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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
Children's Intensive In-home Behavior Support

C. Waiver Number:WA.40669

D. Amendment Number:

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

09/01/14

Approved Effective Date of Waiver being Amended: 09/01/12

2. Purpose(s) of Amendment

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

• Updated performance measures to a) comply with the latest sub-assurances, b) increase comparability across Washington State's HCBS waivers for individuals with developmental disabilities, c) and reflect current waiver operation (QA sections);
• Performance measure changes include a) re-wording, b) elimination of some current Performance measures, and c(the addition of new performance measures;
• Renumbered all performance measures to reflect their location within the waiver (QA sections);
• A revised sampling methodology to allow sampling across waivers that will facilitate collection of a full data for all performance measures on an annual
basis (Additional Information at the end of the Main body of the waiver);
• Completed sections relevant to the analysis of HCB setting requirements and the HCB setting transition plan (Attachment #2, Appendix C-5);
• An updated definition of "developmental disability", which does not require removal from the waiver of any current waiver participants and increases the
number of community members eligible to receive services funded by the Developmental Disabilities Administration (Appendix B-1.b ;
• An updated implementation date for payment via a MMIS for some waiver services (Appendix I, QA section, c (Timelines);
• Re-projected cost of Medicaid State Plan services by waiver participants (Factor D') and the cost of ICF/IID services (Factor G) on more recent data

(Appendix J-2, Waiver Renewal Years 3, 4 and 5);
• A revised definition of Respite services to allow more individuals to access the service (Appendix C-1);
• Increased waiver capacity and updated projections of all services for Waiver Renewal Years 3, 4 and 5 due to serving more individuals than originally
anticipated;
• Updated terminology throughout the waiver;
• Replaced Division of Developmental Disabilities (DDD) with the Developmental Disabilities Administration (DDA);
• Replaced Waiver Management Oversight Committee with HCBS Medicaid Waiver Management Committee to reflect current terminology;
• Replaced CMIS with CARE to reflect the current information system for DDA;
• Changed Quality Control and compliance (QCC) to Quality Compliance Coordinator (QCC) in sections relating to quality assurance to reflect
current terminology;
• Replaced some references to "client" with "waiver participant";
• Updated language to reflect current practice and current CMS requirements (e.g., concerning person-centered plans);
• Appendix C -2 (a and b) concerning background check requirements;
• Appendix D-1 (c, d, e, f, g) concerning service plan development;
• Appendix D-2.a concerning service plan implementation and monitoring;
• Appendix G concerning waiver participant safeguards.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☑ **Waiver Application**	7;8; A-Attach # 2;B-9
☑ **Appendix A – Waiver Administration and Operation**	QA
☑ **Appendix B – Participant Access and Eligibility**	QA; B-1.b;B-2.a.
☑ **Appendix C – Participant Services**	QA;C1/C3;C-2.a.
☑ **Appendix D – Participant Centered Service Planning and Delivery**	QA;D-1(c,d,e,f,g);D-2
☑ **Appendix E – Participant Direction of Services**	E-1.n.
☑ **Appendix F – Participant Rights**	
☑ **Appendix G – Participant Safeguards**	
☑ **Appendix H**	
☑ **Appendix I – Financial Accountability**	QA
☑ **Appendix J – Cost-Neutrality Demonstration**	Yrs 3,4,5

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

☑ **Modify target group(s)**
☐ **Modify Medicaid eligibility**
☐ **Add/delete services**
☑ **Revise service specifications**
☐ **Revise provider qualifications**
☑ **Increase/decrease number of participants**
☑ **Revise cost neutrality demonstration**
☐ **Add participant-direction of services**
☑ **Other**
Specify:

This amendment includes:

- Updated performance measures to a) comply with the latest sub-assurances, b) increase comparability across Washington State's HCBS waivers for individuals with developmental disabilities, c) and reflect current waiver operation (QA sections);
  - Performance measure changes include a) re-wording, b) elimination of some current performance measures, and c(the addition of new performance measures;
- Renumbered performance measures to reflect their location within the waiver (QA sections);
- A revised sampling methodology to allow sampling across waivers that will facilitate collection of a full data for all performance measures on an annual basis (Additional Information at the end of the Main body of the waiver);
- Completed sections relevant to the analysis of HCB setting requirements and the HCB setting transition plan (Attachment #2, Appendix C-5);
- An updated definition of “developmental disability”, which does not require removal from the waiver of any current waiver participants and increases the number of community members eligible to receive services funded by the Developmental Disabilities Administration (Appendix B-1.b ;
- An updated implementation date for payment via a MMIS for some waiver services (Appendix I, QA section, c (Timelines);
- Updated terminology throughout the waiver;
  - Replaced Division of Developmental Disabilities (DDD) with the Developmental Disabilities Administration (DDA);
  - Added “HCA” (Health Care Authority) to the beginning of the name of the Medicaid Agency Waiver Management Committee to reflect current terminology;
  - Replaced CMIS with CARE to reflect the current information system for DDA;
  - Changed Quality Control and compliance (QCC) to Quality Compliance Coordinator (QCC) in sections relating to quality assurance to reflect current terminology;
  - Replaced some reference to “client” with “waiver participant”;
  - Used adult residential care (ARC) as a facility title instead of “assisted living facility”, since for the Basic Plus Waiver, the latter refers to the type of license, not the name of the facility;
- Updated language to reflect current practice and current CMS requirements (e.g., concerning person-centered plans);
  - Appendix C -2 (a and b) concerning background check requirements;
  - Appendix D-1 (c, d, e, f, g) concerning service plan development;
  - Appendix D-2.a concerning service plan implementation and monitoring;
  - Appendix G concerning waiver participant safeguards.

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

1. Request Information (1 of 3)

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

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Children's Intensive In-home Behavior Support

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Draft ID: **WA.014.01.02**

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 09/01/12
Approved Effective Date of Waiver being Amended: 09/01/12

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

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

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

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

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

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

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

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

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The purpose of the Children's Intensive In-home Behavioral Support (CIIBS) Waiver is to support children and youth, ages 8 through 20, to remain living in their family home while difficult behavioral issues are addressed through the evidence-based practice of Positive Behavior Support and Wraparound service delivery. The likelihood of achieving lasting positive outcomes for children increases if positive outcomes are also achieved for the family members supporting the child. Thus, the intent of CIIBS waiver services is to meet not only the needs of the child participant, but to also meet the needs of the family members as they relate to the needs of the child.

The primary objective of CIIBS is for families to partner with professionals in order to design and implement interventions that will work for their child and family. Upon a child's enrollment on the waiver, families will select a contracted behavior specialist of their choice and work together to develop a positive behavior support plan tailored to the individual needs and characteristics of the child and family. Families will be actively involved in supporting their child and addressing behaviors through the agreed upon interventions.

Continuing the objective of people working together, families will assist in building a team of support people for each child. The support team will include the child, parents/guardians, natural supports, waiver service providers, school staff and other involved professionals. The CIIBS program is designed to develop a comprehensive and consistent approach that will support the child across environments such as home, school, and the community. Waiver case managers will facilitate these support team meetings, which will occur every month for the first three months of enrollment and at least quarterly thereafter.

Waiver participants will be identified using an algorithm from the DDA Assessment. The algorithm uses client, caregiver, and backup caregiver characteristics to identify children at high risk for out-of-home placement. (Note: If an identified client is on another program, such as one of the waivers or Individual Family Services (a state funded program), the case manager will assist the family in determining how to meet identified needs through the program resources already available to the person. If the child's assessed needs exceed the scope of their current waiver or state program, they will be considered a first priority for enrollment.)

With regard to the organizational structure, the State of Washington’s HCBS CIIBS Waiver is managed by the Developmental Disabilities Administration (DDA, within the Department of Social and Health Services (DSHS) which is the Operating Agency for the CIIBS Waiver. All aspects of the Waiver are directly managed by the state. DDA operates this waiver within applicable federal regulations, manages the day-to-day administration and maintains operational responsibility for the waiver. No waiver operational functions are delegated outside of DSHS.

Services will be provided through contracted vendors with the emphasis on in-home services. The core of the service package is the delivery of positive behavior supports in the family environment and respite services to provide regularly scheduled caregiving breaks.

3. Components of the Waiver Request

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

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

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

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

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

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

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

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

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

4. Waiver(s) Requested

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

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

- (●) **Not Applicable**
- ( ) **No**
- ( ) **Yes**

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

- (●) **No**
- ( ) **Yes**

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

- [ ] **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

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

5. Assurances

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

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

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

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

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

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

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

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

1. Informed of any feasible alternatives under the waiver; and,

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

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

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals

under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

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

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

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

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

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

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

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

I. Public Input. Describe how the State secures public input into the development of the waiver:
The State regularly secures public input by working closely with the following:

* The Legislature and other state agencies.
* The State of Washington Developmental Disabilities Council.
* The Arc of Washington (advocacy organization).
* The Community Advocacy Coalition made up of advocates and providers.
* The HCBS (DDA) Waivers Quality Assurance Committee composed of self-advocates, advocates and providers.

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

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

7. Contact Person(s)

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

Last Name: Perez

First Name: Evelyn

Title: Assistant Secretary

Agency: Developmental Disabilities Administration

Address: P.O. Box 45310

Address 2:

City: Olympia

State: **Washington**
Zip:
Phone: 98504-5310

Fax:
(360) 725-3461 **Ext:** ☐ **TTY**

E-mail:
(360) 407-0954

PerezE@dshs.wa.gov

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

Last Name:
Beckman

First Name:
Bob

Title:
Interim Waiver Services Unit Manager

Agency:
Developmental Disabilities Administration/Program and Policy Development

Address:
P.O. Box 45310

Address 2:

City:
Olympia

State: **Washington**
Zip:
98504-5310

Phone:
(360) 725-3445 **Ext:** ☐ **TTY**

Fax:
(360) 407-0955

E-mail:
Beckmbc@dshs.wa.gov

8. Authorizing Signature

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

specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name: Perez

First Name: Evelyn

Title: Assistant Secretary, Developmental Disabilities Administration

Agency: Department of Social and Health Services

Address: 4450 10th Ave SE

Address 2:

City: Lacey

State: **Washington**

Zip: 98504

Phone: (360) 725-3461 **Ext:** ☐ **TTY**

Fax: (360) 407-0954

E-mail: PerezE@dshs.wa.gov

Attachments

Attachment #1: Transition Plan

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

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**

☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

The criteria for ICF/ID level of care (as contained in Appendix B-6.d.) for individuals age 16 and older have changed. As a result of this change, no one currently enrolled on the Children's Intensive In-Home Supports Waiver (CIIBS) Waiver is expected to lose eligibility for the CIIBS Waiver. The new ICF/ID level of care criteria will be implemented at the individual level at the time of their next regularly scheduled annual assessment. If any individual is determined to no longer be eligible for the CIIBS Waiver at that time, s/he will be provided notification of their right to an administrative hearing and be disenrolled from the CIIBS Waiver.

The DDA will assist individuals determined to no longer be eligible for the DDA HCBS waiver program to identify:
(a) Natural supports;
(b) Supports available via the Medicaid State Plan;
(c) Supports available via other payment or social service mechanisms; and/or
(d) Available non-waiver DDA services.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301 (c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Washington State has submitted a statewide HCBS settings transition plan to CMS on March 6th, 2015.

All settings used for the CIIBS Waiver fully comply with HCBS requirements (see Appendix C-5).

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Washington State is modifying its sampling design for compiling data on its performance measures from sampling waivers individually to drawing a single sample across all of its DDA HCBS waivers. The DDA HCBS waiver program meets the conditions that are a requirement for the use of this sampling method and will allow a one-year cycle for data collection on performance measures, compared with the previous two-year cycle necessitated by the larger total sample size.

1. Design of the waivers

The DDA waivers are all very similar in design in that the waivers have many services in common, participant safeguards are common across waivers, and a single quality management and improvement strategy is used for the entire DDA waiver program. In addition, waiver program case management is provided by state employees for all waiver participants and the same assessment is used to develop the individual support plan (ISP).

2.a. Participant Services

Many services are identical across waivers, and the rest are much more similar than different. And oversight of services (e.g., to ensure provider contracts are in place, providers are qualified, services authorized are being provided) is based on

the same processes across all waivers.

The following services are covered by all of DDA's current waivers and will be covered in the new IFS Waiver: behavioral health stabilization services (behavior support and consultation, crisis diversion beds, specialized psychiatric services), environmental accessibility adaptations, extended state plan services (physical therapy, occupational therapy, speech, hearing and language services), nurse delegation, sexual deviancy evaluations, specialized medical equipment and supplies, specialized psychiatric services, and staff/family consultation and training,

The following services are/will be covered by three or four of the DDA waivers: respite care, skilled nursing, supported employment, and transportation.

Services specific to some waivers are residential habilitation, day habilitation, and specialized supports such as specialized nutrition and specialized assistive technology.

2.b. Participant Safeguards

1. Response to Critical Events or Incidents

Responses to critical events or incidents are not differentiated based on waiver type. Differences in response are based on the setting (e.g., licensed, certified or private residences) and/or the entity responsible for investigating (i.e., Child Protective Services, Adult Protective Services, Residential Care Services). Critical events or incidents must be reported irrespective of the setting or waiver enrollment.

2. Safeguards concerning restraints and restrictive interventions

DDA's extensive protocols concerning the use of restraints and restrictive procedures are not waiver-specific. (Please see Appendix G-2 for an inventory of relevant DDA policies.) In addition, reporting and investigating of abuse and neglect apply to all settings.

2.c. Quality Management Processes and Mechanisms

Critical components of the quality management system include:
- DDA Assessment
- CARE (Comprehensive Assessment Reporting and Evaluation)
- Quality Compliance Coordinator (QCC) Protocols and Data Base
- DDA Incident Reporting System
- Individual Support Plan Meeting Survey
- Complaint Data Base
- Administrative Hearing Data Base
- Agency Contracts Database (ACD)
- National Core Indicators Survey

3.a. Methodology for discovering information (e.g., data systems, sample selection)

The methodologies for discovering information are common across the entire DDA HCBS waiver program. These methodologies include:
- Quality Compliance Coordinator (QCC) sampling of waiver participant files and file reviews to ensure waiver assurances are being met.
- Individual Support Plan (ISP) Meeting Survey, which is mailed within one month of the ISP planning meeting and gives waiver participants an opportunity to respond to a series of questions about the ISP process.
- National Core Indicators (NCI) Survey, which includes a standardized set of questions used by all participating states. In addition, WA State has added questions about waiver services. Waiver participants as well as parents/guardians receive the survey.
- FAMLINK, which is an electronic system that maintains notifications, investigative, and outcome information for Child Protective Services (CPS). Data from FAMLINK is used to track and trend information related to allegations of abuse, neglect, abandonment and financial exploitation.
- TIVA (Tracking Investigations of Vulnerable Adults), which is an electronic system that maintains notifications, investigative, and outcome information for the Resident and Client Protection Program (RCPP) in Residential Care Services (RCS) and Adult Protective Services (APS)

investigations. An additional data feed from ProviderOne has also been included to allow TIVA to collect information related to children and adolescents (under age 21 years) who are receiving mental health services and involved in abuse, neglect, and/or exploitation investigations. Data from TIVA is also used to track and trend information related to allegations of abuse, neglect, abandonment and financial exploitation.
- Administrative Hearing Data Base, which tracks requests for administrative hearings requested by waiver participants who disagree with decisions made by DDA. DDA uses data from this data base to review the concerns of waiver participants to determine if there are system issues that need to be addressed.
- Agency Contracts Data Base (ACD), which is used to monitor provider compliance with contracting requirements, including background check requirements, training requirements, and licensure and certification requirements.
- Mortality Review Team (MRT) Reviews of waiver participant deaths.

3.b. Manner in which individual issues are remedied.

Since all waiver participants have a state-employed Case/Resource Manager or Social Services Specialist, remediation activities typically begin at the case management level. In all cases, the DDA strives to provide waiver participants, families and DDA employees with the tools and information necessary to implement HCBS waivers that successfully support individuals in their communities.

When issues with respect to individual waiver participants are identified, case management staff are notified so that immediate action can be taken to address the issues.

Information from the various data sources described above is analyzed to determine: a) whether issues are systemic or individual, and b) the optimum strategy to address the issues identified.

