.*

*Approved Waiver Application.* Please see the information in Sub-assurance 1.

Sub-assurance 5: Participants are afforded choice: (1) between waiver services and institutional care; and (2) among waiver services and providers.

The CMS reviewed the evidence package and ISP Wrap-Up form to assess compliance with the sub-assurance.

*Evidence Package. Performance Measure 1: The percentage of waiver participant records that contain a signed voluntary participation statement in lieu of institutional care. The State's internal audit found that 24 percent of the files it reviewed did not contain the ISP Wrap-Up form. The State remediation for the deficiency was to modify the CARE system (effective July 2010) to require the CRM to verify choice has been provided and documented. The State's remediation efforts include a requirement in the CARE system for the CRM to verify that the waiver participant accepts services in the community, and the annual 2009-2010 training addressed the issue in further detail. For review purposes CMS would expect to see signed documentation of the waiver participant's choice, in addition to a completed field in the CARE tool.*

*Evidence Package. Performance Measure 2. The percentage of waiver participant records that contain the annual ISP Wrap-Up, which includes verification that the waiver participant had a choice of providers, and if not satisfied was able to select another qualified provider. The data submitted by the State documented a 76 percent compliance with the performance measure. The remediation efforts that the State will employ are identical to Performance Measure 1.*

*ISP Wrap-Up Form, CMS File Review.* The State submitted the ISP Wrap-Up form as evidence that participants were afforded freedom of choice between waiver services versus institutional

care and among services and providers. The choice form is signed and dated by the waiver participant or legal guardian and is placed in the waiver participant's file after the ISP process is completed. The ISP Wrap-Up form was present in all files reviewed during the CMS on-site visit. However, the State's internal QA review found inconsistency in the completion of the form by the CRMs, see Performance Measure 1 and 2 above.

**CMS Required Recommendations:**

Sub-assurance 1: Performance measure 1(b). CMS recommends the State refine the performance measure to capture the percentage of service plans that include goals. The current measure does not provide CMS with sufficient evidence to determine the impact of the measure.

State Response: Washington agrees with this recommendation and will change our performance measure to the percentage of waiver participants who identified personal goals in their assessment. The denominator would be the total number of Waiver participants.

Final CMS Response: CMS has no additional recommendations for the sub-assurance.

Sub-assurance 1, 3 and 4: CMS strongly recommends that the State increase its minimum frequency for CRM contact with the waiver participant or guardian to assure that the service plan continues to adequately address the needs of the individual and safeguards their health and welfare.

State Response: DDD is changing current practice for client monitoring. The new practice will require the CRM to contact the client and/or legal representative to review the client's service plan, identify if the plan is working and/or if changes are required. This monitoring will be documented in the SER's under the purpose code of monitoring plan. This is a change in practice. Before case managers could consider conversations with providers, review of plans and/or progress notes as appropriate monitoring activities. The change in monitoring expectations will be trained to in February and March of 2012.

Final CMS Response: CMS is requesting a copy of the February and March 2012 training materials and agenda. Additionally, please provide CMS with any guidelines or P&P documents that describe how the CRM review of the service plan results in a service plan monitoring schedule that includes a contact with the waiver participant or his/her representative. Please submit the materials to CMS no later than 60 days from the date of the final training.

Sub-assurance 2: CMS has no recommendations for this sub-assurance.

Sub-assurance 3: Performance Measure 1. To assure compliance with ISP timeline requirements, CMS recommends that the State continue its current CO remediation strategy until a tickler system is operational at the RO management level.

State Response: We are following your recommendation. Case Resource Managers have electronic reports (tickler system) which identify assessments that have not been completed within 12 months of the last annual assessment. Regional Waiver Coordinators now have access to the Assessment Activity Timeliness report. Monthly, Regional Waiver Coordinators review

timeliness report and distribute information to case resource managers to promote completing assessments timely as well as to seek follow up on getting overdue assessments completed. CO Waiver Program Manager will continue to review the assessment activity report to address system issues regarding timely completion of assessments.

Final CMS Response: CMS has no additional recommendations for the sub-assurance.

*Performance Measure 10.* The State must submit a corrective action plan (CAP) documenting how it will assure that the service plan is amended when a critical incident occurs that indicates a change in the waiver participant's needs. The plan must be submitted to CMS no later than 60 days from the receipt of the final report.

State Response: We have refined the implementation of this recommendation. The DDD central office IRT requests regional staff to make 100% corrections when it is identified an ISP amendment is required. The IRT documents follow up of required corrections in SharePoint site and reviews follow up to insure ISP amendment was completed if needed. This is a current practice of the IRT.

Final CMS Response: Please submit a report from the SharePoint system that documents the full IR team's cycle of review, including ISP amendment. The report must be submitted to CMS no later than 60 days from the receipt of the final report. CMS will withdraw its request for a CAP upon receipt of documentation that sufficiently demonstrates the State's resolution of the issue.

Sub-assurance 4: Please see sub-assurance 1.

Sub-assurance 5: CMS recommends that the State continue its remediation work to assure waiver participants are provided a choice of waiver services and providers, and documentation is maintained.

State Response: DDD agrees with this recommendation. DDD's system was updated in 2010 to identify a box on the ISP for the CRM to document that the client has signed to voluntary participation choice statement for the specific waiver program they are eligible for. In addition, the voluntary participation statement form has been updated and separated from the Assessment Meeting Wrap-up form.

Final CMS Response: CMS has no additional recommendations for the sub-assurance.

### **III. Qualified Providers Serve Waiver Participants.**

**The State must demonstrate that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.**

*Authority: 42 CFR 441.302; and SMM 4442.4.*

**Compliance:** The State substantially meets this assurance.

Sub-assurance 1: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other State standards prior to their furnishing services.

The CMS reviewed the following information to assess compliance with the sub-assurance:

- Evidence Package
- Residential Programs
  - Supported Living Certification List (database report) example, Region 1
  - Residential Care Services (RCS) Database: Evaluation Citation Tracking Database
  - Client Services Contract: Community Residential Services
  - Monitoring and Quality Improvement of Adult Family Home Services (Policy 4.08) Issued November 1, 2010
  - DDD AFH Quality Improvement Visit Assessment Template (DSHS 15-215)
  - Certification Evaluation Report: Community Residential Services and Support
- All Providers
  - Enterprise All Contracts Database (EACD)
  - Background Check Unit Process

*Evidence Package. Performance Measures 1 and 2.* The State submitted data in its evidence package documenting a 99.7 percent compliance rate for contracted providers requiring licensure and a 100 percent compliance rate for Supported Living providers requiring certification. The State will continue to monitor the contractor compliance three times a year at the Field Service Administrator's meeting and certification compliance through the Residential Program Managers.

*Residential Programs.*

*Supported Living Certification List, Region 1.* The State submitted a copy of the Supported Living Certification List, Region 1, as an example of its ability to track the certifications for supported living homes. The certification report provided evidence of the State's ability to track evaluation certification dates by provider's name, previous evaluation date, current evaluation date, certification date, length of certification, certification expiration, and dates for on-site CAP follow-ups.

*RCS Database: Evaluation Citation Tracking Database.* The State submitted a print out from the database for Evaluation Citation Tracking. The sheet provided the CMS review team with information on the region, agency name, visit start date, evaluation follow-up, certification start and end dates, length of certification, number of clients in the program, number of clients in the sample, Washington Administrative Code (WAC) citation and subsection, findings category, first action due date, and CAP received date. The report provided evidence of RCS' ability to track certification reviews through the CAP submission process.

*Client Services Contract: Community Residential Services.* The client services contract was submitted by the State to detail the requirements of the contractual relationship between the DDD and its providers.

The contract template requires providers to maintain all necessary licenses and remain current on criminal history background checks. The contract template also includes a statement of work (including mandatory reporting requirements, as well as reporting and facilitating client service need changes), rate information, billing and payment requirements, insurance requirements, dispute process, the requirement for a drug-free workplace, applicable WACs and the number of individuals to be served in the home. The contract is executed by the contractor and Department of Social and Health Services (DSHS) RA or designee.

*Monitoring and Quality Improvement of Adult Family Home (AFH) Services (Policy 4.08) Issued November 1, 2010.* The policy directs the DDD CRMs and Performance and Quality Improvement (PQI) staff on the procedures for monitoring the AFH. The procedures require the DDD staff to: complete face-to-face DDD assessments with waiver participants at least once per year; review the AFH negotiated care plans when they are received and follow-up on any concern regarding the plan; consult with the PQI prior to placing a waiver participant in an AFH; ensure that the AFH has a current license and contract in place; share all critical incidents with the PQI; and discuss any technical assistance requests for the AFH residents with the PQI. The PQI are required to visit the AFHs each time there is a new placement and are required to monitor the AFH to assure that all licenses are current and contracts are in place.