Strategies to address issues in the DDA HCBS waiver program include:
- Edits in computer-based systems to require necessary information be included or to prevent inappropriate action;
- Additions to or development of computer-based systems to accommodate waiver processes such as person-centered planning and quality improvement activities such as monitoring of waiver participant abuse and neglect;
- Revisions in Washington Administrative Code (WAC) to clarify waiver requirements so that waiver participants, families and DDA staff all understand waiver requirements;
- Revisions or additions to DDA publications that provide waiver participants, guardians and families with up-to-date information on the HCBA waivers available, including the populations served, services covered, how to request waiver enrollment, and administrative hearing rights and procedures;
- Revisions or additions to DDA publications provide waiver participants, guardians and families with up-to-date information on waiver quality assurance and quality improvement processes and results; and
- Revisions or additions to guidance (e.g., staff training, the DDA waiver manual, management bulletins, WAC) provided to DDA case management staff on the waivers and waiver-related processes (e.g., waiver enrollment, development of the person-centered plan, provision of waiver services, oversight of the individual support plan).

3.c. Process for identifying and analyzing patterns/trends.

The processes for identifying and analyzing patterns/trends are identical across all DDA HCBS waivers.

Data that is analyzed to identify patterns and trends comes from:
- QCC reviews
- National Core Indicators
- ISP satisfactions surveys
- Fiscal reports
- CRM face to face meeting data
- Incident Reports
- Complaint Data Base
- Mortality Review Team Reviews

Many entities help the DDA identify and analyze patterns and trends by reviewing reports and QIS data, including:
- DDA Executive Management, including the DDA Assistant Secretary, DDA Deputy Assistant Secretary,

DDA Office Chiefs, DDA Unit Managers, and DDA regional waiver and quality assurance specialists.
- DDA Incident Review Team, which meets monthly to review aggregate data from the Electronic Incident Reporting System and makes recommendations to prevent incidents.
- DDA Mortality Review Team, which meets monthly to review deaths of waiver participants and identify, monitor and make recommendations concerning mortality trends and patterns.
- Stakeholders, who can access a dedicated internet site which offers them an opportunity to review annual waiver reports, review quality assurance activities, provide input on needed changes, provide suggestions for ways to better served waiver participants, and participate in an on-going dialogue about the quality of services for individuals on the DDA HCBS waivers.
- DDA HCBS Waiver Quality Assurance Committee, which is sponsored by the DDC and is comprised of self-advocates, family members, providers and Department representatives and meets four times a year (with provision for sub-committees as needed) to provide oversight of and guidance for the DDA HCBS Waiver program.
- Developmental Disabilities Council (DDC) which provides recommendations for improvement using the National Core Indicators Survey as the tool to identify trends and patterns.
- HCA Medicaid Agency Waiver Management Committee, which includes representatives from the Health Care Authority (the single State Medicaid Agency) and Administrations/Divisions within the operating agency and meets quarterly to review all functions delegated to the operating agency, current quality assurance activities and reports, pending waiver activity and potential waiver policy and rule changes and quality improvement activities.

3.d. Majority of the performance indicators are the same.

Currently approximately one-half of the performance measures that apply/will apply (i.e., with approval of the IFS Waiver) to the DDA HCBS waiver program are common across all five waivers. The remainder are unique to individual waivers based on the populations served, the types of services covered, or (in the case of the IFS Waiver) the addition of new sub-assurances.

This amendment will more closely align performance measures across the DDA waivers.

4. The provider network is the same or very similar.

Provider networks across all waivers are very similar due to the services that the waivers have in common.

5.Provider oversight is the same or very similar.

Provider oversight is the same across all waivers due to the use of common mechanisms (e.g., Agency Contracts Database), standardized contracts, and standardized protocols for provider oversight that are implemented by state staff employed at the regional level.

Appendix A: Waiver Administration and Operation

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

   ○ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:
Department of Social and Health Services/Developmental Disabilities Administration

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

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

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

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

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

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

The HCA Medicaid Agency Waiver Management Committee includes representatives from the Health Care Authority (the Single State Medicaid Agency) and divisions within the operating agency: DDA, HCS, RCS, and DBHR. The committee meets at least quarterly to review all functions delegated to the operating agency, current quality assurance activity, pending waiver activity (e.g., amendments, renewals), potential waiver policy and rule changes and quality improvement activities.

Appendix A: Waiver Administration and Operation

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

   ○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

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

Appendix A: Waiver Administration and Operation

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

   ○ **Not applicable**

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

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

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

   WA State Regional Support Networks (RSN)

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

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
   Each biennium, DDA reviews and evaluates the state's RSN subcontract. The evaluation incorporate all contractual requirements including but not limited to waiver participant direct services, program quality assurance, indirect systems, policies and procedure, and fiscal soundness.

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

   i. **Performance Measures**

   For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures

found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

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

Where possible, include numerator/denominator.

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

Performance Measure:
A.1: The percent of waiver amendments and waiver renewal requests for which approval was obtained from the Single State Medicaid Agency. Numerator: The number of waiver amendments and waiver renewal requests for which approval was obtained from the Single State Medicaid Agency. Denominator: The total number of waiver amendments and waiver renewal requests submitted to CMS.

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:

A.2: The percentage of scheduled meetings of the HCA Medicaid Agency Waiver Management Committee that are actually held. Numerator: The number of scheduled meetings of the HCA Medicaid Agency Waiver Management Committee that are held. Denominator: The total number of scheduled meetings of the HCA Medicaid Agency Waiver Management Committee.

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
A.3: The percent of certified Regional Support Network (RSN) contracts that were monitored annually by regional resource managers to verify contract compliance. N= The number of contracts with certified RSNs that were monitored. D= The number of contracts with certified RSNs.

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

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
A.1: The State Operating Agency obtains written approval from the Single State Medicaid Agency (Health Care Authority-HCA)to submit initial waiver requests, waiver amendment requests and waiver renewal requests to CMS. The Waiver Program Manager verifies annually that approval from the HCA was obtained for all waiver amendment requests and waiver renewal requests submitted to CMS.

A.2: The HCA Medicaid Agency Waiver Management Committee includes representatives from the HCA and Administrations and Divisions within the operating agency: DDA, HCS, RCS, and BHSIA. The committee meets at least quarterly to review all functions delegated to the operating agency, current quality assurance activity, pending waiver activity (e.g., amendments, renewals), potential waiver policy and rule changes and quality improvement activities. The Waiver Program Manager verifies annually that these meetings were held.

A.3: Regional resource managers annually monitor the certified RSNs to ensure compliance with contract requirements.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
A.1: If it is determined that HCA approval was not obtained for all initial waiver requests, waiver amendment or waiver renewal requests submitted to CMS, the Waiver Program Manager will ensure that approval from the HCA will be obtained and processes will be reviewed and evaluated to determine if changes need to be made to ensure prospective approval is obtained in the future.

A.2: If the HCA Medicaid Agency Waiver Management Committee did not meet quarterly, the Waiver Program Manager will ensure the process is modified as necessary so that in the future quarterly meetings are held.

A.3: If certified RSNs are out of compliance with contract requirements, a corrective action plan is required and compliance is monitored by the regional resource manager. If a RSN is determined to have lost certification, the contract is terminated and renewed once the RSN has gain obtained certification.

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☑ **Intellectual Disability or Developmental Disability, or Both**					

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Autism			☐
	☑	Developmental Disability	8	20	☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

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

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

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

(a) Be attributable to intellectual disabilities, cerebral palsy, epilepsy, autism, oranother neurological or other condition found by DDA to be closely related to
intellectual disaiblity or requiring treatment similar to that required for individuals with intellectual disability;

(b) Originate prior to age eighteen;

(c) Be expected to continue indefinitely; and

(d) Results in substantial limitations as defined in Washington Administrative Code (WAC)388-823-0210 (definition of substantial limitations).

Individuals must meet ICF/ID level of care guidelines and:
o Live with family or in another setting with assistance and are at high risk of out-of-home placement or loss of their current living situation; or
o Require out-of-home placement and their health and welfare needs can be met in an adult family home or adult residential care facility.

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

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Participants in the CIIBS waiver will be transitioned to one of the other 4 DDA waivers or another available program at the age of 21. Transition will be discussed with the participant and other support team members during the year prior to transition, beginning with the annual assessment preceding the participant's 21st birthday. This discussion will include information regarding services available under other programs, including the other 4 waivers, and planning for employment. At least 30 days prior to the participant's 21st birthday, a referral will be made to the program that will best meet the individual's assessed needs at that time.

Appendix B: Participant Access and Eligibility

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

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- (●) **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

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

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - ( ) **Other**

    Specify:

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

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

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

  - ( ) **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

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

      Specify the formula:

    - ( ) **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
  - ( ) **The following percentage that is less than 100% of the institutional average:**

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

- **The participant is referred to another waiver that can accommodate the individual's needs.**
- **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

- **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	100
Year 2	100
Year 3	104
Year 4	

Waiver Year	Unduplicated Number of Participants
	107
Year 5	107

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

- **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	100
Year 2	100
Year 3	100
Year 4	100
Year 5	100

Appendix B: Participant Access and Eligibility

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

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

- **Not applicable. The state does not reserve capacity.**
- **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

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

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

- **The waiver is not subject to a phase-in or a phase-out schedule.**
- **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- **Waiver capacity is allocated/managed on a statewide basis.**
- **Waiver capacity is allocated to local/regional non-state entities.**

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

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

The state of Washington applies a screening process to identify those children with intensive behavioral support needs who could potentially benefit from services designed to support families to successfully maintain their children at home. This selection is accomplished by a combination of risk scores and clinical judgment. Once the initial screening is accomplished, additional factors must be considered to determine prioritization of eligible clients for the monthly phase-in schedule.

Program Eligibility Requirements –

1. Clients must first receive the Support Assessment within the DDA Assessment and meet ICF/ID level of care.

2. The client must be living with his/her family. Family is defined in Waiver WAC 388-845-0001, which contains definitions of key terms.
3. The client's risk score from the algorithm must be High or Severe. (Clients will be selected from High and Severe each month.)

4. Caregiver Acuity must be at least Medium.

5. Behavior Acuity must be High.

6. Client and family must accept full participation in the program after being informed of the requirements and prior to being accepted into the program. Full participation means that the family agrees to assist in the development and implementation of their child's positive behavior support plan.

Screening Process

The legislature has allocated funding to provide services to 100 children with intensive behavior. Regions prioritize the needs of eligible children and families and request approval for those who are the highest priority based upon a combination of the following considerations:

* Children residing in an institutional setting whose families are interested in supporting them at home
* Children for whom intervention can be provided soon after the appearance of challenging behaviors that result in high or severe risk of out of home placement;
* Available resources will be taken into consideration with priority placed on resource development according to location of eligible clients and community;
* Children with assessed needs that exceed the scope of their current waiver or state program;
* Sibling of a CIIBS participant;
* Children for whom we have documentation during the preceding 12 months of the following:
  a) CPS or CWS involvement – When CPS is involved, only those referrals closed due to unsubstantiated findings will be considered; or
  b) Behavioral incident resulting in injury to self or others requiring more than first aid; or
  c) Injury to self or others resulting from physical restraint; or
  d) Inpatient hospitalization related to behavior; or
  e) Incident(s) of elopement; or
  f) Shortened school day or suspensions.
* Children whose families experience the following additional stressors, as evidenced in the client record:
  a) Marital distress, single parent household; or
  b) Parent(s) diagnosed with chronic mental health or physical health condition; or
  c) Isolation or lack of natural supports.
* all factors being equal, children with the earliest date of referral for waiver services, as documented in the Waiver Enrollment Request database.

For each child identified for phased-in enrollment, the CIIBS case manager must obtain a commitment from each family for full participation in the program prior to enrollment.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (•) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - (•) **No**
   - ( ) **Yes**

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

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

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

  Select one:

  - ( ) **100% of the Federal poverty level (FPL)**
  - ( ) **% of FPL, which is lower than 100% of FPL.**

    Specify percentage:

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  Specify:

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

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

Select one:

- **300% of the SSI Federal Benefit Rate (FBR)**
- **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

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

Specify dollar amount:

- **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- **Aged and disabled individuals who have income at:**

Select one:

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☐ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

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

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

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

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

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

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

b. Regular Post-Eligibility Treatment of Income: SSI State.

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

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

◉ **The following standard included under the State plan**

Select one:

○ **SSI standard**
○ **Optional State supplement standard**
○ **Medically needy income standard**
◉ **The special income level for institutionalized persons**

(*select one*):

- (●) **300% of the SSI Federal Benefit Rate (FBR)**
- ( ) **A percentage of the FBR, which is less than 300%**

  Specify the percentage:
- ( ) **A dollar amount which is less than 300%.**

  Specify dollar amount:

( ) **A percentage of the Federal poverty level**

Specify percentage:

( ) **Other standard included under the State Plan**

Specify:

( ) **The following dollar amount**

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

( ) **The following formula is used to determine the needs allowance:**

Specify:

( ) **Other**

Specify:

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

- (●) **Not Applicable**
- ( ) **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

  Specify:

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

  - ( ) **SSI standard**
  - ( ) **Optional State supplement standard**
  - ( ) **Medically needy income standard**
  - ( ) **The following dollar amount:**

    Specify dollar amount: If this amount changes, this item will be revised.
  - ( ) **The amount is determined using the following formula:**

    Specify:

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

- **Not Applicable (see instructions)**
- **AFDC need standard**
- **Medically needy income standard**
- **The following dollar amount:**

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

  Specify:
- **Other**

  Specify:

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

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State establishes the following reasonable limits**

  Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The special income level for institutionalized persons**
- **A percentage of the Federal poverty level**

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

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

  Specify formula:
- **Other**

  Specify:

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

Select one:

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

  Explanation of difference:

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

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

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

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

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

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

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

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

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

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

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

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the

provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. **Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. **Frequency of services.** The State requires (select one):

- **The provision of waiver services at least monthly**
- **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

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

- **Directly by the Medicaid agency**
- **By the operating agency specified in Appendix A**
- **By an entity under contract with the Medicaid agency.**

Specify the entity:

- **Other**

Specify:

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

Case management services will be provided by employees of the Developmental Disabilities Administration of the Department of Social and Health Services that are employed as a DDA Case/Resource Manager or a Social Worker 3 (or, in instances where staffing vacancies necessitate, a DDA Case-Resource Supervisor) and therefore meet the following qualifications:

DDA Case/Resource Manager

A Bachelor's degree in social sciences, social services, human services, behavioral sciences or an allied field and two years of experience providing social services to people with developmental disabilities, graduate training in social science, social services, human services, behavioral sciences or an allied field will substitute, year for year, for one year of the experience providing social services to people with developmental disabilities.

Social Service Specialist 3

One year as a Social Worker 2 since July 1, 1988.

OR

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

OR

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

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

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

NOTE: Equivalent social service experience would include the previous classes of Caseworker 3 or higher.

OR

For Promotion Only: A Bachelor's degree and three years of experience as a Caseworker 3, Social Worker 1A or B, Social Worker 2, Casework Supervisor Trainee, Casework Supervisor, Juvenile Rehabilitation Supervisor 1 or 2, or Juvenile Rehabilitation Counselor 2 in State service.

DDA Case-Resource Supervisor

Three years of experience, in the Washington State service, equivalent to a Developmental Disabilities Case/Resource Manager.

OR

A Bachelor's degree in a social services field and four years of experience in a social services field, of which three years must have involved people with developmental disabilities or other handicapping conditions.

Graduate training in a social services field may be substituted, year for year, for one year of the required experience.

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

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

The Supports Intensity Scale evaluates individuals using the following subscales:
A. Home Living
B. Community Living
C. Lifelong Learning
D. Employment
E. Health & Safety
F. Social

The state of Washington has adapted a ICF/ID Level of Care tool that was originally used to assess individuals through age 12 to assess individuals through age 15. This assessment consists of 18 items, 13 of which are used to determine ICF/ID Level of Care.

Support needs are assessed in the following areas:
A. Activities of Daily Living
B. Instrumental Activities of Daily Living
C. Family Supports
D. Safety & Interactions
E. Peer Relationships

ICF/ID Level of Care as described in Washington Administrative Code (WAC) Chapter 388-828:

How does DDA determine my score for ICF/ID Level of Care if I am age birth through fifteen years old? DDA determines your ICF/ID Level of Care score by adding your acuity scores for each question in the ICF/ID Level of Care Assessment for Children.

How does DDA determine if I meet the eligibility requirements for ICF/ID Level of care if I am age birth through 15 years old? DDA determines you to be eligible for ICF/ID Level of care when you meet at least one of the following:

1. You are age birth through five years old and the total of your acuity scores is five or more; or
2. You are age six through fifteen years old and the total of your acuity scores is seven or more.

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

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

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

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

A qualified and trained interviewer (DDA Case Resource Manager or DDA Social Worker or DDA Case-Resource Supervisor completes the SIS or the ICF/MR Level of Care Assessment for Children at least annually by obtaining information about the person's support needs via a face to face interview with the person and one or more respondents who know the person well.

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

- ( ) **Every three months**
- ( ) **Every six months**
- (●) **Every twelve months**
- ( ) **Other schedule**
  Specify the other schedule:

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

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**
  Specify the qualifications:

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

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

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

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
B.a.1: The percentage of all waiver applicants for whom an evaluation for LOC was completed prior to a completed request for enrollment. Numerator = All applicants who have a completed level of care assessment prior to a completed waiver enrollment request Denominator = All applicants with commpleted request for waiver enrollment

Data Source (Select one):
Record reviews, off-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
B.c.1: The percentage of inter-rater (IRR) LOC determinations made where the LOC criteria were accurately applied. Numerator = the number of IRR LOC eligibility determinations consistent with LOC criteria Denominator = IRR LOC determinations subject to review

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

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

		Confidence Interval = 95%
☑ **Other** Specify: Joint Requirements Planning Team within DDA	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

B.a.1.

Administrative data is collected in real time in DDA's Comprehensive Assessment Reporting and Evaluation (CARE) system, which is the database of record for client information. Waiver enrollment requests are processed in CARE, which will not allow completion of the request without a completed level of care assessment. A report based on data in CARE is used to identify all applicants for waiver enrollment for whom an evaluation for LOC was completed prior to a completed request for waiver enrollment and to identify all waiver enrollment applicants.

B.c.1.

When new case managers are hired, the Joint Requirements Planning (JRP) Team provides them with comprehensive training in a classroom environment regarding the use and administration of the LOC Assessment. Within 30 days of completing training, JRP staff must perform a 1:1 evaluation of new case managers to ensure that the LOC assessment is administered correctly. In addition, JRP staff conduct an annual 1:1 evaluation of all case managers to ensure that they maintain their skills in administering the LOC assessment in a consistent and reliable manner. During the initial and annual 1:1 evaluations, JRP staff accompany case managers on a LOC assessment interview. The case manager conducts the assessment interview and both the JRP staff and case manager independently complete separate LOC assessments based on the information provided in the interview. The case manager's LOC assessment is then compared to the JRP staff's to ensure that the case manager's determination of ICF/IID LOC eligibility is consistent with that of the JRP staff. JRP staff also evaluates the case manager's interviewing skills in the following areas: introduction to the tool, mechanics and style of the interview process, and understanding of scoring.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Capacity Remediation: In the first year of the Basic Plus waiver program September 2012 through August 2013, DDA provided services to a greater number of individuals on the Basic Plus waiver program than we had capacity. Basic Plus waiver capacity was exceeded by 264 waiver participants. An amendment had not been completed as it was not identified that we were over capacity until the review of our 372 report. As a result of the new tracking system DDA was able to identify this system problem. We have remediated these issues by developing a data system that tracks capacity at a point in time which includes the number of people who enrolled and exited the program each month. In addition a separate database was developed that tracks the total unduplicated number of waiver participants. This data is now accessible by the Waiver Program Manager and monitored on a monthly basis. The report for identifying unduplicated numbers of individuals comes from the DDA DataMart. This pulls data from payments for individuals on a waiver program. It will identify every waiver recipient who has received a paid service under the waiver program. In addition, the point in time capacity reports will identify the number of individual who exit and enter the waiver program. This is updated every half hour. In addition, the report identifies the specific capacity for each waiver and identifies the amount of available capacity. DDA program manager will monitor both reports on a monthly basis, review for available capacity at the point in time as well as the total number of unduplicated individuals who have received a paid waiver services. If discrepancies are identified that DDA will review the data again for the individual cases and if needed will complete an amendment to increase capacity within the waiver program.

B.c.1: Individuals whose reevaluation reveals that the LOC tools were inappropriately applied receive additional training.

ii. Remediation Data Aggregation

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

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

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

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

The DDA Case/Resource Manager (CRM) or DDA Social Service Specialist (SSS) discuss the alternatives available as a part of the annual assessment process. The individual and or their legal representative sign the Voluntary Participation Statement to indicate their choice of community based services or ICF/ID services.

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

A hard copy of the Voluntary Participation Statement to include signatures is maintained in the individual record located in the local DDA field service office.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
Service access to limited English Proficient individuals is ensured by providing bilingual staff or contracted interpreter services at no cost to the participant. Program materials are translated into the participant's primary language. Outreach materials explaining the program are translated into eight different languages.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Personal Care**		
Statutory Service	**Respite**		
Extended State Plan Service	**Occupational Therapy**		
Extended State Plan Service	**Physical therapy**		

Service Type	Service
Extended State Plan Service	Speech, Hearing, and Language Services
Other Service	Assistive Technology
Other Service	Behavior Support and Consultation
Other Service	Behavioral Health Crisis Stabilization Services-Specialized Psychiatric Services
Other Service	Behavioral Health Stabilization Services-Behavior Support and Consultation
Other Service	Behavioral Health Stabilization Services-Crisis Diversion Bed Services
Other Service	Environmental Accessibility Adaptations
Other Service	Nurse Delegation
Other Service	Sexual Deviancy Evaluation
Other Service	Specialized Clothing
Other Service	Specialized Medical Equipment and Supplies
Other Service	Specialized Nutrition
Other Service	Specialized Psychiatric Services
Other Service	Staff/Family Consultation and Training
Other Service	Therapeutic Equipment and Supplies
Other Service	Transportation
Other Service	Vehicle Modifications

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Personal care under the waiver differs in scope from personal care services in the State plan in that it may only be provided to waiver participants who are not eligible for State plan personal care or whose needs exceed what can be provided solely under State plan personal care. Personal care services consist of a range of physical and/or verbal assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) due to functional limitations. Assistance is evaluated with the use of assistive devices and takes available natural supports into account. Assistance ranges from set up and supervision to full physical support.

Assistance with ADLs includes bathing, bed mobility, body care, dressing, eating, locomotion and ability to walk in the home and outside the home, medication management, toilet use, transfer, and personal hygiene.

Assistance with IADLs include meal preparation, ordinary housework, essential shopping, wood supply, and travel to medical appointments, managing finances, and telephone use.

Personal care can be furnished outside the home if it is written into the participant's service plan. Individual providers of personal care receive paid vacation in accordance with the amount of hours worked. Individual service plans indicate who supervises the individual paid provider when an agency is not the employer. Personal care can be participant or family directed, which involves hiring, firing, scheduling, and designation of duties within the scope of the service plan. Personal care transportation includes transportation for medical appointments and essential shopping, for recipients age 18 or older, and can be included in the service plan when necessary.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The maximum hours of personal care received are determined by the approved department assessment for Medicaid personal care services. Age guidelines are taken into consideration for children that include the legal responsibility of a natural, step, or adoptive parent to provide assistance with personal care for their child as well as typical developmental milestones.

Personal care transportation is limited to participants age 18 or older, and to 60 miles of transportation to and from essential shopping and/or medical appointments required by the participant as a part of the personal care service. Personal care transportation is only utilized when other State Medicaid resources do not meet the participant’s transportation need and as a result the personal care provider transports the participant in the provider’s own personal vehicle.

To distinguish personal care transportation from the transportation service provided under this waiver, the waiver transportation service is provided in order to ensure the participant’s access to waiver services identified in the ISP. Waiver transportation would only be authorized to and from the following CIIBS waiver services if State Medicaid transportation resources do not meet the participant’s transportation need:
* Behavior Management and Consultation;
* Respite Care;
* Sexual Deviancy Evaluation; and
* Specialized Psychiatric Services.
Personal Care is not included as one of the services. Personal Care Transportation and Waiver Transportation have separate and distinct service authorization codes and descriptions. They are also identified as separate services in the ISP.

Waiver transportation requires providers to submit DSHS form 14-463 to the CRM, which documents mileage and purpose of travel. Waiver transportation includes reimbursement to professional transportation providers and reimbursement for use of the state ferry system, bus, or taxi, as well as reimbursement to individual providers when their own personal vehicle is used.

• Body care excludes:
(i) Foot care if the individual is diabetic or has poor circulation; or
(ii) Changing bandages or dressings when sterile procedures are required.
• The following tasks CANNOT be delegated:
  o Injections
  o Central Lines
  o Sterile procedures
  o Tasks that require nursing judgment

• Provider rates are standardized based on negotiations with the State Employees International Union (SEIU)and

funding provided by the Legislature.
• When transportation to essential services is included in the personal care service plan, individual providers are also reimbursed for their mileage if they use their own private vehicle, up to a maximum of 60 miles per month (per the Collective Bargaining Agreement).
• Payments for health care benefits for individual and agency providers who provide personal care for at least 20 hours per month also have insurance premiums paid in the rate.
• All payments are made directly from the State Operating Agency (DDA) to the agency provider or individual provider of services.

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Certified Nursing Assistant
Individual	Individual In-Home Provider
Agency	Home Care Agency
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:
Individual
Provider Type:
Certified Nursing Assistant
Provider Qualifications

License *(specify):*

Certificate *(specify):*
Certified Nursing Assistant (CNA) I.P. for nurse delegated tasks

Chapter 18.88A RCW (state law concerning nursing assistants, including requirements for certification)

Chapter 246-841 WAC (Department of Health administrative code concerning nursing assistants, including certified training programs)

Other Standard *(specify):*
WAC 388-71-0500 through WAC 388-71-0556 (DSHS administrative code concerning individual provider and home care agency provider qualifications)

WAC 388-71-05670 through WAC 388-71-05799 (DSHS administrative code concerning orientation, training, and continuing education for individual providers and home care agency providers, including an exemption for parent providers in WAC 388-71-05765)

WAC 257-05-020 through 257-05-240 (Home Care Quality Authority administrative code concerning safety training requirements for an Individual Provider)

Chapter 246-841 WAC (Department of Health administrative code concerning nursing assistants, including certified training programs and other requirements)

WAC 388-71-05805 through 05865 (DSHS administrative code concerning nurse delegation core training, including safety training, and competency testing)

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:
Individual

Provider Type:
Individual In-Home Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
WAC 388-71-0500 through WAC 388-71-0556 (DSHS administrative code concerning individual provider and home care agency provider qualifications)

WAC 388-71-05670 through WAC 388-71-05799 (DSHS administrative code concerning orientation, basic training, modified basic training, exemption for IP parents for adult children, and continuing education for individual providers and home care agency providers)

WAC 257-05-020 through WAC 257-05-240 (Health Care Quality Authority administrative code concerning safety training requirements for an individual provider)

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:
Agency
Provider Type:
Home Care Agency
Provider Qualifications

License *(specify):*
Chapter 70.127 RCW (State law concerning licensing of home health, hospice, and home care agencies)

WAC 246-335-020 (Department of Health administrative code concerning the licensing requirement for agencies that provide home health, home care, hospice, and hospice care center services)

Certificate *(specify):*

Other Standard *(specify):*
Chapter 246-335 WAC, Part 1 (Department of Health administrative code concerning requirements for agencies licensed to provide home health, home care, hospice and hospice care center services)

WAC 388-71-0500 through WAC 388-71-0556 (DSHS administrative code concerning individual provider and home care agency provider qualifications)

WAC 388-71-05670 through WAC 388-71-05799 (DSHS administrative code concerning orientation, training, and continuing education for individual providers and home care agency providers)

A home care agency provides nonmedical services and assistance (e.g. personal care services) to individuals who are ill, disabled or vulnerable to enable them to remain in their residence.

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications

License *(specify):*

Chapter 70.127 RCW (State law concerning licensing of home health, hospice, and home care agencies)

WAC 246-335-020 (Department of Health administrative code concerning the licensing requirement for agencies that provide home health, home care, hospice, and hospice care center services)

Certificate *(specify):*

Other Standard *(specify):*

Chapter 246-335 WAC, Part 1 (Department of Health administrative code concerning requirements for agencies licensed to provide home health, home care, hospice and hospice care center services)

WAC 388-71-0500 through WAC 388-71-0556 (DSHS administrative code concerning individual provider and home care agency provider qualifications)

WAC 388-71-05670 through WAC 388-71-05799 (DSHS administrative code concerning orientation, training, and continuing education for individual providers and home care agency providers)

A home health agency provides medical and nonmedical services to individuals who are ill, disabled or vulnerable residing in temporary or permanent residences.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Short-term, intermittent relief to persons normally providing care for the participant; provided both in-home and out-of-home. A provider of in-home respite is not precluded from taking the client into the community while providing respite.

FFP will be claimed for room and board when out-of-home respite is provided in the following licensed settings:

- Licensed staffed residential
- Adult Family Home
- Child Foster Care Home
- Child Foster Group Care
- Adult Residential Care Center
- Group Care Home

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Respite under CIIBS is limited to participants under age 18 living with their natural, step, or adoptive parent(s) or of any age living with a family caregiver when no one living them is paid to provide their personal care services.

Respite amounts are determined by the DDA assessment and are relative to the impact of a person's caregiving needs upon the caregiver(s). Respite hours range from 240-528 hrs per year (no monthly limits). Requests for additional respite are reviewed through exceptions to rule.

The following limitations apply to the respite care that an individual can receive and are included in WAC 388-845-1620 (DDA administrative code that lists the limits to respite care),

* The DDA assessment will determine how much respite an individual can receive per chapter 388-828 WAC (DSHS administative code concerning the DDA assessment).

* Respite cannot replace daycare while a parent or guardian is at work; and/or personal care hours available to the individual. When determining unmet need, DDA will first consider the personal care hours available to the individual.

* Respite may be provided in the family home. If respite is provided in a private home other than a family member's home, the home must be licensed and services provided in accordance with their license. Respite providers may accompany clients into the community as a part of the service (for example attend the movies, go to a park, eat at a restaurant, etc.). Respite may also be provided in a community-based setting, such as a camp or a parks and recreation facility.

* The individual's caregiver (the beneficiary of the relief from caregiving) cannot provide paid respite services during the time they are receiving the respite break.

* DDA cannot pay for any fees associated with the respite care; for example, membership fees at a recreational facility, or insurance fees.

Individual provider and agency hourly rates are based upon the rates provided to personal care providers as negotiated with the SEIU (provider union) and funding provided by the Legislature allows. Rates for community-based settings such as recreational camps and activities are based upon usual and customary charges and must be posted on the provider's website.

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Child Care Center
Agency	Adult Family Home
Agency	Licensed Staffed Residential
Individual	Certified Nursing Assistant
Agency	Child Foster Group Care
Agency	Child Foster Care Home
Agency	Group Care Home
Agency	Child Day Care Center
Agency	Camps and Recreation Programs
Agency	Home Care Agency
Agency	Home Health Agency
Individual	Individual In-home Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Child Care Center
Provider Qualifications
License *(specify):*
Chapter 388-151 WAC (DSHS administrative code concerning licensing requirements for school-age child care centers)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standard
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in

conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Adult Family Home
Provider Qualifications
License *(specify):*
Chapter 388-76 WAC (DSHS administrative code concerning licensing requirements for adult family homes)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

WAC 388-78A-2490 (DSHS administrative code concerning assisted living facility licensing requirements, inlcuding specialized training for caregivers that serve residents with developmental disabilities)
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 18 months

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Licensed Staffed Residential
Provider Qualifications
License *(specify):*
Chapter 388-148 WAC (DSHS administrative code concerning licensing requirements for child foster homes, staffed residential homes, group residential facilities, and child-placing agencies
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:

Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual

Provider Type:
Certified Nursing Assistant

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Certified Nursing Assistant (CNA) I.P. for nurse delegated tasks

Chapter 18.88A RCW (state law concerning nursing assistants, including requirements for certification)

Chapter 246-841 WAC (Department of Health administrative code concerning nursing assistants, including certified training programs)

Other Standard *(specify):*
WAC 388-71-0500 through WAC 388-71-0556 (DSHS administrative code concerning individual provider and home care agency provider qualifications)

WAC 388-71-05670 through WAC 388-71-05799 (DSHS administrative code concerning orientation, training, and continuing education for individual providers and home care agency providers, including an exemption for parent providers in WAC 388-71-05765)

WAC 257-05-020 through 257-05-240 (Home Care Quality Authority administrative code concerning safety training requirements for an Individual Provider)

Chapter 246-841 WAC (Department of Health administrative code concerning nursing assistants, including certified training programs and other requirements)

WAC 388-71-05805 through 05865 (DSHS administrative code concerning nurse delegation core training, including safety training, and competency testing)

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Child Foster Group Care
Provider Qualifications
License *(specify):*
Chapter 388-148 WAC (DSHS administrative code concerning licensing requirements for child foster homes, staffed residential homes, group residential facilities, and child-placing agencies
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Child Foster Care Home
Provider Qualifications
License *(specify):*
Chapter 388-148 WAC (DSHS administrative code concerning licensing requirements for child foster homes, staffed residential homes, group residential facilities, and child-placing agencies)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:

Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Group Care Home
Provider Qualifications
License *(specify):*
Chapter 388-78A WAC (DSHS administrative code concerning licensing requirements for assisted living facilities)
Certificate *(specify):*
Chapter 388-101 WAC (DSHS administrative code concerning certification requirements for community residential services and supports)
Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 2 years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Child Day Care Center
Provider Qualifications
License *(specify):*
Chapter 388-150 WAC (DSHS administrative code concerning licensing requirements for child day care centers)
Chapter 388-155 WAC (DSHS administrative code concerning licensing requirements for family child day care homes)
Certificate *(specify):*
Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Camps and Recreation Programs
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Community settings providing respite (e.g. classes, camps, or other recreation programs that serve as respite to the caregiver) must meet the regulations governing their business or activity.
Agencies must conduct criminal history background checks and receive clearance on all employees and volunteers who will have unsupervised access to clients in the course of performing respite.
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Home Care Agency
Provider Qualifications
License *(specify):*
Chapter 70.127 RCW (State law concerning licensing of home health, hospice, and home care agencies)

WAC 246-335-020 (Department of Health administrative code concerning the licensing requirement for agencies that provide home health, home care, hospice, and hospice care center services)
Certificate *(specify):*

Other Standard *(specify):*
Chapter 246-335 WAC, Part 1 (Department of Health administrative code concerning requirements for agencies licensed to provide home health, home care, hospice and hospice care center services)

WAC 388-71-0500 through WAC 388-71-0556 (DSHS administrative code concerning individual provider and home care agency provider qualifications)

WAC 388-71-05670 through WAC 388-71-05799 (DSHS administrative code concerning orientation, training, and continuing education for individual providers and home care agency providers)

A home care agency provides nonmedical services and assistance (e.g. personal care services) to individuals who are ill, disabled or vulnerable to enable them to remain in their residence.