*DDD AFH Quality Improvement Visit Assessment Template (DSHS 15-215).* The State submitted the template as an example of how it collects information when on site. The assessment includes: the facility and provider's identifying information (address, phone, license number, Social Service Payment System (SSPS) provider number, DSHS license capacity, contract expiration date); the name of DDD residents in the home (including the resident's CRM, waiver status, DD number, evacuation level, and date of birth); the reason for the visit; name of staff interviewed and/or observed during the visit; other non-residents in the home; positive comments regarding household; issues/concerns; reason for move (new residents only); negotiated care plan (current/not current); DDD assessment (current/not current); and the CRM's comments/concerns regarding competence, health and safety, integration, relationships, power and choice, and status. The form is then signed by the CRM and a box is checked off to verify that a SER note was completed.

*Certification Evaluation Report: Community Residential Services and Support.* The State submitted an example of a Certification Evaluation Report for the Community Residential Services and Support Program as evidence of provider oversight. The evaluation report includes: an operational history of the operator; the number of clients served under the program; and the number of clients in the home receiving different types of support (the report submitted included documentation of clients receiving group home services, community protection services, behavioral support plans, prescribed psychoactive medications, vocational/employment programs, restrictive programs, 40 hours or more of staff time monthly, whether the funds are managed by the agency, the number of crisis beds available, and vehicles operated by owner). The report documents individuals interviewed by the evaluator and any additional information

gathered. The face page is followed by the evaluator's findings, which includes the WAC and DDD policy violation, and is followed by the provider's CAP information, due date for status updates, and the provider's signature and date. Additionally, the report provides space for the provider to comment on the report. The report concludes with an Evaluator's Corrective Action Follow-up section documenting whether the CAP has been accepted. The submitted report provided evidence of the State's review of the home, identification of issues, a CAP that was developed by the home, and reviewed and followed by the State through remediation.

*All Providers.*

*EACD.* The State utilizes the EACD to track all contracts for all licensed and unlicensed providers. The information may be entered into the system by the Division of Licensing, RCS, DDD CRM, or contract staff. The database tracks compliance with background check requirements, training requirements, evidence of licensure requirements, and the timeliness of contracts. The CRMs are required to verify that all service providers authorized in the service plan are current and compliant in the EACD, prior to the authorization of services. The QCC review of the CRM files monitors to assure that the CRM completed the review of service providers prior to authorizing services. The EACD provides the State with an effective way of verifying that the contracted providers meet all state requirements.

*Background Check Unit process.* The Background Check Unit is responsible for processing background check requests against the police and FBI system if the applicant has not continuously resided in the state for the last three years. The background check system also includes all substantiated RCS, Child Protective Services (CPS), and Adult Protective Services (APS) findings.

Sub-assurance 2: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

The CMS reviewed the evidence package and the EACD to assess compliance with the sub-assurance.

*Evidence Package. Performance Measure 1(a): The percentage of waiver files reviewed for which all authorized providers met DDD contract standards.* The State submitted data in its evidence package documenting a 92 percent compliance rate for the 139 waiver files reviewed in which all authorized providers met DDD contract standards. Additionally, the state reported that data from the EACD documented that of the 2,508 non-licensed/non-certified providers, seven failed to meet all contract standards.

*EACD.* The EACD is utilized by the State to monitor all state contracts and by the CRM to assure that provider contracts are valid prior to authorizing services. Unlicensed providers must be actively connected to a waiver individual. Unlicensed providers secure provider contracts through the State's contract staff. The unlicensed contracts are signed by the RO supervisor and the information is entered into EACD. The contract staff is responsible for monitoring the quality of care delivered by these providers.

Sub-assurance 3: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

The CMS reviewed the EACD to assess compliance with the sub-assurance.

*EACD and File Review.* The State tracks provider training through the EACD and through file reviews. The State's evidence package documented a 99.9 percent compliance rate documented through file review and 99.9 compliance rate as pulled from the EACD. The State verifies that training was completed through the presence of a valid license in the database and/or documentation in the file review.

**CMS Required Recommendations:** CMS has no recommendations for this assurance.

#### **IV. Health and Welfare of Waiver Participants.**

**The State must demonstrate that, on an ongoing basis, it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.**

*Authority: 42 CFR 441.302; 42 CFR 441.303; SMM 4442.4; and SMM 4442.9.*

**Compliance:** The State does not fully or substantially demonstrate the assurance, though there is evidence that may be clarified or readily addressed.

The CMS reviewed the following information to assess compliance with the assurance:

- Evidence Package
- Complaint Tracking
  - DDD Complaint Database
  - CARE SER Notes
  - Complaints- County Contracts
  - DDD Client Complaints Policy 5.03
- Critical Incident Tracking
  - DD Incident Reporting (IR) System
  - APS
  - CPS
  - RCS
- Incident Review Team (IRT)
  - IRT
  - Staff to Client Alleged Incidents Reported
  - IR Committee Case File Review Example
  - QA Review
- Restrictive Interventions
  - PBSP (Policy 5.14/Functional Assessment [FA]).
  - Positive Behavioral Support Plan (PBSP)
  - PBSP in Supported Living

- Mortality Review
  - DDD Mortality Review Team (MRT)
  - DDD Mortality Reporting Process
  
- Residential Home Web-based System

*Evidence Package. Performance Measure 1: The percentage of incidents alleging abuse, neglect abandonment and/or financial exploitation of waiver clients that were reported by DDD, per policy, to APS or RCS. The State reported a 94 percent compliance rate with the performance measure. For this measure, the State reported that its remediation efforts included a continued monitoring to assess that reporting requirements are being met.*

*Evidence Package. Performance Measure 2: The number of allegations of abuse neglect, abandonment, or financial exploitation substantiated by APS by allegation. The State provided evidence of its ability to track substantiated APS allegations by incident type and waiver. The State system is able to capture the number of substantiated incidents categorized by abuse, financial exploitation, physical exploitation, neglect, sexual abuse, self neglect, mental abuse and physical abuse for each DD waiver.*

*Evidence Package. Performance Measure 3: The number of allegations of abuse, neglect, abandonment, or financial exploitation substantiated by RCS by allegation. The State was not able to provide this data at the time of the review and stated, “At this time, the RCS database did not support tracking the performance measure at the individual level.” The State reported that it would be working with RCS to identify methods of tracking at the individual level.*

*Evidence Package. Performance Measure 7: The percentage of waiver participants whose death was subject to review that were reviewed by the MRT. The State reported that 100 percent of the 46 deaths were reviewed.*

*Evidence Package. Performance Measure 8: The number of waiver recipient deaths reviewed by the MRT by cause of death. The State provided evidence of its ability to break out cause of death in 12 categories and by waiver. The State has used this information to develop trainings for providers, and CRM and to send out caregiver alerts on pneumonia (aspiration type), which was identified as the number one cause of death for the DD waiver participants.*

*Evidence Package. Performance Measure 9: The percentage of waiver participants with three or more incidents during the calendar year reviewed by QA managers to verify that appropriate actions were taken. The State reported a 100 percent compliance rate with this performance measure. The regional QA managers reviewed all cases where three or more incidents were recorded during the calendar year. In instances where the QA manager determined that appropriate actions were not recorded, the QA manager followed up and remediated 100 percent of the issues.*

*Evidence Package, Appendix G. Performance Measure 12: The percentage of complaints, by type, filed in the DDD complaints database. The complaints database recorded four complaints*

in its database. Two (50 percent) complaints were related to contracted providers. At this time the complaint database only tracks complaints once they reach the RA level. The current policy for tracking complaints in the database does not permit the State to draw an accurate conclusion regarding the waiver program because it fails to capture enough data to track and trend.

*Complaint Tracking.* The State tracks complaints through the DDD Complaint database, the CARE SER notes, and county contractor files.

- *DDD Complaint Database.* The State submitted a snapshot of the DDD complaint log database. The form is completed when a CRM is unable to resolve the complaint at either the CRM or RO supervisory level. The database records: the date of receipt; the individual who received the complaint; complainant's program/waiver name; the complainant's contact information; the client's identifying information; an explanation of the issue; previous actions taken; most recent actions taken; who is assigned; completion date; outcome; description of the outcome; and date complainant process is completed. The form captures a significant amount of information; however, CMS is concerned that the tracking does not occur within a central database until it reaches a RA level. Lower level complaints are currently kept in waiver participants' files and may not be adequately tracked to identify trends of concern. The lack of a system tracking data at a lower/staff level results in a gap in the State's ability to quickly identify, and respond to trends that may impact the health and welfare of waiver participants.
- *CARE SER Notes.* The CRM have the ability to enter complaints into the CARE tool SERs. The SER may be tagged to identify that the note regards a complaint, though the CMS file review found that SERs were inconsistently tagged to identify complaints. The State only begins to track complaints in a state database once they have risen to the RA level. The State Client Complaint Policy 5.03 requires complaints to be resolved at the lowest possible level, with the exception of complaints concerning services in the Residential Habilitation Centers (RHC) and State Operated Living Alternatives (SOLAs), which are required to be directed to the RA. As the CRM complaint notes are housed in individual files, the State is not currently able to track and trend the majority of the complaints received to identify regional or statewide trends requiring State action.
- *Complaints-County Contracts.* The county contracts require each county to have a complaint process; however, it does not require the counties to have centralized documentation systems to track complaints. The State reported that the complaints are currently kept in individual files. The lack of a contractor level tracking system does not allow for trends to be identified and reported to the State for resolution. Under the current process the review of a documented complaint by the State only occurs when a waiver participant's file is randomly pulled for review and contains a complaint.
- *DDD Client Complaints Policy (Policy 5.03).* The policy directs the actions to be taken by DDD staff when a complaint is received from the client, family members, legal representatives or advocates. The policy requires the complaints to be addressed at the lowest staff level possible and outlines the steps to be taken by staff if resolution is not completed at the CRM level. The complaint is documented in the individual waiver

participant's file (SER notes) unless it escalates to the RA level. Once a complaint reaches the RA level it is entered into the DD complaint tracking (CT) database. The RA or his/her staff will document the resolution of the investigation in the CT or transfer the complaint to the CO if resolution does not occur. Complaints made directly to the RA or CO, are transferred down to the CRM for resolution. The Office of Quality Programs and Services reviews the complaints entered into the CT database during its review cycle. The current policy does not provide the State with sufficient information to adequately track and trend complaints, as the database does not capture all complaints, and SER notes may not always be coded to identify complaints in the system.