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications

License *(specify):*
Chapter 70.127 RCW (State law concerning licensing of home health, hospice, and home care agencies)

WAC 246-335-020 (Department of Health administrative code concerning the licensing requirement for agencies that provide home health, home care, hospice, and hospice care center services)
Certificate *(specify):*

Other Standard *(specify):*
Chapter 246-335 WAC, Part 1 (Department of Health administrative code concerning requirements for agencies licensed to provide home health, home care, hospice and hospice care center services)

WAC 388-71-0500 through WAC 388-71-0556 (DSHS administrative code concerning individual provider and home care agency provider qualifications)

WAC 388-71-05670 through WAC 388-71-05799 (DSHS administrative code concerning orientation, training, and continuing education for individual providers and home care agency

providers)

A home health agency provides medical and nonmedical services to individuals who are ill, disabled or vulnerable residing in temporary or permanent residences.

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual

Provider Type:
Individual In-home Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
WAC 388-71-0500 through WAC 388-71-0556 (DSHS administrative code concerning individual provider and home care agency provider qualifications)

WAC 388-71-05670 through WAC 388-71-05799 (DSHS administrative code concerning orientation, training, and continuing education for individual providers and home care agency providers, including an exemption for parent providers in WAC 388-71-05765)

WAC 257-05-020 through 257-05-240 (Home Care Quality Authority administrative code concerning safety training requirements for an Individual Provider)

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Occupational Therapy

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Occupational therapy services are available through the waiver when a Medicaid provider is not available in the area in which a child lives or when the service is not covered due to medical necessity, but is determined necessary for remedial benefit. An example of the need for OT as a waiver service would be to allow the therapy to be provided in the family home. State plan services are provided in clinical settings and few providers are willing to come into the home to provide service. Children on the CIIBS waiver often require or benefit more from therapy provided in the home with the inclusion of family members due to high anxiety and challenging behavior that prevents them from accessing the clinical setting. In-home services offer the additional benefits of the natural environment which allows therapy to be incorporated into regular child and family routines.

This waiver service will in no way impede a child's access to services to which they are entitled under EPSDT.

Before this therapy is offered as a waiver service, DSHS Form 13-734, Documentation of First Use of Medicaid Benefits, is used to document that clients have first accessed services to which they are entitled through the State Plan (including EPSDT).

"Occupational therapy" is the scientifically based use of purposeful activity with individuals who are limited by physical injury or illness, psychosocial dysfunction, developmental or learning disabilities, or the aging process in order to maximize independence, prevent disability, and maintain health. The practice encompasses evaluation, treatment, and consultation. Services are provided when the availability or limits of occupational therapy under the approved State plan and EPSDT are exhausted. Specific occupational therapy services include, but are not limited to: Using specifically designed activities and exercises to enhance neurodevelopmental, cognitive, perceptual motor, sensory integrative, and psychomotor functioning; administering and interpreting tests such as manual muscle and sensory integration; teaching daily living skills; developing prevocational skills and play and avocational capabilities; designing, fabricating, or applying selected orthotic and prosthetic devices or selected adaptive equipment; and adapting environments for the handicapped. These services are provided individually, in groups, or through social systems. (An example of

OT provided through a social system would be therapy provided in the home environment with the involvement of family members. A goal would be to incorporate therapeutic activities into natural family and household routines.)

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Occupational therapy is not subject to limits other than the amount determined necessary to meet the needs of the participant. OT will decrease as participant goals are achieved and methods of providing ongoing support through natural routines are determined successful.

(1) Additional therapy may be authorized as a waiver service only after you have accessed what is available to you under Medicaid, EPSDT, and any other private health insurance plan;

(2) The department does not pay for treatment determined by DSHS to be experimental;

(3) The department and the treating professional determine the need for and amount of service the individual can receive:

(a) The department reserves the right to require a second opinion from a department-selected provider.
(b) The department will require evidence that the individual has accessed her/his full benefits through Medicaid, EPSDT, and private insurance before authorizing this waiver service.

Rates for occupational therapy are negotiated by DDA regional staff on a provider-specific basis. All payments are made directly from the Single State Agency (DDA) to the provider of service.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Occupational Therapist
Agency	Occupational Therapist

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:
Individual

Provider Type:
Occupational Therapist

Provider Qualifications

License *(specify):*
Providers of extended state plan services must be certified, registered or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

Per RCWs 18.59.020, 18.59.050, 18.59.060 and 18.59.070, "Occupational Therapy" services must be provided by a person licensed to provide Occupational Therapy in the State of Washington. These requirements are comparable to the qualifications specified in 42 CFR 440.110.

RCW 18.59.050 (Washington state law concerning licensing requirements for occupational therapists and occupational therapy assistants)

RCW 18.59.060 (Washington state law concerning an examination as part of the requirement for licensure as an occupational therapist)

Chapter 246-847 WAC (Department of Health administrative code concerning occupational therapist requirements including licensure and standards of professional conduct)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:
Agency

Provider Type:
Occupational Therapist

Provider Qualifications

License *(specify):*
Providers of extended state plan services must be certified, registered or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

Per RCWs 18.59.020, 18.59.050, 18.59.060 and 18.59.070, "Occupational Therapy" services must be provided by a person licensed to provide Occupational Therapy in the State of Washington. These requirements are comparable to the qualifications specified in 42 CFR 440.110.

RCW 18.59.050 (Washington state law concerning licensing requirements for occupational therapists and occupational therapy assistants)

RCW 18.59.060 (Washington state law concerning an examination as part of the requirement for licensure as an occupational therapist)

Chapter 246-847 WAC (Department of Health administrative code concerning occupational therapist requirements including licensure and standards of professional conduct)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Extended State Plan Service

Service Title:
Physical therapy

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Physical therapy services are available under the waiver when a Medicaid provider is not available in the area in which a child lives or when the service is not covered due to medical necessity, but is determined necessary for remedial benefit. An example of the need for PT as a waiver service would be to allow the therapy to be provided in the family home. State plan services are provided in clinical settings and few providers are willing to come into the home to provide service. Children on the CIIBS waiver often require or benefit more from therapy provided in the home with the inclusion of family members due to high anxiety and challenging behavior that prevents them from accessing the clinical setting. In-home services offer the additional benefits of the natural environment which allows therapy to be incorporated into regular child and family routines.

This waiver service will in no way impede a child's access to services to which they are entitled under EPSDT.

Before this therapy is offered as a waiver service, DSHS Form 13-734, Documentation of First Use of Medicaid Benefits, is used to document that clients have first accessed services to which they are entitled through the State Plan (including EPSDT).

Per RCW 18.74.010 (Washington state law that defines physical therapy), "Physical Therapy" means the treatment of any bodily or mental condition of a person by the use of the physical, chemical, or other properties of heat, cold, air, light, water, electricity, sound massage, and therapeutic exercise, which includes posture and rehabilitation procedures; the performance of tests and measurements of neuromuscular function as an aid to the diagnosis or treatment of any human condition; performance of treatments on the basis of test findings after consultation with and periodic review by an authorized health care practitioner.
Services are provided when the availability or limits of physical therapy under the approved State plan and EPSDT are exhausted.

Per RCW 18.74.010, RCW 18.74.030 (Washington state law concerning the qualifications of applicants for a physical therapy license)and 18.74.035 (Washington state law concerning the examination for a physical therapy license), "Physical Therapy" services must be provided by a person licensed to provide this service in the State of Washington. These requirements are comparable to the qualifications specified in 42 CFR 440.110.

Physical therapy is covered under the waiver as an extended state plan service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Physical therapy is not subject to limits other than the amount determined necessary to meet the needs of the participant. PT will decrease as participant goals are achieved and methods of providing ongoing support through natural routines are determined successful.

Providers of extended state plan services must be certified, registered or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

(1) Additional therapy may be authorized as a waiver service only after the individual has accessed what is available to her/him under Medicaid, EPSDT, and any other private health insurance plan;

(2) The department does not pay for treatment determined by DSHS to be experimental;

(3) The department and the treating professional determine the need for and amount of service the individual can receive:

(a) The department reserves the right to require a second opinion from a department-selected provider.
(b) The department will require evidence that the individual has accessed her/his full benefits through Medicaid, EPSDT, and private insurance before authorizing this waiver service.

Rates for physical therapy services are negotiated by DDA regional staff on a provider-specific basis. All payments are made directly from the Single State Agency (DDA) directly to the provider of service.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Physical Therapist
Agency	Physical Therapist

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Physical therapy

Provider Category:
Individual
Provider Type:
Physical Therapist
Provider Qualifications
License *(specify):*
RCW 18.74.030 (Washington state law concerning necessary qualifications to apply for a license as a physical therapist)

RCW 18.74.035 (Washington state law concerning the examination for licensure as a physical therapist)

RCW 18.74.040 (Washington state law concerning licenses for physical therapists)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Chapter 246.915 WAC (Department of Health administrative code concerning requirements for physical therapists, including licensure and principles of professional conduct)
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Physical therapy

Provider Category:
Agency
Provider Type:
Physical Therapist
Provider Qualifications
License *(specify):*
RCW 18.74.030 (Washington state law concerning necessary qualifications to apply for a license as a physical therapist)

RCW 18.74.035 (Washington state law concerning the examination for licensure as a physical therapist)

RCW 18.74.040 (Washington state law concerning licenses for physical therapists)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Chapter 246.915 WAC (Department of Health administrative code concerning requirements for physical therapists, including licensure and principles of professional conduct)

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Extended State Plan Service
Service Title:
Speech, Hearing, and Language Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Speech, hearing and language services are available under the waiver when a Medicaid provider is not available in the area in which a child lives or when the service is not covered due to medical necessity, but is determined necessary for remedial benefit. An example of the need for ST as a waiver service would be to allow the therapy to be provided in the family home. State plan services are provided in clinical settings and few providers are willing to come into the home to provide service. Children on the CIIBS waiver often require or benefit more from therapy provided in the home with the inclusion of family members due to high anxiety and challenging behavior that prevents them from accessing the clinical setting. In-home services offer the additional benefits of the natural environment which allows therapy to be incorporated into regular child and family routines.

This waiver service will in no way impede a child's access to services to which they are entitled under EPSDT.

Before this therapy is offered as a waiver service, DSHS Form 13-734, Documentation of First Use of Medicaid Benefits, is used to document that clients have first accessed services to which they are entitled through the State Plan (including EPSDT).

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

Per RCW 18.35.010 (DSHS administrative code which defines hearing and speech services), "Speech-language pathology" means the application of principles, methods, and procedures related to the development and disorders, whether of organic or nonorganic origin, that impede oral, pharyngeal, or laryngeal sensorimotor competencies and the normal process of human communication including, but not limited to, disorders and related disorders of speech, articulation, fluency, voice, verbal and written language, auditory comprehension, cognition/communication, and the application of augmentative communication treatment and devices for treatment of such disorders

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

Per RCW 18.35.010 (Washington state law which defines hearing and speech services, RCW 18.35.040 (Washington state law concerning qualifcations for applicants for licensure as a audiologist or speech-language pathologist) and RCW 18.35.080 (Washington state law concerning requirements for licensure as a audiologist or speech-language pathologist), “Speech-language pathology” and “Audiology” services must be provided by a person licensed to provide these services in the State of Washington. These requirements are comparable to the qualifications specified in 42 CFR 440.110.

Services are provided when the availability or limits of speech, hearing and language services under the approved State plan and EPSDT are exhausted.

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

Speech, hearing, and language therapy is not subject to limits other than the amount determined necessary to meet the needs of the participant. The amount of therapy will decrease as participant goals are achieved and methods of providing ongoing support through natural routines are determined successful.

(1) Additional therapy may be authorized as a waiver service only after the individual has accessed what is available to her/him under Medicaid, EPSDT, and any other private health insurance plan;

(2) The department does not pay for treatment determined by DSHS to be experimental;

(3) The department and the treating professional determine the need for and amount of service the individual can receive:

(a) The department reserves the right to require a second opinion from a department-selected provider.
(b) The department will require evidence that the individual has accessed her/his full benefits through Medicaid, EPSDT, and private

insurance before authorizing this waiver service.

Rates for speech, hearing and language services are negotiated by DDA regional staff on a provider-specific basis. All payments are made directly from the Single State Agency(DDA) to the provider of service.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Speech-Language Pathologist
Agency	Audiologist
Individual	Speech-Language Pathologist
Individual	Audiologist

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech, Hearing, and Language Services

Provider Category:
Agency
Provider Type:
Speech-Language Pathologist
Provider Qualifications

License *(specify):*
RCW 18.35.040 (Washington state law concerning minimum qualifications for an applicant for licensure as a language-speech pathologist or audiologist)

RCW 18.35.080 (Washington state law concerning licenses for speech-language pathology and audiology)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

WAC 246-828-105 (Department of Health administrative rule concerning minimum standards of practice for speech-language pathology)

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in

conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech, Hearing, and Language Services

Provider Category:
Agency
Provider Type:
Audiologist
Provider Qualifications
License *(specify):*
RCW 18.35.040 (Washington state law concerning minimum qualifications for an applicant for licensure as an audiologist or speech-language pathologist)

RCW 18.35.080 (Washington state law concerning licenses for audiology and speech-language pathology)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

WAC 246-828-095 (Department of Health administrative rule concerning minimum standards of practice for audiology)
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech, Hearing, and Language Services

Provider Category:
Individual
Provider Type:
Speech-Language Pathologist
Provider Qualifications
License *(specify):*
Providers of extended state plan services must be certified, registered or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

RCW 18.35.040 (Washington state law concerning minimum qualifications for an applicant for

licensure as a language-speech pathologist or audiologist)

RCW 18.35.080 (Washington state law concerning licenses for speech-language pathology and audiology)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

WAC 246-828-105 (Department of Health administrative rule concerning minimum standards of practice for speech-language pathology)

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech, Hearing, and Language Services

Provider Category:
Individual

Provider Type:
Audiologist

Provider Qualifications

License *(specify):*
Providers of extended state plan services must be certified, registered or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

RCW 18.35.040 (Washington state law concerning minimum qualifications for an applicant for licensure as an audiologist or speech-language pathologist)

RCW 18.35.080 (Washington state law concerning licenses for audiology and speech-language pathology)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

WAC 246-828-095 (Department of Health administrative rule concerning minimum standards of practice for audiology)

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Technology

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Items, equipment, or product systems used to increase, maintain, or improve functional capabilities of participants, as well as services to directly assist the participant and caregivers to select, acquire, and use the technology. Services are provided when outside the scope of Medicaid State Plan and EPSDT benefits.

"Assistive device" means any item, piece of equipment, or product system, whether acquired commercially off-the-shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of children with disabilities. The term "assistive technology service" means any service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device. Assistive technology service includes:

(1) The evaluation of the needs of a child with a disability, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the child in the child's customary environment;

(2) Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by children with disabilities;

(3) Selecting, designing, fitting, customizing, adapting, applying, retaining, repairing, or replacing of assistive technology devices;

(4) Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;

(5) Training or technical assistance for a child with a disability or if appropriate, the child's family; and

(6) Training or technical assistance for professionals, including individuals providing education and rehabilitation services, employers, or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of children with disabilities.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Providers of assistive technology services must be certified, registered or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

Vendors of assistive technology must maintain a business license required by law for the type of product they are providing and contracted with DDA.

Assistive Technology may be authorized as a waiver service only after Medicaid, EPSDT, and any other private health insurance plan benefits have been exhausted.

The department does not pay for technology determined by DSHS to be experimental;

Recommendation required from a treating or other relevant health professional who has assessed the client and determined individual need for the service.

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

The department will require evidence that participants have accessed the full benefits of Medicaid, EPSDT, and private insurance before authorizing this waiver service. Initial denial of funding or other evidence that the service is not covered by another source will suffice.

All rates are based upon the usual and customary charges for the assistive technology. Payments are made directly from the Single State Agency (DDA) to the provider of the assistive technology.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Audiologist
Agency	Recreation Therapist
Individual	Music Therapist
Agency	Audiologist
Agency	Physical Therapist

Provider Category	Provider Type Title
Individual	Physical Therapist
Individual	Recreation Therapist
Agency	Music Therapist
Agency	Speech-Language Pathologist
Individual	Speech-Language Pathologist
Agency	Occupational Therapist
Individual	Occupational Therapist
Agency	Assistive Technology Vendor
Individual	Rehabilitation Counselor
Agency	Rehabilitation Counselor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Individual

Provider Type:
Audiologist

Provider Qualifications

License *(specify):*
RCW 18.35.040 (Washington state law concerning minimum qualifications for an applicant for licensure as an audiologist or speech-language pathologist)

RCW 18.35.080 (Washington state law concerning licenses for audiology and speech-language pathology)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

WAC 246-828-095 (Department of Health administrative rule concerning minimum standards of practice for audiology)

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:
Recreation Therapist
Provider Qualifications
License *(specify):*

Certificate *(specify):*
State registration through the Department of Health; and

National certification through the National Council for Therapeutic Recreation Certification
Other Standard *(specify):*
Master's degree in recreation therapy, psychology, education, or related discipline.

Additional Qualifications:
o 800 hrs of relevant course work in principles of recreation therapy, child development, learning theory, positive behavioral support techniques, and/or behavioral analysis. May be included as part of the degree program.
o One year of relevant experience in designing and/or implementing comprehensive therapies for children with developmental disabilities and challenging behavior
o 50 hrs every 5 years continuing education related to children with developmental disabilities and behavior

Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Individual
Provider Type:
Music Therapist
Provider Qualifications
License *(specify):*

Certificate *(specify):*
National certification through the Certification Board for Music Therapists
Other Standard *(specify):*
Master's degree in music therapy, psychology, education, or related discipline

Additional Qualifications:
o 800 hrs of relevant course work in principles of music therapy, child development, learning theory, positive behavioral support techniques, and/or behavioral analysis. May be included as part of the degree

program.
o One year of relevant experience in designing and/or implementing comprehensive therapies for children with developmental disabilities and challenging behavior
o 50 hrs every 5 years continuing education related to children with developmental disabilities and behavior

Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Agency
Provider Type:
Audiologist
Provider Qualifications

License *(specify):*
RCW 18.35.040 (Washington state law concerning minimum qualifications for an applicant for licensure as an audiologist or speech-language pathologist)

RCW 18.35.080 (Washington state law concerning licenses for audiology and speech-language pathology)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

WAC 246-828-095 (Department of Health administrative rule concerning minimum standards of practice for audiology)

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Agency
Provider Type:
Physical Therapist
Provider Qualifications
License *(specify):*
Providers of assistive technology services must be certified, registered or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

RCW 18.74.030 (Washington state law concerning necessary qualifications to apply for a license as a physical therapist)

RCW 18.74.035 (Washington state law concerning the examination for licensure as a physical therapist)

RCW 18.74.040 (Washington state law concerning licenses for physical therapists)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Chapter 246.915 WAC (Department of Health administrative code concerning requirements for physical therapists, including licensure and principles of professional conduct)
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Individual
Provider Type:
Physical Therapist
Provider Qualifications
License *(specify):*
Providers of assistive technology services must be certified, registered or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

RCW 18.74.030 (Washington state law concerning necessary qualifications to apply for a license as a physical therapist)

RCW 18.74.035 (Washington state law concerning the examination for licensure as a physical therapist)

RCW 18.74.040 (Washington state law concerning licenses for physical therapists)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Chapter 246.915 WAC (Department of Health administrative code concerning requirements for physical therapists, including licensure and principles of professional conduct)

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Individual

Provider Type:
Recreation Therapist

Provider Qualifications

License *(specify):*

Certificate *(specify):*
National certification through the National Council for Therapeutic Recreation Certification

Other Standard *(specify):*
Master's degree in recreation therapy, psychology, education, or related discipline.

Additional Qualifications:
- o 800 hrs of relevant course work in principles of recreation therapy, child development, learning theory, positive behavioral support techniques, and/or behavioral analysis. May be included as part of the degree program.
- o One year of relevant experience in designing and/or implementing comprehensive therapies for children with developmental disabilities and challenging behavior
- o 50 hrs every 5 years continuing education related to children with developmental disabilities and behavior.

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Agency
Provider Type:
Music Therapist
Provider Qualifications
License *(specify):*

Certificate *(specify):*
National certification through the Certification Board for Music Therapists
Other Standard *(specify):*
Master's degree in music therapy, psychology, education, or related discipline.

Additional Qualifications:
o 800 hrs of relevant course work in principles of music therapy, child development, learning theory, positive behavioral support techniques, and/or behavioral analysis. May be included as part of the degree program.
o One year of relevant experience in designing and/or implementing comprehensive therapies for children with developmental disabilities and challenging behavior
o 50 hrs every 5 years continuing education related to children with developmental disabilities and behavior

Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Agency
Provider Type:
Speech-Language Pathologist
Provider Qualifications
License *(specify):*
Providers of assistive technology services must be certified, registered or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

RCW 18.35.040 (Washington state law concerning minimum qualifications for an applicant for licensure as a language-speech pathologist or audiologist)

RCW 18.35.080 (Washington state law concerning licenses for speech-language pathology and audiology)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

WAC 246-828-105 (Department of Health administrative rule concerning minimum standards of practice for speech-language pathology)
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Individual
Provider Type:
Speech-Language Pathologist
Provider Qualifications
License *(specify):*
Providers of assistive technology services must be certified, registered or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

RCW 18.35.040 (Washington state law concerning minimum qualifications for an applicant for licensure as a language-speech pathologist or audiologist)

RCW 18.35.080 (Washington state law concerning licenses for speech-language pathology and audiology)
Certificate *(specify):*

Other Standard *(specify):*

Contract Standards

WAC 246-828-105 (Department of Health administrative rule concerning minimum standards of practice for speech-language pathology)

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Agency

Provider Type:
Occupational Therapist

Provider Qualifications

License *(specify):*
Providers of assistive technology services must be certified, registered or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

RCW 18.59.050 (Washington state law concerning licensing requirements for occupational therapists and occupational therapy assistants)

RCW 18.59.060 (Washington state law concerning an examination as part of the requirement for licensure as an occupational therapist)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Chapter 246-847 WAC (Department of Health administrative code concerning occupational therapist requirements including licensure and standards of professional conduct)

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Individual

Provider Type:
Occupational Therapist

Provider Qualifications

License *(specify):*
Providers of assistive technology services must be certified, registered or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

RCW 18.59.050 (Washington state law concerning licensing requirements for occupational therapists and occupational therapy assistants)

RCW 18.59.060 (Washington state law concerning an examination as part of the requirement for licensure as an occupational therapist)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Chapter 246-847 WAC (Department of Health administrative code concerning occupational therapist requirements including licensure and standards of professional conduct)

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Agency

Provider Type:
Assistive Technology Vendor

Provider Qualifications

License *(specify):*
Chapter 19.02 RCW (Washington state law concerning business licenses)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Individual

Provider Type:
Rehabilitation Counselor

Provider Qualifications

License *(specify):*
Counseling or related licensure through the Washington State Department of Health

Certificate *(specify):*
Certification through the Commission on Rehabilitation Counselor Certification

Other Standard *(specify):*
Unlicensed providers must be registered or certified through the Washington State Department of Health in accordance with Chapter 18.19 RCW (Counselors)

DDA Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Agency

Provider Type:
Rehabilitation Counselor

Provider Qualifications

License *(specify):*
Counseling or related licensure through the Washington State Department of Health

Certificate *(specify):*
Certification through the Commission on Rehabilitation Counselor Certification
Other Standard *(specify):*
Unlicensed providers must be registered or certified through the Washington State Department of Health in accordance with Chapter 18.19 RCW (Counselors)

DDA Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

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

Service Title:
Behavior Support and Consultation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
(1)Professional assistance to participants to develop and implement:

(a) Strategies for effectively relating to caregivers and other people in the waiver participant's life; and
(b) Direct interventions to decrease aggressive, destructive,

and sexually inappropriate or other behaviors that compromise his or her ability to remain in the family home and community (i.e., training, specialized cognitive counseling, development and implementation of a positive behavior support plan).

(2)Treatment must be evidence based, consistent with Positive Behavioral Support, and include the following components:

(a) Functional Assessment of behavior, which takes into account the overall quality of a child's life; factors that increase the likelihood of both challenging and positive behavior; underlying physical and/or mental health conditions; and the function or purpose of the challenging behavior; and
(b) Development of a Positive Behavior Support Plan, based on the Functional Assessment, which includes recommendations for improving the child's overall quality of life; recommendations to include therapeutically appropriate activities in the child's day; teaching methods and environmental changes designed to decrease the effectiveness of the challenging behavior and increase the effectiveness of positive behavior in achieving desired outcomes, and recommendations for treating mental or physical health symptoms.

Treatment may include music and/or recreational therapy as a means of supporting positive behavior. Music and recreation therapy is defined for this purpose as the research-based, data-driven use of music or recreation related strategies in the child's home to create positive changes in a child's behavior, resolve conflicts leading to stronger family and peer relationships, explore personal feelings, make positive changes in mood and emotional states, increase a sense of control over life through successful experiences, and strengthen communication skills and physical coordination skills which enhance their health, functional abilities, independence and quality of life.

(3)Treatment goals must be objective and measurable. The goals must relate to a decrease in challenging behaviors that impede quality of life for the child and family as well as an increase in skill development as it relates to the challenging behavior.

(4)Behavioral support strategies will be individualized and coordinated across all environments, such as home, school, and community, in order to ensure a consistent approach among all involved persons.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The following limits apply to receipt of behavior support and consultation:

(1) DDA and the treating professional will determine the need and amount of services received.

(2) DDA reserves the right to require a second opinion from a department-selected provider.

(3) DDA will only cover evidence-based treatment.

The term "evidence-based treatment" (EBT) refers to the use of mental and behavioral health interventions for which systematic empirical research has provided evidence of statistically significant effectiveness as treatments for specific problems. Alternate terms with the same meaning are evidence-based practice (EBP) and empirically-supported treatment (EST).

Non-evidence-based (e.g., complementary and alternative) therapies are not covered because there are key questions relative to their use that are yet to be answered through well-designed scientific studies--questions such as whether these therapies are safe and whether they work for the diseases or medical conditions for which they are used.

(4) These services are only covered under the CIIBS Waiver when they are outside the definition of service available through the Medicaid State Plan and EPSDT or the child does not meet access to care definitions(i.e., via the Regional Support Networks). It is anticipated some CIIBS Waiver clients will not be eligible for these services under the Medicaid State Plan, since an individual must have a mental health (MH) diagnosis to receive mental health State Plan services. A MH diagnosis is not a requirement for enrollment on the CIIBS Waiver.

Regional DDA staff negotiate rates on a provider-specific basis. All payments are made directly from the Single State Agency (DDA) to the provider of behavior management/consultation services.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Psychologist
Agency	Behavior Specialist
Individual	Behavior Specialist
Agency	Psychologist
Agency	Behavior Technician
Individual	Behavior Technician
Individual	Marriage and Family Therapist
Agency	Marriage and Family Therapist
Agency	Mental Health Counselor
Agency	Licensed Social Worker
Individual	Licensed Social Worker
Individual	Mental Health Counselor
Individual	Sex Offender Treatment Provider
Agency	Sex Offender Treatment Provider
Individual	Polygrapher
Agency	Polygrapher

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support and Consultation

Provider Category:
Individual
Provider Type:
Psychologist
Provider Qualifications
License *(specify):*
Chapter 246-924 WAC (DOH administrative code concerning requirements for psychologists)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support and Consultation

Provider Category:
Agency

Provider Type:
Behavior Specialist

Provider Qualifications

License *(specify):*
Individuals employed by an agency to perform the role of the Behavior Specialist must meet all licensing and certification standards required of the individual for the specific discipline.

Certificate *(specify):*
Individuals employed by an agency to perform the role of the Behavior Specialist must meet all licensing and certification standards required of the individual for the specific discipline.

Other Standard *(specify):*
Individuals employed by an agency to perform the role of the Behavior Specialist must meet all degree, experience, and training standards required of an individual Behavior Specialist.

Contract Standards, which includes ensuring all agency employees pass a criminal history background check as required by RCW 43.20A.710, and carrying liability insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support and Consultation

Provider Category:

Individual

Provider Type:
Behavior Specialist
Provider Qualifications
License *(specify):*
State licensure and certification as required for the specific discipline:

Chapter 246-809 WAC (Department of Health administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Chapter 246-924 WAC (Department of Health administrative code concerning requirements to become a licensed psychologist)

Chapter 18.71 RCW (Washington state law governing physician practice and licensure)

Chapter 18.71A RCW (Washington state law congerning physician assistant practice and licensure)
Certificate *(specify):*
Chapter 18.19 RCW (Washington state law concerning counselors, including certification)

Chapter 246-810 WAC (Department of Health administrative code concerning the practice of counseling)
Other Standard *(specify):*
Doctoral degree in psychology, education, medicine, or related discipline

Additional Qualifications:
- o 1500 hours of relevant course work or training in principles of child development, learning theory, positive behavior support techniques, and/or behavior analysis. May be included as part of the degree program.
- o Two years of relevant experience in designing and implementing comprehensive behavioral therapies for children with developmental disabilities and challenging behavior.
- o 30 hours every 3 years continuing education related to children with developmental disabilities and challenging behavior.

OR

Master's degree in psychology, education, or related discipline

Additional Qualifications:
- o 1500 hours of relevant course work or training in principles of child development, learning theory, positive behavior support techniques, and/or behavior analysis. May be included as part of the degree program.
- o Two years of relevant experience in designing and implementing comprehensive behavioral therapies for children with developmental disabilities and challenging behavior.
- o 45 hours every 3 years continuing education related to children with developmental disabilities and challenging behavior.

Contract Standards, which includes passing a criminal history background check as required by RCW 43.20A.710, and carrying liability insurance.

Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in

conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support and Consultation

Provider Category:
Agency
Provider Type:
Psychologist
Provider Qualifications
License *(specify):*
Chapter 246-924 WAC (DOH administrative code concerning requirements for psychologists)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support and Consultation

Provider Category:
Agency
Provider Type:
Behavior Technician
Provider Qualifications
License *(specify):*
State licensure and certification as required for the specific discipline:

Chapter 246-809 WAC (Department of Health administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)
Certificate *(specify):*
Chapter 18.19 RCW (Washington state law concerning counselors, including certification)

Chapter 246-810 WAC (Department of Health administrative code concerning the practice of counseling)
Other Standard *(specify):*
Individuals employed by an agency to perform the role of the Behavior Technician must meet the qualifications of the Individual Behavior Technician.

Contract Standards, which includes ensuring all agency employees pass a criminal history background check as required by RCW 43.20A.710, and carrying liability insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support and Consultation

Provider Category:
Individual

Provider Type:
Behavior Technician

Provider Qualifications

License *(specify):*
State licensure and certification as required for the specific discipline:

Chapter 246-809 WAC (Department of Health administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Certificate *(specify):*
Chapter 18.19 RCW (Washington state law concerning counselors, including certification)

Chapter 246-810 WAC (Department of Health administrative code concerning the practice of counseling)

Other Standard *(specify):*
Master's degree in psychology, education, or related discipline

Additional Qualifications:
- o 800 hours of relevant course work or training in principles of child development, learning theory, positive behavior support techniques, and/or behavior analysis. May be included as part of the degree program.
- o One year of relevant experience in designing and/or implementing comprehensive behavioral therapies for children with developmental disabilities and challenging behavior.
- o 45 hours every 3 years continuing education related to children with developmental disabilities and challenging behavior.