*Critical Incident Tracking.* The DDD utilizes the IR database to record and track critical incidents through the remediation process. DDD coordinates with APS, CPS and RCS to respond to critical incidents related to the State's population with Developmental Disabilities.

- *DDD IR System:* The DDD uses the IR system to document and track the resolution of critical incidents. Critical incident information is entered into the IR tracking database by the CRM upon being informed of an incident. The IR system is designed to track and trend by incident type through resolution, but does not effectively track IRs by provider. Once the IR entry is completed, it is sent to management, the IR Team and APS, CPS or RCS, as appropriate, for investigation. The CRM is required to follow up on the IR by the 30<sup>th</sup> day; however, the current system does not contain a tickler to remind the CRM of that date. Additionally, during the CMS on-site review, the state staff and management reported that they have had issues with closing out the IRs due to inconsistent receipt of final resolution reports for investigations completed by APS, CPS, and RCS.

The current IR system is very effective at documenting IRs received by the CRMs; however, a critical gap occurs if the incident is not reported to the CRM or APS directly. Critical incidents received by either RCS or CPS may never be entered into the IR system because CPS and RCS do not currently have the ability to identify waiver participants when they receive critical incident reports.

- *APS.* APS receives critical incident reports and is responsible for investigating and making an official finding for allegations of abuse (physical, mental, sexual and exploitation of person), abandonment, neglect, self neglect, and financial exploitation for individuals who do not reside in a licensed setting, or are served by a licensed residential service. APS has a central office in Olympia and an office in each of the ROs. All investigations are prioritized into three categories - high, medium and low. High priority requires a face-to-face response within 24 hours; medium priority requires a response within five days and a low priority allegation requires a response within ten working days.

Critical incidents reported to APS are logged in the APS report database and assigned a priority level which drives the timeframe for the investigation. The APS staff members have access to the CARE database and may connect with the system to identify whether the reported critical incident is related to a DDD waiver participant. Reports received by the CRMs are logged into the IR database once the allegation is substantiated or unsubstantiated.

- *CPS.* CPS is operated statewide by the Children’s Administration (CA) of the State’s DSHS. CPS is responsible for the investigation of allegations of abuse, neglect or exploitation of children. In its response to critical incidents, CPS is responsible for contacting the child and his/her collateral contacts to assess and investigate the allegation. They are not authorized to remove the child from the home, as this responsibility is delegated to law enforcement. The CPS staff complete a safety assessment and safety plan, interview the alleged perpetrator and work with the family to reduce risks. The information from the assessment is recorded in the FamLink system, which is the case management information system utilized by CPS to track allegations of abuse.

CPS does not have access to the CARE system, and therefore is unable to verify through the system whether a child is a DD waiver participant. At the time of the review, CPS and DDD staff interviewed stated that in the RO informal strategies may be in place to notify the CRM of critical incidents related to DD waiver participants, but that a formal system had not been implemented to date. The current system leaves the DDD at risk of missing critical incidents related to the children served under the waiver.

- *RCS.* RCS is responsible for the investigation and making official findings of alleged incidents of abuse and neglect occurring in nursing homes, boarding homes, AFHs, and supported living programs.

Critical incidents reported to RCS are entered into the RCS system and are tracked electronically for the AFH and Boarding Homes. RCS staff members do not have access to the CARE system and do not have the ability to identify whether the allegation is related to a DD waiver participant. This break in communication leaves the DDD at risk of missing critical incidents related to the DD waiver participants. During the CMS on-site review, the state DDD staff interviewed stated that they were not consistently receiving final reports from RCS, resulting in the DDD CRM being unable to close out IRs in the DDD IR database.

Additionally, during the course of the CMS review, the providers reported that they had called RCS on occasion and had no response; and that RCS did not come out to investigate a claim of abuse. The providers stated that they were aware of cases where they had fired providers due to the agency’s internal incident review process, and the terminated providers had moved to other agencies and continued to serve waiver participants. The providers stated, and this was confirmed by the State, that the investigative arm of RCS was under staffed. Interviews with state staff indicated that there were currently three investigators in the state assigned to respond to initial reports of abuse in the supported living homes. The supported living homes currently serve approximately 3,000 waiver participants. State staff interviewed reported that a request had been sent forward for additional staff on the Resident and Client Protection Program (RCPP) team which is responsible for investigating individual providers in residential settings.

*Incident Review Team (IRT).* The State has established an IRT that is responsible for monitoring the State’s response to critical incidents for the DD waivers. The team meets monthly to analyze

data pulled from the DD IR database to identify cause and to ensure that remediation has occurred. The State submitted examples of the team's reports as evidence of its oversight of the current IR process. The IR team reviews monthly counts for seven indicators, including: physical abuse; sexual abuse; mental abuse; financial exploitation; neglect; staff to client incidents; and client to client incidents.

- *IRT Alleged Incidents Reported Waiver Review, PowerPoint, May 2010.* The State submitted the PowerPoint presentation to document its ability to track the number of critical incidents reported, both by waiver and total incident reports for all DD waivers.
- *Staff to Client Alleged Incidents Reported - Monthly Totals August 2008 - March 2010.* The State submitted evidence of its ability to track staff to client alleged incidents by waiver. The data is part of the IRT monthly analysis of IR data.
- *IR Committee Case File Review Example.* The State submitted a snapshot from its IR committee case file review as evidence of its oversight of the IR system and DDD staff response. The snapshot provided evidence of DDD management oversight of the IRs received to assure that the CRMs followed state procedures. The snapshot documented whether the supervisor had verified the system's response to the incident was sufficient, and if not, what was missing (insufficient SERs, PBSP not updated, no IR follow-up, necessary referrals not completed, or other); comments on system response; whether the waiver participant's plan was updated; comments on the plan update; whether the incident was reported to the proper investigative authority; whether mandatory reporter timeframes were followed; whether alleged abuse was reported to law enforcement; and follow-up notes. The snapshot provided an example of a thorough review process for IR reports to assure that staff members are consistently using the IR system. All files selected are reviewed to assure 100 percent remediation has occurred.
- *QA Review.* The QA staff in each of the ROs are responsible for reviewing any waiver participant file that receives three or more critical incident reports in a year. This report is then reviewed by the CO manager who is responsible for determining whether reported incidents are connected to a systems issue. When systems issues are identified, they are shared with the CO management and the waiver oversight committee. The identification of systemic issues may result in staff trainings, informational bulletins or changes to DDD policy.

*Restrictive Interventions.* The State documents and monitors the use of restrictive intervention through the review and approval of PBSPs.

- *PBSP (Policy 5.14/FA).* The State conducts FAs for individuals who have challenging behaviors that may impact their ability to have positive life experiences. The FA serves as the building block for the PBSP. The FA evaluates the individual's overall quality of life; factors that might increase the likelihood of challenging behavior; factors that might increase the likelihood for appropriate behavior; when and where challenging behavior occurs most frequently; the presence of a diagnosed mental illness or neurological dysfunction that may trigger a challenging behavior; and the function or purpose of the

challenging behavior. The State provides the providers with guidelines for the development of a functional assessment in Attachment A of the policy.

- *PBSP*. Individuals served under the waiver are required to have a PBSP developed when they have challenging behaviors which may result in the threat of injury to themselves or others, or threaten significant damage to the property of others. PBSPs are also required when restrictive interventions are applied to an individual. The PBSP, which is developed from the functional assessment, includes prevention strategies (environmental, psychosocial/interpersonal, and intrapersonal), teaching/training supports, and strategies for responding to challenging behaviors. During the on-site review, the state staff and management interviewed identified that there was a current workload issue that impacts the staff's ability to complete exception to policy (ETP) reviews to assure that providers are in compliance with the PBSP.
- *PBSP in the Supported Living Homes*. Information gathered during interviews with DDD leadership, supported living providers and the review of state policy reflect that there are currently no provider qualifications or training requirements which must be met by the individuals who develop the PBSP in the supported living homes. The lack of requirements for the individuals that develop the PBSP has the potential to adversely affect health and welfare of the participants served in the supported living environment.