OR

- o Bachelor's degree
- o 800 hours of relevant course work or training in principles of child development, learning theory, positive behavior support techniques, and/or behavior analysis. May be included as part of the degree program.
- o Two years of relevant experience in designing and/or implementing comprehensive behavioral therapies for children with developmental disabilities and challenging behavior.
- o 45 hours every 3 years continuing education related to children with

developmental disabilities and challenging behavior.

OR

o High School diploma or GED
o Minimum age of 21
o 120 hours of supervised implementation of positive behavior support plans for children with developmental disabilities and challenging behavior.
o One year of experience providing care for children with developmental disabilities and challenging behavior.
o First 8 hours of service under direct supervision of a Behavioral Specialist with monthly supervision thereafter.

Contract Standards, which includes passing a criminal history background check as required by RCW 43.20A.710, and carrying liability insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support and Consultation

Provider Category:
Individual

Provider Type:
Marriage and Family Therapist

Provider Qualifications

License *(specify):*
Chapter 246-809 WAC (Department of Health-DOH-administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support and Consultation

Provider Category:
Agency
Provider Type:
Marriage and Family Therapist
Provider Qualifications
License *(specify):*
Chapter 246-809 WAC (DOH administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support and Consultation

Provider Category:
Agency
Provider Type:
Mental Health Counselor
Provider Qualifications
License *(specify):*
Chapter 246-809 WAC (DOH administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g.

license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support and Consultation

Provider Category:
Agency
Provider Type:
Licensed Social Worker
Provider Qualifications
License *(specify):*
Chapter 246-809 WAC (DOH administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support and Consultation

Provider Category:
Individual
Provider Type:
Licensed Social Worker
Provider Qualifications
License *(specify):*
Chapter 246-809 WAC (DOH administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support and Consultation

Provider Category:
Individual

Provider Type:
Mental Health Counselor

Provider Qualifications

License *(specify):*
Chapter 246-809 WAC (DOH administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support and Consultation

Provider Category:
Individual

Provider Type:
Sex Offender Treatment Provider

Provider Qualifications

License *(specify):*
State licensure as required for the specific discipline:

Chapter 246-809 WAC (Department of Health administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Chapter 246-924 WAC (Department of Health administrative code concerning requirements to become a licensed psychologist)
Certificate *(specify):*
Chapter 246-930 WAC (Department of Health administrative code concerning sex offender treatment provider requirements, including certification)

WAC 246-930-020 (Department of Health administrative code indicating only credentialed health care professionals may be certified as a sex offender treatment provider)

WAC 246-930-030 (Department of Health administrative code concerning the education required prior to examination to become a certified sex offender treatment provider)

WAC 246-930-040 (Department of Health administrative code concerning the professional experience required prior to examination to become a certified sex offender treatment provider)
Other Standard *(specify):*
Contract Standards

Provider must have experience assessing sexually aggressive youth.

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support and Consultation

Provider Category:
Agency
Provider Type:
Sex Offender Treatment Provider
Provider Qualifications

License *(specify):*
State licensure as required for the specific discipline:

Chapter 246-809 WAC (Department of Health administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Chapter 246-924 WAC (Department of Health administrative code concerning requirements to become a licensed psychologist)
Certificate *(specify):*
Chapter 246-930 WAC (Department of Health administrative code concerning sex offender treatment provider requirements, including certification)

WAC 246-930-020 (Department of Health administrative code indicating only credentialed health care professionals may be certified as a sex offender treatment provider)

WAC 246-930-030 (Department of Health administrative code concerning the education required prior to examination to become a certified sex offender treatment provider)

WAC 246-930-040 (Department of Health administrative code concerning the professional experience required prior to examination to become a certified sex offender treatment provider)
Other Standard *(specify):*
Contract Standards

Individuals hired by an agency as an SOTP must meet the requirements of an individual SOTP.

Provider must have experience assessing sexually aggressive youth.

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support and Consultation

Provider Category:
Individual
Provider Type:
Polygrapher
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Must be an experienced polygrapher who is a graduate of an accredited polygraph school.

Contract Standards, which includes passing a criminal history background check as required by RCW 43.20A.710, and carrying liability insurance.

Note: A polygrapher would only be involved if recommended by the Sex Offender Treatment Provider as one component of treatment for sexually aggressive youth to help identify and verify those situations that trigger aggressive sexual behavior and to identify and verify the individual's ideation and behavior in response to those situations.

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support and Consultation

Provider Category:
Agency
Provider Type:
Polygrapher
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Must be an experienced polygrapher who is a graduate of an accredited polygraph school.

Contract Standards

Note: A polygrapher would only be involved if recommended by the Sex Offender Treatment Provider as one component of treatment for sexually aggressive youth to help identify and verify those situations that trigger aggressive sexual behavior and to identify and verify the individual's ideation and behavior in response to those situations.

Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Behavioral Health Crisis Stabilization Services-Specialized Psychiatric Services

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Behavioral health stabilization services assist persons who are experiencing a behavioral health crisis. These services are available to individuals determined by behavioral health professionals or DDA to be at risk of institutionalization in a psychiatric hospital without (one or more of) the following services:

- Behavioral health crisis diversion bed services
- Behavior support and consultation
- Specialized psychiatric services

Specialized psychiatric services, which as stipulated in DDA state regulations:
(1) Are specific to the individual needs of persons with developmental disabilities who are experiencing mental health symptoms.

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

These services are only covered under the CIIBS Waiver when they are outside the definition of service available through the Medicaid State Plan and EPSDT or the child does not meet access to care definitions (i.e., via the Regional Support Networks). It is anticipated some CIIBS Waiver clients will not be eligible for these services under the Medicaid State Plan, since an individual must have a mental health (MH) diagnosis to receive mental health State Plan services. A MH diagnosis is not a requirement for enrollment on the CIIBS Waiver.

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

Most Medicaid mental health services in Washington are provided through a 1915-B waiver, which clarifies Access to Care criteria for those individuals needing more intensive mental health supports. Community mental health services through the waiver are provided through Regional Support Networks, which carry out the contracting for local mental health care. Access to Care criteria excludes the DSM diagnoses classes that include mental retardation; learning, motor skills and communication disorders; and pervasive developmental disorders. Individuals with primary diagnoses and functional impairments that are only a result of these diagnoses are not eligible for mental health waiver services. As a result, individuals with these issues must display an additional covered diagnosis in order to be served through the mental health system, must be able to benefit from the intervention, and their unmet needs cannot be met more appropriately by another formal or informal system, such as the Developmental Disabilities Administration or community natural supports.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

There is no pre-determined limit to the amount of service that may be provided. The amount of service provided is based on professional judgment of mental health professionals and DDA staff. Once the crisis situation is resolved and the individual is stabilized, behavioral health crisis stabilization services will be terminated. Any need for ongoing specialized psychiatric services will be met under the stand-alone specialized psychiatric services category.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Physician Assistant
Individual	Advanced Registered Nurse Practitioner
Individual	Psychiatrist
Agency	Physician Assistant
Agency	Psychiatrist
Agency	Advanced Registered Nurse Practitioner

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Crisis Stabilization Services-Specialized Psychiatric Services

Provider Category:
Individual

Provider Type:
Physician Assistant

Provider Qualifications

License *(specify):*
Chapter 18.71A RCW (State law concerning requirements for Physician Assistants)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
EVery 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Crisis Stabilization Services-Specialized Psychiatric Services

Provider Category:
Individual

Provider Type:
Advanced Registered Nurse Practitioner

Provider Qualifications

License *(specify):*
RCW 18.79.050 (State law concerning "Advanced registered nursing practice" and exceptions)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Crisis Stabilization Services-Specialized Psychiatric Services

Provider Category:
Individual

Provider Type:
Psychiatrist

Provider Qualifications

License *(specify):*
Chapter 18.71 RCW (State law concerning requirements for Physicians)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Crisis Stabilization Services-Specialized Psychiatric Services

Provider Category:
Agency
Provider Type:
Physician Assistant
Provider Qualifications
License *(specify):*
Chapter 18.71A RCW (State law concerning requirements for Physician Assistants)
Certificate *(specify):*
Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Crisis Stabilization Services-Specialized Psychiatric Services

Provider Category:
Agency
Provider Type:
Psychiatrist
Provider Qualifications
License *(specify):*
Chapter 18.71 RCW (State law concerning requirements for Physicians)
Certificate *(specify):*
Other Standard *(specify):*
Contract Stsandards
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Crisis Stabilization Services-Specialized Psychiatric Services

Provider Category:
Agency
Provider Type:
Advanced Registered Nurse Practitioner
Provider Qualifications
License *(specify):*
RCW 18.79.050 (State law concerning "Advanced registered nursing practice" and exceptions)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

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

Service Title:
Behavioral Health Stabilization Services-Behavior Support and Consultation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Behavioral health stabilization services assist persons who are experiencing a behavioral health crisis. These services are available to individuals determined by behavioral health professionals or DDA to be at risk of institutionalization in a psychiatric hospital without (one or more of) the following services:

- Behavioral health crisis diversion bed services
- Behavior support and consultation
- Specialized psychiatric services

Behavior Support and Consultation:
(1)Includes the development and implementation of programs designed to support waiver participants using:

a) Strategies for effectively relating to caregivers and other people in the waiver participant's life; and
b) Direct interventions with the person to decrease aggressive, destructive, and sexually inappropriate or other

behaviors that compromise their ability to remain in the community (i.e.,training, specialized cognitive counseling).

These services are provided to individuals who are experiencing a behavioral health crisis that overwhelms their family and current providers, placing them at risk of psychiatric hospitalization. Once the crisis situation is resolved and the individual is stabilized, behavior support and consultation as a component of behavioral health crisis stabilization services is terminated. Any need for ongoing behavior support and consultation is met under the stand-alone behavior support and consultation service category.

A behavior support and consultation agency can be either privately-contracted or state-staffed.

Most Medicaid mental health services in Washington are provided through a 1915-B waiver, which clarifies Access to Care criteria for those individuals needing more intensive mental health supports. Community mental health services through the waiver are provided through Regional Support Networks, which carry out the contracting for local mental health care. Access to Care criteria excludes the DSM diagnoses classes that include mental retardation; learning, motor skills and communication disorders; and pervasive developmental disorders. Individuals with primary diagnoses and functional impairments that are only a result of these diagnoses are not eligible for mental health waiver services. As a result, individuals with these issues must display an additional covered diagnosis in order to be served through the mental health system, must be able to benefit from the intervention, and their unmet needs cannot be met more appropriately by another formal or informal system, such as the Developmental Disabilities Administration or community natural supports.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
- Behavioral health stabilization services are intermittent and short-term.
- The duration and amount of services needed to stabilize the individual in crisis is determined by a mental health professional and/or DDA.
- Behavioral health stabilization services require prior approval by DDA or its designee.

"Short-term" reflects the fact that these services are not provided on an on-going basis. However, there is no pre -determined limit on the duration of these services. They are provided to individuals who are experiencing a behavioral health crisis and are at risk of psychiatric hospitalization. Once the crisis situation is resolved and the individual is stabilized, behavioral health crisis stabilization services will be terminated. Any ongoing need for behavior support and consultation will be met under the stand-alone behavior support and consultation services category.

Rates for privately-contracted behavior support and consultation as a component of behavioral health stabilization services are negotiated by DDA regional staff with the Regional Support Network (RSN) and/or individual providers. Payments are made from the DDA to the RSN or individual provider of service.

These services are only covered under the CIIBS Waiver when they are outside the definition of service available through the Medicaid State Plan and EPSDT or the child does not meet access to care definitions (i.e., via the Regional Support Networks). It is anticipated some CIIBS Waiver clients will not be eligible for these services under the Medicaid State Plan, since an individual must have a mental health (MH) diagnosis to receive mental health State Plan services. A MH diagnosis is not a requirement for enrollment on the CIIBS Waiver.

DDA works closely with the Behavioral Health and Service Integration Administration (BHSIA) to prevent duplication of RSN/State Plan BH Services. DSHS's expectation is that any DDA eligible client who meets the BHSIA access to care and medical necessity standards will receive behavioral health services through Regional Support Networks (RSNs) or Prepaid Inpatient Health Plans (PIHP). Individuals that do not meet access to care or medical necessity standards for the service type may be served under the crisis prevention and intervention contracts.

Rates for state-staffed behavior support and consultation as a component of behavioral health stabilization services are established on a prospective basis by the DDA cost reimbursement section.

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

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

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Sex Offender Treatment Provider (SOTP)
Agency	Behavior Support Agency Provider (Privately Contracted)
Agency	Behavior Support Agency Provider (State-Operated)
Individual	Registered Nurse (RN) or Licensed Practical Nurse (LPN)
Individual	Marriage and Family Therapist
Individual	Registered or Certified Counselor
Individual	Mental Health Counselor
Individual	Behavior Support Provider with five years of experience serving individuals with developmental disabilities.
Individual	Psychiatrist
Individual	Psychologist
Individual	Physician Assistant working under the supervision of a Psychiatrist
Individual	Social Worker
Individual	Psychiatric Advanced Registered Nurse Practitioner (ARNP)
Individual	Polygrapher

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services-Behavior Support and Consultation

Provider Category:
Individual

Provider Type:
Sex Offender Treatment Provider (SOTP)

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Chapter 246-930 WAC (DOH administrative code concerning requirements for Sex Offender Treatment Providers)

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services-Behavior Support and Consultation

Provider Category:
Agency
Provider Type:
Behavior Support Agency Provider (Privately Contracted)
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Other Standard *(specify):*
A contracted agency could employee any of the provider types listed above and the employees must meet the qualifications listed.

Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services-Behavior Support and Consultation

Provider Category:
Agency
Provider Type:
Behavior Support Agency Provider (State-Operated)
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Other Standard *(specify):*
A state-operated agency (i.e., with state employees as staff) could employ any of the provider types listed and the employees must meet the qualifications listed.
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services-Behavior Support and Consultation

Provider Category:

Individual

Provider Type:
Registered Nurse (RN) or Licensed Practical Nurse (LPN)
Provider Qualifications
License *(specify):*
Chapter 246-840 WAC (DOH administrative code concerning requirements for Practical and Registered Nursing)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services-Behavior Support and Consultation

Provider Category:
Individual
Provider Type:
Marriage and Family Therapist
Provider Qualifications
License *(specify):*
Chapter 246-809 WAC (Department of Health-DOH-administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
state Operating Agency
Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services-Behavior Support and Consultation

Provider Category:
Individual
Provider Type:
Registered or Certified Counselor
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Chapter 246-810 WAC (DOH administrative code concerning requirements for counselors)
Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services-Behavior Support and Consultation

Provider Category:
Individual

Provider Type:
Mental Health Counselor

Provider Qualifications
License *(specify):*
Chapter 246-809 WAC (DOH administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services-Behavior Support and Consultation

Provider Category:
Individual

Provider Type:
Behavior Support Provider with five years of experience serving individuals with developmental disabilities.

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Five years experience serving individuals with Developmental Disabilities.

Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services-Behavior Support and Consultation

Provider Category:
Individual

Provider Type:
Psychiatrist

Provider Qualifications

License *(specify):*
Chapter 18.71 RCW (State law concerning requirements for Physicians)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services-Behavior Support and Consultation

Provider Category:
Individual

Provider Type:
Psychologist

Provider Qualifications

License *(specify):*
Chapter 246-924 WAC (DOH administrative code concerning requirements for psychologists)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:

EVery 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services-Behavior Support and Consultation

Provider Category:
Individual
Provider Type:
Physician Assistant working under the supervision of a Psychiatrist
Provider Qualifications
License *(specify):*
Chapter 18.71A RCW (State law concerning requirements for Physician Assistants)
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services-Behavior Support and Consultation

Provider Category:
Individual
Provider Type:
Social Worker
Provider Qualifications
License *(specify):*
Chapter 246-809 WAC (DOH administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services-Behavior Support and Consultation

Provider Category:
Individual

Provider Type:
Psychiatric Advanced Registered Nurse Practitioner (ARNP)

Provider Qualifications

License *(specify):*
RCW 18.79.050 (State law concerning "Advanced registered nursing practice" and exceptions)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services-Behavior Support and Consultation

Provider Category:
Individual

Provider Type:
Polygrapher

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavioral Health Stabilization Services-Crisis Diversion Bed Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Behavioral health stabilization services assist persons who are experiencing a behavioral health crisis. These services are available to individuals determined by behavioral health professionals or DDA to be at risk of institutionalization in a psychiatric hospital without (one or more of) the following services:

- Behavioral health crisis diversion bed services
- Behavior support and consultation
- Specialized psychiatric services

Behavioral health crisis diversion bed services:
Are temporary residential and behavioral services that may be provided in a client's home or licensed or certified setting or in a setting staffed and operated by state employees. These services are available to eligible clients who are at risk of serious decline of mental functioning and who have been determined to be at risk of psychiatric hospitalization. These services also provide respite to the primary caregiver to promote the client's return to her/his home.