CMS is concerned that the CRM are not always aware of a PBSP development in the supported living homes, or that the CRM are not able to monitor the PBSP to meet state requirements due to workload issues.

#### *DDD Mortality Review.*

- *DDD MRT*. The State has formed an MRT that meets on a monthly basis. The MRT Policy 7.05 requires the team to review the deaths of all individuals receiving support from supported living providers or who reside in an AFH, companion home, group home, RHC, or ICF/MR. The review process includes an analysis of a report from the provider, a report from the regional QA staff, signatures from the CRM and regional manager and a final review by a multidisciplinary committee at central office. Systems issues identified during the review process are shared at the quarterly Full Management Team meeting. The State submitted an overview of the team's activities and tracking as part of the evidence package.
- *DDD Mortality Report (DSHS 10-331)*. The DDD Mortality Report is a three part report including a provider report, regional quality assurance report, and a CO review.
  - The provider report is completed by the provider and sent to the CRM within 14 days of the waiver participant's death. The provider report includes: the deceased's identifying information; date and time of death; apparent cause of death; co-existing causes; other significant conditions contributing to the death; whether 911 was called; whether the case was referred to the medical examiner; place of death; deceased's type of residence; medical information; whether a health care provider treated the

deceased in the last 30 days; the deceased's medications; mental health issues; circumstances of death; and a verification that the CRM reviewed the provider report. The provider report is signed and dated by the CRM and then sent forward to the regional QA program manager. The program manager reviews the provider report with CRM comments and completes the regional QA part of the report. The QA report captures information on whether abuse and/or neglect were suspected, whether the medical examiner was contacted, if an autopsy was conducted, if the death was suspicious, whether there were any incident reports for the deceased in the last two years (total number of APS/CPS/RCS referrals, number of substantiations, open investigation) and whether law enforcement is investigating the death. The form also documents all reports reviewed by the QA manager related to the deceased and is signed, dated and sent forward to the CO within 21 days.

- The CO MRT reviews the submitted report within 60 days of receipt. Each report is reviewed by three members of the team. The MRT report documents whether the MRT agreed with the RO and regional QA manager's analysis, and any recommendations for follow up. The MRT determines whether additional actions are necessary, and the cause and manner of death. The MRT findings report and death certificate are sent to the region upon the completion of the review by the MRT. Information gathered by the MRT is presented to the Full Management Team once or twice a year. Systemic issues identified by the MRT may result in training, or changes to state rules or policy.

*Residential Home Web-based System.* The State has developed a web-based residential home finder for the AFH, boarding and nursing homes. The website allows the public to look up the residential home providers by zip code, county, specialty, contract type, and whether there have been enforcement issues. Any home that has received an enforcement letter (post April 2010), will have that information listed on the website. The site also provides the browser with the number of beds in the home, address (with a link to directions) and whether the home accepts Medicaid.

### **CMS Required Recommendations:**

*Evidence Package. Performance Measure 1.* The State reported a 94 percent compliance rate with the performance measure. The State must submit a CAP detailing how it will monitor to assure that the CRMs consistently send notification of critical incidents to APS, CPS or RCS. The plan must be submitted to CMS no later than 60 days from the receipt of the final report.

State Response: The Corrective Action plan was approved by Centers for Medicare and Medicaid Services in April 2011. The Corrective Action Plan identifies a system process for CRM to be notified of critical incidents. The information will be documented in FAMLINK.

In addition:

- DDD has an incident report system which records incident type, date of incident, date incident was reported, details of the incident, follow up and who was notified of the incident.

- The CO IR review team currently monitor to case managers reporting to the proper entities.

DDD is now developing guidelines for central office and regional staff which will include review expectations to ensure current reporting policy is followed. These guidelines will be trained to and implemented February and March of 2012.

Final CMS Response: The requirement will be met upon successful implementation and completion of the State's CAP. The State must continue to meet with CMS to discuss the progress in meeting the CAP requirements in order to be in compliance with the assurance.

*Evidence Package. Performance Measure 3.* The State must submit a CAP detailing how it will track substantiated allegations of abuse, neglect, abandonment or financial exploitation that are reported through RCS. The plan must be submitted to CMS no later than 60 days from the receipt of the final report.

State Response: The Corrective Action plan was approved by Centers for Medicare and Medicaid Services in April 2011. The Corrective Action Plan identifies a system process for CRM to be notified of critical incidents. The information will be documented in FAMLINK. This information will allow us to track and trend substantiated allegations on waiver recipients.

Final CMS Response: The requirement will be met upon successful implementation and completion of the State's CAP. The State must continue to meet with CMS to discuss the progress in meeting the CAP requirements in order to be in compliance with the assurance.

*DDD Complaint Database and CARE SER notes.* The current complaint policy does not allow the State to effectively track and trend complaints, as it only begins to centrally record complaints in the database once they have been raised to the RA's level. All lower level complaints are logged in individual files through SER notes, which impede the early detection of trends with the potential to impact the health and welfare of waiver participants. CMS strongly recommends that the State develop, or amend the current policy for tracking complaints in the DDD Complaint database to allow for data entry at the CRM level for all complaints.

State Response: DDD is taking this recommendation into consideration and will be evaluating the current complaint policy and the ability of the CARE system to be modified to be able to track and trend complaints.

DDD will emphasize training for case managers regarding documenting complaints in the current CARE SER system. The CARE system currently has SER codes for complaints and provider concerns. DDD will be emphasizing the requirement to follow up on the complaints. DDD will continue to use the complaints database to track complaints that rise to the Regional Administrator's level.

Final CMS Response: CMS strongly recommends that the State develop, or amend the current policy for tracking complaints in the DDD Complaint database to allow for data entry at the CRM level for all complaints.

*Complaints-County Contracts.* CMS strongly recommends that the State amend its current contractual requirements with the counties to require a centralized county complaint tracking system. Lower level complaints are currently kept in waiver participant's files and may not be adequately tracked to identify trends of concern. The lack of a system tracking data at a lower/staff level results in a gap in the State's ability to quickly identify, and respond to trends that may impact the health and welfare of waiver participants.

State Response: Currently, counties have a contractual requirement with the providers which requires each agency to have a complaint policy that is explained to each client annually. DDD will explore this option in the future with the counties.

Final CMS Response: CMS strongly recommends that the State amend its current contractual requirements with the counties to require a centralized county complaint tracking system. Lower level complaints are currently kept in waiver participants' files and may not be adequately tracked to identify trends of concern. The lack of a system tracking data at a lower/staff level results in a gap in the State's ability to quickly identify and respond to trends that may impact the health and welfare of waiver participants.

*Client Complaints Policy (Policy 5.03).* CMS strongly recommends that the State revise the current complaint tracking policy to require the use of a centralized tracking system at the CRM level.

State Response: DDD is taking this recommendation into consideration and will be evaluating the current Complaint policy and the ability of the CARE system to be modified to be able to track and trend complaints.

DDD will emphasize training for case manager regarding documenting complaints in the current CARE SER system. The CARE system currently has SER codes for complaints and provider concerns. DDD will be emphasizing the requirement to follow up on the complaints. DDD will continue to use the complaints database to track complaints that rise to the RA's level.

Final CMS Response: CMS strongly recommends that the State implement a complaint tracking system that captures data received at all staff levels. A centralized tracking system enhances the State's ability to comprehensively track and trend complaints resulting in earlier detection of issues impacting waiver participants' health and welfare.

*Critical Incidents.* The State must submit a CAP to CMS that details a coordinated interagency (DDD, APS, CPS and RCS) identification of and response to critical incidents to assure that the State is able to identify, track, trend, and remediate instances of abuse, neglect and/or exploitation. The CAP must include: how the State partner agencies will identify waiver participants; the coordination of interagency efforts throughout the investigative process; and the process for reporting the results of critical incident allegation investigations. CMS recommends that the State update the current IR tracking system to allow for the system to track by provider. Additionally, CMS strongly recommends that the State increase the staff employed by RCS to respond to allegations of abuse. The plan must be submitted to CMS no later than 60 days from the receipt of the final report.

State Response: The Centers for Medicare and Medicaid Services approved the CAP in April 2011. The CAP identifies a system process for CRM to be notified of critical incidents. DDD continues to participate in follow up conversations with CMS to update states status of CAP.

The Aging and Disability Service Administration is currently implementing the CAP that was approved in April 2011. The State response in CAP identifies integrating APS and RCS into the FAMLINK system that is currently used by CPS for their case management. FAMLINK has the capability of tracking by provider. DDD will be able to access the information to track and trend issues by provider type.

RCS requested additional investigative staff in last legislative session.

Final CMS Response: The requirement will be met upon successful implementation and completion of the State's CAP. The State must continue to meet with CMS to discuss the progress in meeting the CAP requirements in order to be in compliance with the assurance.

*Restrictive Interventions/ PBSP.* The State must submit a CAP to CMS documenting how it will assure that the CRMs are completing the required ETP reviews to assure providers are compliant with the PBSP. CMS strongly recommends that the state develop provider qualifications and training requirements for staff in the supported living homes that develop PBSP. The plan must be submitted to CMS no later than 60 days from the receipt of the final report.

State Response: DDD agrees with this recommendation. DDD will add a Waiver audit question to the 2012-2013 Waiver audit years. The QCC team will review PBSP for restrictive procedures and then compare if an ETP was in the client file if needed.

Final CMS Response: CMS is requesting a copy of the waiver audit question that will be used to review PBSP for restrictive procedures and then compare if an ETP was in the client file if needed. Additionally, CMS is requesting a copy of the audit review findings for this question once the 2012-13 audit cycle has been completed. The audit review findings should include the remediation of any identified issues. The State must submit a copy of the audit question to CMS within 60 days of its receipt of the final report. The State must submit a copy of the 2012-13 waiver audit findings within 60 days of the State's audit release date. CMS' receipt of the documents will represent a complete State response to Restrictive Intervention/PBSP CAP requirement.

## **V. State Medicaid Agency Retains Administrative Authority Over the Waiver Program**

**The State must demonstrate that it retains ultimate administrative authority over the waiver program and that its administration of the waiver program is consistent with its approved waiver application.**

*Authority: 42 CFR 441.303; 42 CFR 431; SMM 4442.6; and SMM 4442.7.*

**Compliance:** The State demonstrates the assurance but CMS recommends improvements or requests additional information.

Sub-assurance 1: 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 and contracted agencies.

The CMS reviewed the following information to assess compliance with the sub-assurance:

- Evidence Package
- County Oversight Activities
  - Oversight of County Contractors
  - County Contract Compliance Tracking Spreadsheet
  - Draft County Review Report 2010
  - County Oversight Committee
- JRP IRR Review
- Fair Hearings
  - Planned Action Notice (PAN)
  - PAN Decision Request for Hearing
  - Barcode: Report of All Administrative Issues, October 2008-October 2009
- Quality Control and Compliance Team
  - DDD Regional Quality Review: Region 3 Report for May-August 2010
- DDD Ternary Report, Region 5 (August 10, 2010)
- DDD Incident Reporting Policy 12.01
- DDD Use of Restrictive Procedures Policy 5.15
- Consent for Use of Restrictive Procedures Requiring an Exception to Rule (ETR) (DSHS 15-385)

*Evidence Package, Appendix A. Performance Measure 1: The percent of contracted counties that submit timely contract monitoring reports.* The State reported an 87 percent compliance rate with the performance measure which was based on information pulled from the County Contract Monitoring Database. To remediate the issue, the State has prioritized the non-compliant counties in the review cycle for on-site monitoring and technical assistance. The State has modified its process from performing a review of a random sample of counties to a review of all counties. Additionally, the review has expanded to include oversight of the state/county and county/vendor contracts.

*Evidence Package, Appendix A. Performance Measure 2: The percentage of counties that comply with their fiscal waiver spending plans provided by the State.* The State reported a 100 percent compliance rate for this performance measure.

*Evidence Package, Appendix A. Performance Measures 4 and 5: The percentage of Regional Support Network (RSN) contracts that were monitored annually by regional resource managers to verify contract compliance.* The State had a 60 percent compliance rate for the measure. The State's oversight activities uncovered that the EACD was not being properly populated to track the monitoring activities for the RSNs. To remediate, the State provided training and a clarification to all applicable staff and the State confirmed that it now has a 100 percent compliance rate for the performance measure.

#### *County Oversight Activities.*

- *Oversight of County Contractors.* The DDD County Services Manager is responsible for the oversight of employment and day services programs. The oversight includes: monitoring of county contracts; policy development; provision of technical assistance to assure consistent contract implementation; training; on-site reviews; monthly monitoring meetings; and verification of provider requirements. In 2008, the State revised its monitoring policy to include an annual review alternating between a contractor self review and State on-site review utilizing the information submitted in the self assessment. The State is current with all county reviews.

The State reviews the county each year alternating between a county self-assessment and an on-site review. The State utilizes the self-assessment information submitted from the previous year to conduct the on-site assessment. The on-site review includes a review of client and direct service staff files.

- *County Contract Compliance Review Checklist.* The State submitted a copy of the county self-assessment form that the county contractors complete every other year. The county must complete the form and return it to the State by the required date or the State is required to complete an on-site review. The self-assessment records: the services delivered by the county; whether the county directly provides any of the services; client eligibility; information on the county's service evaluation system; whether subcontractors have been reviewed; credentials and minimum requirements; county requirements to avoid duplicative funding; background/criminal history check information; verification of the existence of policies and procedures; and criteria for the county evaluation system (must include a file review section and employment program documentation).
  - *County Contract Compliance Review Tracking Spreadsheet.* The State submitted its tracking spreadsheet that compiles the results for the county self-assessments. The spreadsheet breaks down each component of the self-assessment by RO and county. The spreadsheet did not contain information for six of the 36 counties.
- *Draft County Review Report 2010.* The State submitted a copy of the new county review report. The revised report: documents data to assess the contractor/county's ability to deliver services according to individual need; assesses the degree of support by the provider; evaluates health and safety; reviews policies protecting individual rights; and evaluates specific contracted services (child development, prevocational employment, group supported employment, individual supported employment, community access

services, and person to person). The report measures county provisions under each subsection and documents findings (including whether the county has met contractual requirements, if State action is required, any required actions, the date for implementation and the DDD staff who verified that the action was taken).

- *County Oversight Committee.* The County Oversight Committee is responsible for monitoring county contracts to assure that services are delivered in accordance with the service plan, to review billings and monitor monthly invoices, respond to complaints, and conduct the Biennium Review. The Biennium Review includes an assessment of the contractor's policies, a personnel file review, a ten percent client file review, and a review of billing.

*JRP IRR Review.* See Assurance 1: LOC Evaluation.

*Fair Hearings.*

- *PAN.* The State submitted an example of a PAN that had been sent to a waiver participant. The PAN identified the waiver participant and her representative, the planned action, effective date of the action, the impacted service(s), the reasons for the action with supporting WAC authorities, an overview of the participant's appeal rights, and state contact information. The State reported that the PAN is sent on all actions even when benefits are continued. The PAN notice submitted served as an effective notification tool for waiver participants.
- *PAN Decision Request for Hearing.* The State submitted a copy of the PAN Decision Request for Hearing form as evidence of a waiver participant's ability to access the fair hearing system. The form identifies the impacted service, the action to be taken, a line to document when the waiver participant was informed of the action, if the waiver participant wished to continue services pending the appeal, information on who may be representing the waiver participant, a box to authorize release of information to the representative, and whether or not the participant needs an interpreter. The form is signed and dated, then returned to the State, by fax or through the mail. The form served as evidence of a user-friendly request format through which waiver participants gain access to the fair hearing system.
- *Barcode: Report of All Administrative Issues - October 2008-October 2009.* The State submitted the administrative issues report that is pulled off of the Barcode system. The report captures administrative hearings information by region and includes: the number of closed and pending cases and whether they are pending or closed; and the results of the administrative hearings by issue/subject (29 issues tracked). Each of the DD ROs employs an individual who serves as the fair hearings coordinator. The coordinators meet monthly with the CO to review the Barcode reports for trends. The report demonstrates the State's ability to track administrative hearing information for the DDD waiver participants. DDD administrative fair hearing information was also available through the State's Fair Hearing Control System.

*QCC Team.* The team is responsible for the annual waiver QA reviews and a secondary review whose focus is determined annually. The QCC team reports its findings to the CO and leadership through quarterly reports. The QCC is also responsible for providing training at the DDD academy.

- *DDD Regional Quality Review Report, Region 3 (May-August 2010).* The Regional Quality Review Report example for Region 3 was submitted by the State as evidence of the regional work to report quality activities up to the CO team. The submitted report contained an overview of alleged incidents reported to CO; clients with three or more critical incidents (chart and analysis); participant deaths and reports (including any special investigations conducted); National CORE Indicator (NCI) survey and issues/observations; AFH QA/QI issues/observations; and supported living/companion homes visits and issues/observations.

*DDD Ternary Report, Region 5 (August 10, 2010).* The State submitted a copy of a Ternary Report for Region 3 as evidence of its ability to Report Regional accomplishments, hot spots, regional enrollment, SSPS monitoring, eligibility reviews, residential vacancies, state hospital and mental health services, voluntary placement services, community protection, employment, early support for infants and toddlers, waiver reports-POC, NCI survey information, supervisory file reviews, QCC Audits, healthcare for workers with disabilities, and performance development plans. The ternary report is reviewed by the central and regional office leadership three times per year and serves as an effective tool for monitoring the waiver administration at the regional level.

*DDD Incident Reporting Policy 12.01.* The State submitted a copy of its incident reporting policy during the on-site review. The policy provides guidelines for DDD employees for reporting critical incidents. All DDD employees are required to follow the policy. The procedures direct the DDD employees on external (APS, CPS, CRU, law enforcement, emergency services, designated mental health professionals [DMHP]) and internal reporting requirements, and include the requirement to use the IR system to record the information. The State has also provided direction to employees for reporting when the IR system is not operational. The policy clearly outlines: the follow-up, closure and documentation requirements; the regional and central office QA responsibilities; and reporting timeline. The timelines are defined and classifies incidents into three categories (A, B, and C) and defines how the incident is to be reported. Category A incidents require response within one hour and requires both a call to CO and an electronic IR. Category B incidents require a response within one day (IR only). Category C incidents require a response within five days (IR only). The policy provides evidence of clear guidance on the incident reporting requirements. The staff interviewed during the course of the on-site review referenced the policy document frequently as their guidance.