If provided in an out-of-home setting, the setting (crisis diversion bed itself) includes a furnished bedroom, and a physical premises that addresses support, monitoring and safety needs for male and female individuals with varying degrees of vulnerability. Staffing includes at least one staff person at all times assigned exclusively to provide supervision and service to individuals utilizing the beds.

The focus of crisis diversion bed services is on behavioral health stabilization and addressing the immediate behavioral health needs of the individual. Crisis diversion staff provide and/or coordinate with others (e.g., community mental health staff members, contracted service providers of the RSN, contracted service providers of DDA, family members and/or guardians of the individuals receiving service) to provide behavioral health counseling, skill development, medication monitoring, and development and/or modification of a positive behavior support plan, the latter following the guidelines contained in Division Policy 5.19 (Positive Behavior

Support for Children and Youth).

Included in Policy 5.19 indicates that:
Using positive behavior support principles and techniques with children and youth can:
• Reduce and prevent challenging behaviors;
• Encourage family/caregiver involvement;
• Improve communication abilities;
• Enhance educational experiences;
• Expand opportunities for social interact; and
• Avoid the need for restrictive procedures.

Components of positive behavior support addressed in Policy 5.19 include:
• Supportive environments and learning opportunities;
• Skill development and status;
• Healthcare; and
• Treatment of mental illness.

There is no pre-determined limit to the duration of these services. However, they are not provided on an on-going basis. They are provided to individuals who are experiencing a behavioral health crisis that overwhelms their family and current providers, placing them at risk of psychiatric hospitalization. Once the crisis situation is resolved and the individual is stabilized, behavioral health crisis diversion bed services will be terminated. Any ongoing need for behavioral health services will be met under the stand-alone service categories (e.g., behavior support and consultation, staff/family consultation and training, specialized psychiatric services).

Crisis diversion bed services are only covered under the CIIBS Waiver when they are outside the definition of service available through the Medicaid State Plan and EPSDT or the child does not meet access to care definitions (i.e., via the Regional Support Networks). It is anticipated some CIIBS Waiver clients will not be eligible for these services under the Medicaid State Plan, since an individual must have a mental health (MH) diagnosis to receive mental health State Plan services. A MH diagnosis is not a requirement for enrollment on the CIIBS Waiver. In addition, it is very difficult to identify the need for crisis diversion bed services in advance (e.g., during an EPSDT screen), since these services are in response to an emergent situation for which the precursors often have not been identified.

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

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

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

There is no pre-determined limit to the amount of service that may be provided. The amount of service provided is based on professional judgment of mental health professionals and/or DDA staff. Once the crisis situation is resolved and the individual is stabilized, behavioral health crisis diversion bed services will be replaced by any needed ongoing services.

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

Rates for state-staffed behavioral health crisis diversion bed services as a component of behavioral health stabilization services are established on a prospective basis by the DDA cost reimbursement section. At the close of each year, a settlement calculation is prepared to recover additional federal funds, or to pay back funds previously received.

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

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

☑ **Provider managed**

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

☐ **Legally Responsible Person**

☑ **Relative**

☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Behavioral Health Stabilization-Behavioral Health Crisis Diversion Bed Services (Supported Living Agency)
Agency	Behavioral Health Stabilization-Behavioral Health Crisis Diversion Bed Services (State-Operated)
Agency	Behvioral Health Stabilization-Behavioral Health Crisis Diversion Bed Services (Other department-certified agencies)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services-Crisis Diversion Bed Services

Provider Category:
Agency
Provider Type:
Behavioral Health Stabilization-Behavioral Health Crisis Diversion Bed Services (Supported Living Agency)
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Chapter 388-101 WAC (ADSA administrative code concerning certified community residential services and Support)
Other Standard *(specify):*
DDA Policy 15.04 (concerning standards for community protection residential services, applicable only if they serve CP clients).

Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 2 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services-Crisis Diversion Bed Services

Provider Category:
Agency
Provider Type:

Behavioral Health Stabilization-Behavioral Health Crisis Diversion Bed Services (State-Operated)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

State-staffed behavioral health crisis diversion bed service providers are certified by Residental Care Services (RCS) of the Aging and and Long-Term Support Administration (ALTSA) within the Department of Social and Health Services (DSHS).

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 2 years.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavioral Health Stabilization Services-Crisis Diversion Bed Services

Provider Category:

Agency

Provider Type:

Behvioral Health Stabilization-Behavioral Health Crisis Diversion Bed Services (Other department-certified agencies)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Chapter 388-101 WAC (ADSA administrative code concerning requirements for Certified Community residential services and support)

Other Standard *(specify):*

Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Accessibility Adaptations

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

(1) Environmental accessibility adaptations provide the physical adaptations to the home needed to:
(a) Ensure the health, welfare and safety of the individual; or
(b) Enable the individual to function with greater independence in the home.
(2) Repairs to the home necessary due to property destruction caused by the participant; limited to the cost of restoration to original condition.

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

(1) Environmental accessibility adaptations require prior approval by the DDA regional administrator or designee.
(2) Environmental accessibility adaptations or improvements to the home are excluded if they are of general utility without direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc.
(3) Environmental accessibility adaptations cannot add to the total square footage of the home.

Rates are based upon bids receive by potential contractors. All payments are made directly from the Single State Agency (DDA) to the contractor.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Registered Contractor

Provider Category	Provider Type Title
Agency	Registered Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Individual
Provider Type:
Registered Contractor
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Chapter 18.27 RCW (Washington state law concerning contractor registration)

Chapter 19.27 RCW (Washington state law concerning the state building code)

Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Agency
Provider Type:
Registered Contractor
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Chapter 18.27 RCW (Washington state law concerning contractor registration)

Chapter 19.27 RCW (Washington state law concerning the state building code)

Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Nurse Delegation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Services provided by a registered nurse or a nursing agency to provide training and nursing management for providers who perform delegated nursing tasks. Delegated tasks include administration of non-injectable medications, blood glucose testing, and tube feedings. Services include the initial visit, additional teaching and supervisory visits. Clients who receive nurse delegation services must be considered "stable and predictable" by the delegating nurse.

As specified in Chapter 388-101 WAC (DSHS administrative code concerning certified community residential

services and supports): “Nurse Delegation” means a licensed practical nurse or registered nurse transfers the performance of selected nursing tasks to competent individuals in selected situations. (Within the scope of their license and pursuant to RCW 18.79.260 (Registered nurse — Activities allowed — Delegation of tasks), delegating nurses determine who is capable of providing a skilled nursing task and which task(s) the nurse determines can be safely delegated.) The licensed practical nurse or registered nurse delegating the task retains the responsibility and accountability for the nursing care of the client. The licensed practical nurse or registered nurse delegating the task supervises the performance of the unlicensed person;

(a) Nursing acts delegated by the licensed practical nurse or registered nurse shall:

(i) Be within the area of responsibility of the licensed practical nurse or registered nurse delegating the act;

(ii) Be such that, in the opinion of the licensed practical nurse or registered nurse, it can be properly and safely performed by the person without jeopardizing the patient welfare;

(iii) Be acts that a reasonable and prudent licensed practical nurse or registered nurse would find are within the scope of sound nursing judgment.

(b) Nursing acts delegated by the licensed practical nurse or registered nurse shall not require the unlicensed person to exercise nursing judgment nor perform acts which must only be performed by a licensed practical nurse or registered nurse, except in an emergency situation (RCW 18.79.240 (1)(b) and (2)(b))(Washington state law concerning provision of nursing assistance in the case of an emergency).

(c) When delegating a nursing act to an unlicensed person it is the registered nurse who shall:

(i) Make an assessment of the patient's nursing care need before delegating the task;

(ii) Instruct the unlicensed person in the delegated task or verify competency to perform or be assured that the person is competent to perform the nursing task as a result of the systems in place by the health care agency;

(iii) Recognize that some nursing interventions require nursing knowledge, judgment, and skill and therefore may not lawfully be delegated to unlicensed persons.

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

Nurse delegation is an intermittent service. The Registered Nurse Delegator is required to visit and provide supervision to the registered or certified nursing assistant (NAR/CNA) at least once every ninety (90) days. If providing diabetic training, the RND must visit the client at least once a week for the first four (4) weeks. However, the RND may determine that some clients need to be seen more often.

Per DDA Policy 6.15 Nurse Delegation Services, a maximum of fifty (50) 15 minute units (12.5 hours) may be authorized each month. If a client needs more than fifty (50) units in a given month to meet his/her needs, the RND must request prior approval through the client's case manager or the regional coordinator.

The following limitations apply to receipt of nurse delegation services:

- The department and the treating professional determine the need for and amount of service.

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

• The following tasks CANNOT be delegated:
  o Injections, other than insulin
  o Central Lines
  o Sterile procedures
  o Tasks that require nursing judgment

The rate for nurse delegation services is based on the Medicaid unit rate with no vacation or overtime or vendor rate increase. All payments are made directly by the Single State Agency (DDA) directly to the provider of service.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Registered Nurse
Individual	Registered Nurse

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nurse Delegation

Provider Category:
Agency
Provider Type:
Registered Nurse
Provider Qualifications
License *(specify):*
Chapter 246-840 WAC (Washington state law governing practical and registered nursing, including licensure)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nurse Delegation

Provider Category:
Individual

Provider Type:
Registered Nurse

Provider Qualifications

License *(specify):*
Chapter 246-840 WAC (Washington state law governing practical and registered nursing, including licensure)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Sexual Deviancy Evaluation

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

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

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

Service Definition *(Scope):*
(1) Sexual deviancy evaluations:
(a) Are professional evaluations that assess the person's needs and the person's level of risk of sexual offending or sexual recidivism;
(b) Determine the need for psychological, medical or therapeutic services; and
(c) Provide treatment recommendations to mitigate any assessed risk.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
(1) The evaluations must meet the standards contained in WAC 246-930-320 (Department of Health administrative code concerning standards for assessment and evaluation reports prepared by sex offender treatment providers).
(2) Sexual deviancy evaluations require prior approval by the DDA regional administrator or designee

The rate per evaluation is provider-specific and is negotiated by DDA regional staff. All payments are made directly by the Single State Agency (DDA) to the provider of service.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Sex Offender Treatment Provider
Individual	Sex Offender Treatment Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Sexual Deviancy Evaluation

Provider Category:
Agency
Provider Type:
Sex Offender Treatment Provider
Provider Qualifications
License *(specify):*
State licensure as required for the specific discipline:

Chapter 246-809 WAC (Department of Health administrative code concerning licensure for

mental health counselors, marriage and family therapists, and social workers)

Chapter 246-924 WAC (Department of Health administrative code concerning requirements to become a licensed psychologist)
Certificate *(specify):*
Chapter 246-930 WAC (Department of Health administrative code concerning sex offender treatment provider requirements, including certification)

WAC 246-930-020 (Department of Health administrative code indicating only credentialed health care professionals may be certified as a sex offender treatment provider)

WAC 246-930-030 (Department of Health administrative code concerning the education required prior to examination to become a certified sex offender treatment provider)

WAC 246-930-040 (Department of Health administrative code concerning the professional experience required prior to examination to become a certified sex offender treatment provider)
Other Standard *(specify):*
Contract Standards

Individuals hired by an agency as an SOTP must meet the requirements of an individual SOTP.

Provider must have experience assessing sexually aggressive youth.

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Sexual Deviancy Evaluation

Provider Category:
Individual
Provider Type:
Sex Offender Treatment Provider
Provider Qualifications

License *(specify):*
State licensure as required for the specific discipline:

Chapter 246-809 WAC (Department of Health administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Chapter 246-924 WAC (Department of Health administrative code concerning requirements to become a licensed psychologist)
Certificate *(specify):*
Chapter 246-930 WAC (Department of Health administrative code concerning sex offender treatment provider requirements, including certification)

WAC 246-930-020 (Department of Health administrative code indicating only credentialed health care professionals may be certified as a sex offender treatment provider)

WAC 246-930-030 (Department of Health administrative code concerning the education required prior to examination to become a certified sex offender treatment provider)

WAC 246-930-040 (Department of Health administrative code concerning the professional experience required prior to examination to become a certified sex offender treatment provider)
Other Standard *(specify):*
Contract Standards

Provider must have experience assessing sexually aggressive youth.
Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Specialized Clothing

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Clothing adapted to the participant's individual needs and related to his/her disability. Specialized clothing can include weighted clothing, clothing designed for tactile defensiveness, specialized footwear, or reinforced clothing. Services are provided when outside the scope of Medicaid State Plan and EPSDT benefits.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Recommendation required from a treating or other relevant health professional who has assessed the client and determined individual need for the service.

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

The department will require evidence that participants have accessed the full benefits of Medicaid, EPSDT, and private insurance before authorizing this waiver service. Initial denial of funding or other evidence that the service is not covered by another source will suffice.

Prior approval by Regional Administrator or designee required.

Rates are based upon the usual and customary charge for specialized clothing products.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Specialized Clothing Vendor
Individual	Specialized Clothing Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Clothing

Provider Category:
Agency
Provider Type:
Specialized Clothing Vendor
Provider Qualifications
License *(specify):*
Chapter 19.02 RCW (Washington state law concerning business licenses)
Certificate *(specify):*
Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:
Every three years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Clothing

Provider Category:
Individual

Provider Type:
Specialized Clothing Vendor

Provider Qualifications

License *(specify):*
Chapter 19.02 RCW (Washington state law concerning business licenses)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency

Frequency of Verification:
Every three years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Specialized Medical Equipment and Supplies

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
(1) Durable and nondurable medical equipment not available through the Medicaid state plan and EPSDT, which enables individuals to:
(a) Increase their abilities to perform their activities of daily living; or
(b) Perceive, control or communicate with the environment in which they live.

(2) Durable and nondurable medical equipment are defined in WAC 388-543-1000 (DSHS administrative code concerning definitions of durable medical equipment and related supplies, prosthetics and orthotics, medical supplies and related services) and 388-543-2800 (DSHS administrative code concerning reusable and disposable medical supplies) respectively.

(3) Also included are items necessary for life support; and ancillary supplies and equipment necessary to the proper functioning of the equipment and supplies described in subsection (1) above.

To meet the definition of durable medical equipment under the state plan (per WAC 388-543-1000) and this waiver service, items must have the following characteristics:
(1) Can withstand repeated use;

(2) Is primarily and customarily used to serve a medical purpose;

(3) Generally is not useful to a person in the absence of illness or injury; and

(4) Is appropriate for use in the client's place of residence.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The following limitations apply to the receipt of specialized medical equipment and supplies:

(1) Specialized medical equipment and supplies require prior approval by the DDA regional administrator or designee for each authorization.

(2) DDA reserves the right to require a second opinion by a department-selected provider.

(3) Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the Medicaid state plan and EPSDT.

(4) Items must be of direct medical or remedial benefit to the individual and necessary as a result of the individual's disability.

(5) Medications, prescribed or nonprescribed, and vitamins are excluded.

Recommendation required from a treating or other relevant health professional who has assessed the client and

determined individual need for the service.

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

The department will require evidence that participants have accessed the full benefits of Medicaid, EPSDT, and private insurance before authorizing this waiver service. Initial denial of funding or other evidence that the service is not covered by another source will suffice.

All rates are based upon the usual and customary charges for the specialized medical equipment/supplies. All payments are made directly from the Single State Agency (DDA) to the provide of the equipment/supplies.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medical Equipment Supplier

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
Medical Equipment Supplier

Provider Qualifications

License *(specify):*
Chapter 19.02 RCW (Washington state law concerning business licenses)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Nutrition

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Specially prepared food, particular types of food needed to sustain the individual in the family home and the services of a certified dietitian to monitor the individual's health and nutrition. Specialized nutrition, including dietitian services, are provided only after available Medicaid State Plan and EPSDT benefits have been exhausted.

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

Special diets must be evidence-based, ordered by the participant’s health practitioner and periodically monitored by a certified dietitian. Special diets will not constitute a full nutritional regime unless an enteral diet is the primary source of nutrition.