*Regional Management Review of CRM work: File Review.* The regional supervisors are responsible for reviewing one file per CRM per month to assure that files reflect oversight of the waiver participants, including SER notes and IRs. Issues identified during the file reviews are resolved with the CRMs.

*DDD Use of Restrictive Procedures Policy 5.15.* The State submitted a copy of its Use of Restrictive Procedures policy during the CMS on-site review. The policy applies to DD clients 18 and older, describes the restrictive procedures that are allowed and prohibited by the state, the circumstances under which they may be utilized, and the requirements for documenting and monitoring their use. The residential settings covered by the policy are the supported living homes, companion homes, group homes, group training homes, alternative living homes, SOLAs, and community ICF/MR, RHC. The policy also covers adult services funded by counties that are funded by DDD (employment, day and vocational programs). The policy states that RCW and WACs for AFH, boarding homes, and nursing homes take precedence over the Policy 5.15. The restrictive procedures are only permitted for the purpose of protection. The policy outlines: the restrictive procedures that require a PBSP and an ETP; the procedures that require approval by the RA; the use of video monitors for client health and safety; procedures that do not require an ETP; non-restrictive procedures; use of restraints during medical or dental treatment; treatment of sexual deviancy; court ordered restrictions; and emergency use of restrictive procedures. The procedures documented in the policy require written communication with the CRM when the use of a restrictive intervention is planned, and requires a discussion with the client and his/her legal representative. The documentation required includes an FA outlining the behavior that the intervention addresses and a written PBSP based on the FA. The PBSP must include a description of the intervention, a plan for recording data on the effectiveness of its use, and a plan for how the state staff will monitor outcomes and evaluate the continued need for the intervention. The PBSP must be approved prior to implementation. Program staff is responsible for monthly monitoring of the PBSP and reporting the use of restrictive interventions, when the interventions result in injury, are implemented under emergency situations, or an animal is abused or neglected.

*Consent for Use of Restrictive Procedures Requiring an ETP (DSHS 15-385).* The documentation on the consent form includes the client's name, targeted behavior, proposed restrictive intervention, risks of proposed intervention, risks of not using the intervention, and alternatives to the procedure. The form is signed and dated by the Program administrator and is only valid for up to 12 months.

### **CMS Required Recommendations:**

*County Contract Compliance Review Tracking Spreadsheet.* CMS is requesting a copy of the fully populated spreadsheet. Please provide the spreadsheet to CMS within 60 days of the receipt of the final report.

State Response: DDD will provide an updated copy of the County Contract Compliance Review Tracking Spreadsheet.

Final CMS Response: The assurance will be met upon receipt of the populated County Contract Compliance Review Tracking Spreadsheet. The spreadsheet must be submitted to CMS within 60 days of the State's receipt of the final report.

## VI. State Provides Financial Accountability for the Waiver

**The State must demonstrate that it has designed and implemented an adequate system for assuring financial accountability of the waiver program.**

*Authority: 42 CFR 441.302; 42 CFR 441.303; 42 CFR 441.308; 45 CFR 74; SMM 2500; SMM 4442.8; and SMM 4442.10.*

**Compliance:** The State does not fully or substantially demonstrate the assurance though there is evidence that may be clarified or readily addressed.

Sub-assurance 1: State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

The CMS reviewed the following information to assess compliance with the sub-assurance:

- Evidence Package, Appendix I
- SSPS
- County Oversight Committee
- DDD Management Bulletin: Individual Provider (IP) Contract Requirements - Verification of Hours Billed (D10-002), Released April 1, 2010
- Eligibility, AFH Residents and SSI

*Evidence Package. Performance Measure 1(a): The percentage of waiver participants who initially met financial eligibility for waiver enrollment. The State reported a 98 percent compliance rate with this measure.*

*Evidence Package. Performance Measure 1(b): The percentage of waiver participants who continued to meet financial eligibility for waiver enrollment. The State reported a 96 percent compliance rate with this measure.*

*Evidence Package. Performance Measure 2: The percentage of waiver participants whose authorized service amounts are equal to or less than the amount identified on the ISP. The State reported a 99 percent compliance rate with this measure.*

*Evidence Package. Performance Measure 3(a): The percentage of waiver participants who initially met disability criteria as established by the Social Security Act. The State reported a 100 percent compliance rate with this measure.*

*Evidence Package. Performance Measure 3(b): The percentage of waiver participants who continue to meet disability criteria as established by the Social Security Act. The State reported a 99 percent compliance rate with this measure.*

**SSPS.** The SSPS is the system responsible for the delivery/purchase and payment of waiver services. The SSPS system interfaces with the Agency Financial Reporting System (AFRS) to maintain accounting records for the DD waiver participants. The AFRS is a mainframe financial system responsible for performing all aspects of the accounting process. DDD audits the SSPS

system to verify that services in the ISP have been authorized appropriately, and that the services have only been authorized after the ISP is approved. The SSPS billing is reviewed by the Regional Waiver Coordinators and RO supervisors on a monthly basis. The reviewers pull three files per CRM/month; all identified issues are remediated with the CRM.

*County Oversight Committee.* The County Oversight Committee is responsible for monitoring county contracts to: assure that services are delivered in accordance with the service plan; review billings and monitor monthly invoices; respond to complaints; and conduct the biennium oversight review. The county program manager reviews bills submitted by the providers through an email system to verify that each bill corresponds with the amount authorized. Once the bill has been verified, the program manager sends the billing information along to the financial officer for processing.

*DDD Management Bulletin, IP Contract Requirements- Verification of Hours Billed. (D10-002, April 1, 2010).* The State submitted a copy of the management bulletin D10-002, that outlines the procedures for field service staff to verify the IP hours billed for personal care services. The bulletin was released in response to a State Auditor's office (SAO) audit of ADSA's personal care program, which found that the administration did not have effective procedures in place to verify PCS service delivery.

The bulletin documented the current process as requiring the IPs to complete a DSHS 10-104A, Service Verification and Attendance Record on a monthly basis. The form is then signed by the waiver participant and the IP, and a copy is to be provided to the waiver participant, and upon request, to the CRM/DSHS. The CRM then can choose whether or not to review the DSHS 10-104A at the annual review.

The bulletin announced the modification to the IP process, to include inserting a notice in the IP SSPS invoice reminding the IP that the timesheet is required, and to inform the IP that beginning August 2010, the State would begin randomly selecting DD IPs to send timesheets to the DDD CO for review. The CO scans the timesheets into the service verification database and compares the timesheets against the SSPS billing data to ensure that the hours billed correspond with hours submitted. Inconsistencies are followed up at the regional level. IPs may be terminated if they fail to submit timesheets or have submitted insufficient documentation. The verification of timesheets against the billing database provides evidence of the State's implementation of a process for oversight of the provider payment system to assure that billed services provided under this waiver program have sufficient documentation to verify service delivery for IP service providers. However, the State findings related to the implementation were not reviewed by CMS during the on-site review.

*Eligibility, AFH Residents and SSI.* The State is also aware that they may be charging AFH residents a client responsibility when the person is not required to pay. Social Security determines Medicaid eligibility for "SSI recipients," however an "SSI recipient" who does not receive an SSI payment can be difficult to identify in the State's Barcode system. This can result in an erroneous client responsibility charge to the participant. The State has been moving the work for determining client responsibility to the Community Services Offices (CSO), which house eligibility staff. The move will facilitate the identification of the SSI individuals, resulting

in fewer payment errors. As of the date of the review, all of the work had not been moved to the CSOs.

### **CMS Required Recommendations.**

*DDD Management bulletin, IP Contract Requirements- Verification of Hours Billed. (D10-002, April 1, 2010).* CMS is requiring the State to submit a copy of the DSHS 10-104A, Service Verification and Attendance Record form, and a copy of any materials documenting the State's review and findings related to the IP timesheet review against SSPS data. Please include the number of IP provider bills reviewed, the results of the review, the remediation by the State, and any modifications to the review process that have resulted from the implementation of the new IP process. In addition, please provide a description of the sampling process used to select the IPs. The information must be received by CMS within 60 days of the receipt of the final report.

State Response: DDD will provide a copy of the service verification and attendance record form and related materials to findings related to the SSPS review.

Final CMS Response: The assurance will be met upon receipt of DSHS 10-104A, Service Verification and Attendance Record form, and a copy of any materials documenting the State's review and findings related to the IP timesheet review against SSPS data. This should include the number of IP provider bills reviewed, the results of the review, the remediation by the State, and any modifications to the review process that have resulted from the implementation of the new IP process. Please include a description of the sampling process used to select the IPs. The requested information must be received by CMS within 60 days of the receipt of the final report.

*Eligibility, AFH Residents and SSI.* CMS is requiring the State to submit a CAP to CMS that documents the State process for correcting the erroneous client responsibility charges. The plan must be submitted to CMS no later than 60 days from the receipt of the final report.

State Response: January of 2011, all client responsibilities calculations were transferred to the Community Service Offices.

Final CMS Response: The State must submit a document to CMS that explains how the transfer of the client responsibilities calculations to the Community Service Offices resolves the erroneous calculation charges. The document must be submitted to CMS no later than 60 days from the receipt of the final report. CMS will withdraw its request for a CAP upon receipt of documentation that sufficiently demonstrates the State's resolution of the issue.

## Appendix A: Summary of Findings

<b>Assurance I: State Conducts Level of Care (LOC) Determinations Consistent with the Need for Institutionalization.</b>		
<b>Sub-assurance</b>	<b>Requirement</b>	<b>CMS Recommendations</b>
1	The LOC of enrolled participants is re-evaluated at least annually or as specified in the approved waiver.	To assure compliance with LOC timeline requirements, CMS recommends that the State continue its current central office (CO) remediation strategy until a tickler system is operational at the regional office (RO) management level.
<p><b>State Response:</b></p> <p>We are following your recommendation. Case resource managers have electronic reports (tickler system) which identify assessments that have not been completed within 12 months of the last annual assessment. Regional Waiver coordinators now have access to the Assessment Activity Timeliness report. Monthly, regional waiver coordinators review the timeliness report and distribute information to case resource managers to promote completing assessments timely as well as to seek follow up on getting overdue assessments completed. Central Office Waiver Program Manager will continue to review the assessment activity report to address system issues regarding timely completion of assessments.</p>		
<p><b>Final CMS Response:</b></p> <p>CMS has no additional recommendations for the sub-assurance.</p>		
2	The State's process and instruments documented in the approved waiver are applied appropriately and according to the approved description to determine participant LOC.	CMS strongly recommends that the State adjust the performance measurement for the sub-assurance to identify components of the comprehensive assessment and reporting evaluation (CARE) assessment tool that require additional case resource manager (CRM) training. An expansion of the inter-rater reliability (IRR) criteria beyond the threshold for LOC, to include an assessment to assure that the CRM was capturing all of the waiver participant's LOC needs, would enhance the current joint requirement planning (JRP) process, and assist the State in identifying additional areas for training.

**State Response:**

Washington State currently completes annual training for case managers based on findings from annual waiver audits. This includes training on ISP development, policies and procedures. DDD is interested in investigating this recommendation more fully in the future although recognizes additional staffing is required to implement.

**Final CMS Response:**

CMS has no additional recommendations for the sub-assurance.

**Assurance II: Service Plans are Responsive to Waiver Participant Needs.**

<b>Sub-assurance</b>	<b>Requirement</b>	<b>CMS Recommendations</b>
1	Service plans address all of the participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means	<i>Performance measure 1(b).</i> CMS recommends the State refine the performance measure to capture the percentage of service plans that include goals. The current measure does not provide CMS with sufficient evidence to determine the impact of the measure.

**State Response:**

Washington agrees with this recommendation and will change our performance measure to the percentage of waiver participants who identified personal goals in their assessment. The denominator would be the total number of Waiver participants.

**Final CMS Response:**

CMS has no additional recommendations for the sub-assurance.

1, 3 and 4	See specific items for sub assurances 1, 3 and 4.	CMS strongly recommends that the State increase its minimum frequency for CRM contact with the waiver participant or guardian to assure that the service plan continues to adequately address the needs of the individual and safeguards their health and welfare.
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**State Response:**

DDD is changing current practice for client monitoring. The new practice will require the CRM to contact the client and/or legal representative to review the client's service plan, identify if the plan is working and/or if changes are required. This monitoring will be documented in the SER's under the purpose code of monitoring plan. This is a change in practice. Before case managers could consider conversations with providers, review of plans and/or progress notes as appropriate monitoring activities. The change in monitoring expectations will be trained in February and March of 2012.

**Final CMS Response:**

CMS is requesting a copy of the February and March 2012 training materials and agenda. Additionally, please provide CMS with any guidelines or P&P documents that describe how the CRM review of the service plan results in a service plan monitoring schedule that includes a contact with the waiver participant or his/her representative. Please submit the materials to CMS no later than 60 days from the date of the final training.

2	The State monitors service plan development in accordance with its policies and procedures.	CMS has no recommendations for this sub-assurance.
3	Service plans are updated/ revised at least annually or when warranted by changes in the participant's LOC.	<p><i>Performance Measure 1.</i> To assure compliance with individual service plan (ISP) timeline requirements, CMS recommends that the State continue its current central office remediation strategy until a tickler system is operational at the regional office management level.</p> <p><i>Performance Measure 10.</i> The State must submit a corrective action plan (CAP) documenting how it will assure that the service plan is amended when a critical incident occurs that indicates a change in the waiver participant's needs. The plan must be submitted to CMS no later than 60 days from the receipt of the final report.</p>

**State Response:**

*Performance Measure 1.* We are following your recommendation. Case Resource Managers have electronic reports (tickler system) which identify assessments that have not been completed within 12 months of the last annual assessment. Regional Waiver Coordinators now have access to the Assessment Activity Timeliness report. Monthly, Regional Waiver Coordinators review timeliness report and distribute information to case resource managers to promote completing assessments timely as well as to seek follow up on getting overdue assessments completed. Central Office Waiver Program Manager will continue to review the assessment activity report to address system issues regarding timely completion of assessments.

*Performance Measure 10.* We have refined the implementation of this recommendation. The DDD central office IRT requests regional staff to make 100% corrections when it is identified an ISP amendment is required. The IRT documents follow up of required corrections in SharePoint site and reviews follow up to insure ISP amendment was completed if needed. This is a current practice of the IRT.

**Final CMS Response:**

*Performance Measure 1.* CMS has no additional recommendations for the sub-assurance.

*Performance Measure 10.* Please submit a report from the SharePoint system that documents the full IR team's cycle of review, including ISP amendment. The report must be submitted to CMS no later than 60 days from the receipt of the final report. CMS will withdraw its request for a CAP upon receipt of documentation that sufficiently demonstrates the State's resolution of the issue.

4	Services are delivered in accordance with the service plan, including type, scope, amount and frequency specified in the plan of care (POC).	See sub-assurance 1.
5	Participants are afforded choice: (1) between waiver services and institutional care, and (2) among waiver services and providers.	CMS recommends that the State continue its remediation work to assure waiver participants are provided a choice of waiver services and providers, and documentation is maintained.

**State Response:**

DDD agrees with this recommendation. DDD's system was updated in 2010 to identify a box on the ISP for the CRM to document that the client has signed to voluntary participation choice statement for the specific waiver program they are eligible for. In addition, the voluntary participation statement form has been updated and separated from the Assessment Meeting Wrap-up form.

**Final CMS Response:**

CMS has no additional recommendations for the sub-assurance.

**Assurance III: Qualified Providers Serve Waiver Participants**

<b>Sub-assurance</b>	<b>Requirement</b>	<b>CMS Recommendations</b>
1	The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other state standards prior to their furnishing services.	CMS has no recommendations for these sub-assurances.
2	The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.	

3	The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.	
<b>Assurance IV: Health and Welfare</b>		
<b>Sub-assurance</b>	<b>Requirement</b>	<b>CMS Recommendations</b>
	The State must demonstrate that, on an ongoing basis, it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.	<p><i>Evidence Package. Performance Measure 1.</i> The State reported a 94 percent compliance rate with the performance measure. The State must submit a CAP detailing how it will monitor to assure that the CRMs consistently send notification of critical incidents to Adult Protective Services (APS), Child Protective Services (CPS), or Residential Care Services (RCS). The plan must be submitted to CMS no later than 60 days from the receipt of the final report.</p> <p><i>Evidence Package. Performance Measure 3.</i> The State must submit a CAP detailing how it will track substantiated allegations of abuse, neglect, abandonment or financial exploitation that are reported through RCS. The plan must be submitted to CMS no later than 60 days from the receipt of the final report.</p>
		<p><i>Division of Developmental Disabilities (DDD) Complaint Database and CARE Service Episode Record (SER) notes.</i> The current complaint policy does not allow the State to effectively track and trend complaints, as it only begins to centrally record complaints in the database once they have been raised to the Regional Administrator's level. All lower level complaints are logged in individual files through SER notes, which impede the early detection of trends with the potential to impact the health and welfare of waiver participants. CMS strongly recommends that the State develop, or amend the current policy for tracking complaints in the DDD Complaint database to allow for data entry at the CRM level for all complaints.</p>

		<p><i>Complaints-County Contracts.</i> CMS strongly recommends that the State amend its current contractual requirements with the counties to require a centralized county complaint tracking system. Lower level complaints are currently kept in waiver participants' files and may not be adequately tracked to identify trends of concern. The lack of a system tracking data at a lower/staff level results in a gap in the State's ability to quickly identify and respond to trends that may impact the health and welfare of waiver participants.</p>
		<p><i>Client Complaints Policy (Policy 5.03).</i> CMS strongly recommends that the State revise the current complaint tracking policy to require the use of a centralized tracking system at the CRM level.</p>
		<p><i>Critical Incidents.</i> The State must submit a CAP to CMS that details a coordinated interagency (DDD, APS, CPS and RCS) identification and response to critical incidents to assure that the State is able to identify, track, trend, and remediate instances of abuse, neglect and/or exploitation. The CAP must include: how the State partner agencies will identify waiver participants; the coordination of interagency efforts throughout the investigative process; and the process for reporting the results of critical incident allegation investigations. CMS recommends that the State update the current IR tracking system to allow for the system to track by provider. Additionally, CMS strongly recommends that the State increase the staff employed by RCS to respond to allegations of abuse. The plan must be submitted to CMS no later than 60 days from the receipt of the final report.</p>
		<p><i>Restrictive Interventions/ PBSP.</i> The State must submit a CAP to CMS documenting how it will assure that the CRMs are completing the required exception to policy (ETP) reviews to assure providers are compliant with the PBSP. CMS strongly recommends that the state develop</p>

		<p>provider qualifications and training requirements for staff in the supported living homes that develop PBSP. The plan must be submitted to CMS no later than 60 days from the receipt of the final report.</p>
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**State Response:**

*Evidence Package. Performance Measure 1.* The Corrective Action plan was approved by Centers for Medicare and Medicaid Services in April 2011. The Corrective Action Plan identifies a system process for CRM to be notified of critical incidents. The information will be documented in FAMLINK.

In addition:

- DDD has an incident report system which records incident type, date of incident, date incident was reported, details of the incident, follow up and who was notified of the incident.
- The central office IR review team currently monitor to case managers reporting to the proper entities.

DDD is now developing guidelines for central office and regional staff which will include review expectations to ensure current reporting policy is followed. These guidelines will be trained to and implemented February and March of 2012.

*Evidence Package. Performance Measure 3.* The Corrective Action plan was approved by Centers for Medicare and Medicaid Services in April 2011. The Corrective Action Plan identifies a system process for CRM to be notified of critical incidents. The information will be documented in FAMLINK. This information will allow us to track and trend substantiated allegations on waiver recipients.

*Division of Developmental Disabilities (DDD) Complaint Database and CARE Service Episode Record (SER) notes.* DDD is taking this recommendation into consideration and will be evaluating the current Complaint policy and the ability of the CARE system to be modified to be able to track and trend complaints.

DDD will emphasize training for case managers regarding documenting complaints in the current CARE SER system. The CARE system currently has SER codes for complaints and provider concerns. DDD will be emphasizing the requirement to follow up on the complaints. DDD will continue to use the complaints database to track complaints that rise to the Regional Administrator's level.

*Complaints-County Contracts.* Currently, counties have a contractual requirement with the providers which requires each agency to have a complaint policy that is explained to each client annually. DDD will explore this option in the future with the counties.

*Client Complaints Policy (Policy 5.03).* DDD is taking this recommendation into consideration and will be evaluating the current Complaint policy and the ability of the CARE system to be modified to be able to track and trend complaints.

DDD will emphasize training for case manager regarding documenting complaints in the current CARE SER system. The CARE system currently has SER codes for complaints and provider concerns. DDD will be emphasizing the requirement to follow up on the complaints.

DDD will continue to use the complaints database to track complaints that rise to the Regional Administrator's level.

*Critical Incidents.* The Centers for Medicare and Medicaid Services approved the Corrective Action plan in April 2011. The Corrective Action Plan identifies a system process for CRM to be notified of critical incidents. DDD continues to participate in follow up conversations with CMS to update states status of CAP.

The Aging and Disability Service Administration is currently implementing the CAP that was approved in April 2011. The State response in CAP identifies integrating APS and RCS into the FAMLINK system that is currently used by CPS for their case management. FAMLINK has the capability of tracking by provider. DDD will be able to access the information to track and trend issues by provider type.

RCS requested additional investigative staff in last legislative session.

*Restrictive Interventions/ PBSP.* DDD agrees with this recommendation. DDD will add a Waiver audit question to the 2012-2013 Waiver audit years. The QCC team will review PBSP for restrictive procedures and then compare if an ETP was in the client file if needed.

**Final CMS Response:**

*Evidence Package. Performance Measure 1.* The requirement will be met upon successful implementation and completion of the State's CAP. The State must continue to meet with CMS to discuss the progress in meeting the CAP requirements in order to be in compliance with the assurance.

*Evidence Package. Performance Measure 3.* The requirement will be met upon successful implementation and completion of the State's CAP. The State must continue to meet with CMS to discuss the progress in meeting the CAP requirements in order to be in compliance with the assurance.

*Division of Developmental Disabilities (DDD) Complaint Database and CARE Service Episode Record (SER) notes.* CMS strongly recommends that the State develop, or amend the current policy for tracking complaints in the DDD Complaint database to allow for data entry at the CRM level for all complaints.

*Complaints-County Contracts.* CMS strongly recommends that the State amend its current contractual requirements with the counties to require a centralized county complaint tracking system.

*Client Complaints Policy (Policy 5.03).* CMS strongly recommends that the State implement a complaint tracking system that captures data received at all staff levels. A centralized tracking system enhances the State's ability to comprehensively track and trend complaints resulting in earlier detection of issues impacting waiver participants' health and welfare.

*Critical Incidents.* The requirement will be met upon successful implementation and completion of the State's CAP. The State must continue to meet with CMS to discuss the progress in meeting the CAP requirements in order to be in compliance with the assurance.

*Restrictive Interventions/ PBSP.* CMS is requesting a copy of the waiver audit question that will be used to review PBSP for restrictive procedures and then compare if an ETP was in the client file if needed. Additionally, CMS is requesting a copy of the audit review findings for this question once the 2012-13 audit cycle has been completed. The audit review findings should include the remediation of any identified issues. The State must submit a copy of the audit question to CMS within 60 days of its receipt of the final report. The State must submit a copy of the 2012-13 waiver audit findings within 60 days of the State's audit release date. CMS' receipt of the documents will represent a complete State response to Restrictive Intervention/PBSP CAP requirement.

**Assurance V: Administrative Authority**

<b>Sub-assurance</b>	<b>Requirement</b>	<b>CMS Recommendations</b>
1	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 and contracted agencies.	<i>County Contract Compliance Review Tracking Spreadsheet.</i> CMS is requesting a copy of the fully populated spreadsheet. Please provide the spreadsheet to CMS within 60 days of the receipt of the final report.

**State Response:** DDD will provide an updated copy of the County Contract Compliance Review Tracking Spreadsheet.

**Final CMS Response:** The assurance will be met upon receipt of the populated County Contract Compliance Review Tracking Spreadsheet. The spreadsheet must be submitted to CMS within 60 days of the State's receipt of the final report.

**Assurance VI: State Provides Financial Accountability for the Waiver**

<b>Sub-assurance</b>	<b>Requirement</b>	<b>CMS Recommendations</b>
1	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>DDD Management bulletin, IP Contract Requirements- Verification of Hours Billed. (D10-002, April 1, 2010).</i> CMS is requiring the State to submit a copy of the DSHS 10-104A, Service Verification and Attendance Record form, and a copy of any materials documenting the State's review and findings related to the IP timesheet review against SSPS data. Please

		<p>include the number of IP provider bills reviewed, the results of the review, the remediation by the State, and any modifications to the review process that have resulted from the implementation of the new IP process. In addition, please provide a description of the sampling process used to select the IPs. The information must be received by CMS within 60 days of the receipt of the final report.</p>
		<p><i>Eligibility, AFH Residents and SSI.</i> CMS is requiring the State to submit a CAP to CMS that documents the State process for correcting the erroneous client responsibility charges. The plan must be submitted to CMS no later than 60 days from the receipt of the final report.</p>

**State Response:**

*DDD Management bulletin, IP Contract Requirements- Verification of Hours Billed. (D10-002, April 1, 2010).* DDD will provide a copy of the service verification and attendance record form and related materials to findings related to the SSPS review.

*Eligibility, AFH Residents and SSI.* January of 2011, all client responsibilities calculations were transferred to the Community Service Offices.

**Final CMS Response:**

*DDD Management bulletin, IP Contract Requirements- Verification of Hours Billed. (D10-002, April 1, 2010).* The assurance will be met upon receipt of DSHS 10-104A, Service Verification and Attendance Record form, and a copy of any materials documenting the State's review and findings related to the IP timesheet review against SSPS data. This should include the number of IP provider bills reviewed, the results of the review, the remediation by the State, and any modifications to the review process that have resulted from the implementation of the new IP process. Please include a description of the sampling process used to select the IPs. The requested information must be received by CMS within 60 days of the receipt of the final report.

*Eligibility, AFH Residents and SSI.* The State must submit a document to CMS that explains how the transfer of the client responsibilities calculations to the Community Service Offices resolves the erroneous calculation charges. The document must be submitted to CMS no later than 60 days from the receipt of the final report. CMS will withdraw its request for a CAP upon receipt of documentation that sufficiently demonstrates the State's resolution of the issue.