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

Prior approval by Regional Administrator or designee required.

Rates are based upon the usual and customary charge for specialized nutrition.

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Dietitian
Individual	Certified Dietitian
Agency	Specialized Nutrition Vendor
Individual	Specialized Nutrition Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Nutrition

Provider Category:
Agency
Provider Type:
Certified Dietitian
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Chapter 18.138 RCW (Washington state law concerning dietitians and nutritionists, including certification)

Chapter 246-822 WAC (Department of Health administrative code concerning certified dietitians and nutritionists)
Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Nutrition

Provider Category:
Individual
Provider Type:
Certified Dietitian
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Chapter 18.138 RCW (Washington state law concerning dietitians and nutritionists, including certification)

Chapter 246-822 WAC (Department of Health administrative code concerning certified dietitians and nutritionists)
Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Nutrition

Provider Category:
Agency
Provider Type:
Specialized Nutrition Vendor
Provider Qualifications
License *(specify):*
Chapter 19.02 RCW (Washington state law concerning business licenses)
Certificate *(specify):*
Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Nutrition

Provider Category:
Individual
Provider Type:
Specialized Nutrition Vendor
Provider Qualifications
License *(specify):*
Chapter 19.02 RCW (Washington state law concerning business licenses)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Specialized Psychiatric Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
(1) Specialized psychiatric services are specific to the individual needs of persons with developmental disabilities who are experiencing mental health symptoms. These services shall not replace Medicaid State Plan and EPSDT covered services.
(2) Service may be any of the following:
(a) Psychiatric evaluation,
(b) Medication evaluation and monitoring,
(c) Psychiatric consultation.

Specialized Psychiatric Services under the CIIBS waiver do not differ from the services available under the State plan and EPSDT. By adding this service to the CIIBS waiver, however, children who are unable to access State plan services due to the Division of Behavioral Health and Recovery Services(DBHR) medical necessity criteria will access these services through the waiver. The inclusion of this waiver service should in no way duplicate or supplant services available to a child through the State Plan and EPSDT. Any coverage herein must only supplement the services under the State Plan, including EPSDT.

DDA works closely with the DBHR to prevent duplication of RSN/State Plan MH Services, including EPSDT. DSHS's expectation is that any DDA eligible client who meets the DBHR medical necessity criteria will receive mental health services through Regional Support Networks (RSNs) or Prepaid Inpatient Health Plans (PIHP). Individuals that do not meet medical necessity criteria for the service type may receive this service through the waiver.

(Most Medicaid mental health services in Washington are provided through a 1915-B waiver, which clarifies Access to Care criteria for those individuals needing more intensive mental health supports. Community mental health services through the waiver are provided through Regional Support Networks, which carry out the contracting for local mental health care. Access to Care criteria excludes the DSM diagnoses classes that include mental retardation; learning, motor skills and communication disorders; and pervasive developmental disorders. Individuals with primary diagnoses and functional impairments that are only a result of these diagnoses are not eligible for mental health waiver services. As a result, individuals with these issues must display an additional covered diagnosis in order to be served through the mental health system, must be able to benefit from the intervention, and their unmet needs cannot be met more appropriately by another formal or informal system, such as the Developmental Disabilities Administration or community natural supports.)
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
(1) Specialized psychiatric services are excluded if they are available through other Medicaid programs or benefits, including EPSDT.

(2) Specialized psychiatric services require prior approval by the DDA regional administrator or designee.

DDA works closely with the Division of Behavioral Health and Recovery (DBHR) to prevent duplication of RSN/State Plan MH Services, including EPSDT. DSHS's expectation is that any DDA eligible client who meets the DBHR medical necessity criteria will receive mental health services through Regional Support Networks (RSNs) or Prepaid Inpatient Health Plans (PIHP). Individuals that do not meet medical necessity criteria for the service type may receive this service through the waiver.

DDA regional staff negotiate with providers on a client-specific basis unit rates that are at or below the DSHS standard rate. All payments are made directly from the Single State Agency (DDA) to the provider of service.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Psychiatrist
Agency	Advanced Registered Nurse Practitioner
Agency	Physician Assistant
Individual	Physician Assistant
Individual	Psychiatrist
Individual	Advanced Registered Nurse Practitioner

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Psychiatric Services

Provider Category:
Agency
Provider Type:
Psychiatrist
Provider Qualifications

License *(specify):*
The psychiatrist provided by an agency must meet the individual provider requirements for a psychiatrist.

Chapter 18.71 RCW (Washington state law governing physicians, including the requirement for licensure)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Psychiatric Services

Provider Category:
Agency
Provider Type:
Advanced Registered Nurse Practitioner
Provider Qualifications

License *(specify):*
Individuals hired by the agency as Advanced Registered Nurse Practitioners must meet the same qualifications as for an individual provider.

Chapter 18.79 RCW (Washington state law governing the practice of nursing care)

RCW 18.79.030 (Washington state law listing the licenses required for nursing practice, including practice as an advanced registered nurse practitioner)

RCW 18.79.050 (Washington state law defining advanced registered nursing practice)
Certificate *(specify):*

Other Standard *(specify):*
ARNP must have pediatric experience or specialty.

Contract standards

RCW 18.79.250 (Washington state law defining the activities allowed as an advanced registered nurse practitioner)

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Psychiatric Services

Provider Category:
Agency
Provider Type:
Physician Assistant
Provider Qualifications

License *(specify):*
Physician assistants (PAs) supplied by an agency must meet the individual provider requirements for a PA.

Chapter 18.71A RCW (Washington state law governing physician assistants, inlcuding licensure and limitations on practice)
Certificate *(specify):*

Other Standard *(specify):*
Physician assistant must have pediatric experience and be working under the supervision of a psychiatrist with pediatric experience or specialty.

Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:

Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Psychiatric Services

Provider Category:
Individual

Provider Type:
Physician Assistant

Provider Qualifications

License *(specify):*
Chapter 18.71A RCW (Washington state law governing physician assistants, including licensure and limitations on practice)

Certificate *(specify):*

Other Standard *(specify):*
Physician assistant must have pediatric experience and be working under the supervision of a psychiatrist with pediatric experience or specialty.

Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Psychiatric Services

Provider Category:
Individual

Provider Type:
Psychiatrist

Provider Qualifications

License *(specify):*
Chapter 18.71 RCW (Washington state law governing physicians, including the requirement for licensure)

Certificate *(specify):*

Other Standard *(specify):*
Contract standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Psychiatric Services

Provider Category:
Individual

Provider Type:
Advanced Registered Nurse Practitioner

Provider Qualifications

License *(specify):*
Chapter 18.79 RCW (Washington state law governing the practice of nursing care)

RCW 18.79.030 (Washington state law listing the licenses required for nursing practice, including practice as an advanced registered nurse practitioner)

RCW 18.79.050 (Washington state law defining advanced registered nursing practice)

Certificate *(specify):*

Other Standard *(specify):*
ARNP must have pediatric experience or specialty.

Contract Standards

RCW 18.79.250 (Washington state law defining the activities allowed as an advanced registered nurse practitioner)

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Staff/Family Consultation and Training

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Professional assistance to families or direct service providers to help them better meet the needs of the participant as outlined in the individual support plan, including:

(1) Health and medication monitoring,
(2) Basic and advanced instructional techniques,
(3) Positive behavior support
(4) Diet and nutritional guidance
(5) Disability information and education
(6) Strategies for effectively and therapeutically interacting with the participant
(7) Environmental consultation (This refers to consultation and training provided regarding modification of the participant's environment in such a way as to increase independence, identify environmental triggers of behavior, and/or support health and wellness); and
(8) Individual and Family Counseling

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

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

Regional DDA staff negotiate rates for staff/family consultation services on a provider-specific basis. All payments are made directly by the Single State Agency (DDA) to the provider of service.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Music Therapist
Individual	Behavior Technician
Individual	Behavior Specialist
Agency	Staff/Family Consultation and Training Agency Provider
Agency	Music Therapist
Individual	Occupational Therapist
Individual	Physical Therapist
Individual	Registered Nurse
Individual	Sex Offender Treatment Provider
Individual	Speech-Language Pathologist
Individual	Certified American Sign Language Instructor
Individual	Certified Dietitian
Individual	Certified Recreation Therapist
Individual	Audiologist
Individual	Licensed Practical Nurse

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Individual
Provider Type:
Music Therapist
Provider Qualifications
License *(specify):*

Certificate *(specify):*
National certification through the Certification Board for Music Therapists
Other Standard *(specify):*
The role of the Music Therapist is to assess, recommend strategies to be incorporated into the child's positive behavior support plan, and provide training to family, providers, and natural supports for their implementation. Goals must coordinate with the overall positive behavior support plan.

Minimum Bachelor's degree in music therapy, psychology, education, or related discipline

Additional Qualifications:
o 800 hrs of relevant course work in principles of music therapy, child development, learning theory, positive behavioral support techniques, and/or behavioral analysis. May be included as part of the degree program.
o One year of relevant experience in designing and/or implementing comprehensive therapies for children with developmental disabilities

and challenging behavior.
o 50 hrs every 5 years continuing education related to children with developmental disabilities and behavior.

Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Individual

Provider Type:
Behavior Technician

Provider Qualifications

License *(specify):*
Related state licensure or certification required for the specific discipline.

Chapter 246-809 WAC (Department of Health administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Certificate *(specify):*
Chapter 18.19 RCW (Washington state law concerning counselors, including certification)

Chapter 246-810 WAC (Department of Health administrative code concerning the practice of counseling)

Other Standard *(specify):*
The role of the Behavioral Technician is to implement the positive behavior support plan as directed by the Behavioral Specialist, including 1:1 behavioral interventions and skill development activity.

Master's degree in psychology, education, or related discipline

Additional Qualifications:
o 800 hours of relevant course work in principles of child development, learning theory, positive behavior support techniques, and/or behavior analysis. May be included as part of the degree program.
o One year of relevant experience in designing and/or implementing comprehensive behavioral therapies for children with developmental disabilities and challenging behavior.
o 45 hours every 3 years continuing education related to children with developmental disabilities and challenging behavior.

OR

o Bachelor's degree
o 800 hours of relevant course work or training in principles of child development, learning theory, positive behavior support techniques,

and/or behavior analysis. May be included as part of the degree program.
o Two years of relevant experience in designing and/or implementing comprehensive behavioral therapies for children with developmental disabilities and challenging behavior.
o 45 hours every 3 years continuing education related to children with developmental disabilities and challenging behavior.

OR

o High School diploma or GED
o Minimum age of 21
o 120 hours of supervised implementation of positive behavior support plans for children with developmental disabilities and challenging behavior.
o One year of experience providing care for children with developmental disabilities and challenging behavior.
o First 8 hours of service under direct supervision of a Behavioral Specialist with monthly supervision thereafter.

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Individual
Provider Type:
Behavior Specialist
Provider Qualifications

License *(specify):*
State licensure and certification as required for the specific discipline:

Chapter 246-809 WAC (Department of Health administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Chapter 246-924 WAC (Department of Health administrative code concerning requirements to become a licensed psychologist)

Chapter 18.71 RCW (Washington state law governing physician practice and licensure)

Chapter 18.71A RCW (Washington state law congerning physician assistant practice and licensure)
Certificate *(specify):*
Chapter 18.19 RCW (Washington state law concerning counselors, including certification)

Chapter 246-810 WAC (Department of Health administrative code concerning the practice of counseling)
Other Standard *(specify):*

The role of the Behavioral Specialist is to develop and oversee the implementation of the positive behavior support plan for the recipient of Behavior Management and Consultation. Responsible for quarterly reports of progress and coordinating all aspects of staff involvement.

Licensure or Certification:
Doctoral degree in psychology, education, or related discipline

Additional Qualifications:
o 1500 hours of relevant course work in principles of child development, learning theory, positive behavior support techniques, and/or behavior analysis. May be included as part of the degree program.
o Two years of relevant experience in designing and implementing comprehensive behavioral therapies for children with developmental disabilities and challenging behavior.
o 30 hours every 3 years continuing education related to children with developmental disabilities and challenging behavior.

OR

Licensure or Certification:
Master's degree in psychology, education, or related discipline

Additional Qualifications:
o 2000 hours of relevant course work in principles of child development, learning theory, positive behavior support techniques, and/or behavior analysis. May be included as part of the degree program.
o Two years of relevant experience in designing and implementing comprehensive behavioral therapies for children with developmental disabilities and challenging behavior.
o 45 hours every 3 years continuing education related to children with developmental disabilities and challenging behavior.

Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Agency
Provider Type:
Staff/Family Consultation and Training Agency Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Employees of agencies must meet the individual provider qualifications, including any licensing or certification requirements, as related to their specific discipline.

Contract standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Agency

Provider Type:
Music Therapist

Provider Qualifications

License *(specify):*

Certificate *(specify):*
National certification through the Certification Board for Music Therapists

Other Standard *(specify):*
The role of the Music Therapist is to assess, recommend strategies to be incorporated into the child's positive behavior support plan, and provide training to family, providers, and natural supports for their implementation. Goals must coordinate with the overall positive behavior support plan.

Minimum Bachelor's degree in music therapy, psychology, education, or related discipline

Additional Qualifications:
- o 800 hrs of relevant course work in principles of music therapy, child development, learning theory, positive behavioral support techniques, and/or behavioral analysis. May be included as part of the degree program.
- o One year of relevant experience in designing and/or implementing comprehensive therapies for children with developmental disabilities and challenging behavior.
- o 50 hrs every 5 years continuing education related to children with developmental disabilities and behavior.

Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Individual
Provider Type:
Occupational Therapist
Provider Qualifications

License *(specify):*
RCW 18.59.050 (Washington state law concerning licensing requirements for occupational therapists and occupational therapy assistants)

RCW 18.59.060 (Washington state law concerning an examination as part of the requirement for licensure as an occupational therapist)

Chapter 246-847 WAC (Department of Health administrative code concerning occupational therapist requirements including licensure and standards of professional conduct)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Individual
Provider Type:
Physical Therapist
Provider Qualifications

License *(specify):*
RCW 18.74.030 (Washington state law concerning necessary qualifications to apply for a license as a physical therapist)

RCW 18.74.035 (Washington state law concerning the examination for licensure as a physical therapist)

RCW 18.74.040 (Washington state law concerning licenses for physical therapists)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Chapter 246.915 WAC (Department of Health administrative code concerning requirements for physical therapists, including licensure and principles of professional conduct)

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Individual
Provider Type:
Registered Nurse
Provider Qualifications

License *(specify):*
Chapter 246-840 WAC (Washington state law governing practical and registered nursing, including licensure)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Individual

Provider Type:
Sex Offender Treatment Provider

Provider Qualifications

License *(specify):*
State licensure as required for the specific discipline:

Chapter 246-809 WAC (Department of Health administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Chapter 246-924 WAC (Department of Health administrative code concerning requirements to become a licensed psychologist)

Certificate *(specify):*
Chapter 246-930 WAC (Department of Health administrative code concerning sex offender treatment provider requirements, including certification)

WAC 246-930-020 (Department of Health administrative code indicating only credentialed health care professionals may be certified as a sex offender treatment provider)

WAC 246-930-030 (Department of Health administrative code concerning the education required prior to examination to become a certified sex offender treatment provider)

WAC 246-930-040 (Department of Health administrative code concerning the professional experience required prior to examination to become a certified sex offender treatment provider)

Other Standard *(specify):*
Must have experience assessing and providing treatment to sexually aggressive youth.

Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Individual

Provider Type:
Speech-Language Pathologist

Provider Qualifications

License *(specify):*
RCW 18.35.040 (Washington state law concerning minimum qualifications for an applicant for licensure as a language-speech pathologist or audiologist)

RCW 18.35.080 (Washington state law concerning licenses for speech-language pathology and audiology)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

WAC 246-828-105 (Department of Health administrative rule concerning minimum standards of practice for speech-language pathology)

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Individual

Provider Type:
Certified American Sign Language Instructor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Individual

Provider Type:
Certified Dietitian

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Chapter 18.138 RCW (Washington state law concerning dietitians and nutritionists, including certification)

Chapter 246-822 WAC (Department of Health administratice code concerning certified dietitians and nutritionists)

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Individual

Provider Type:
Certified Recreation Therapist

Provider Qualifications

License *(specify):*

Certificate *(specify):*
National certification through the National Council for Therapeutic Recreation Certification
Washington State Registration

Other Standard *(specify):*
The role of the Music Therapist is to assess, recommend strategies to be incorporated into the child's positive behavior support plan, and provide training to family, providers, and natural supports for their implementation. Goals must coordinate with the overall positive behavior support plan.

Licensure or Certification:
Master's degree in recreation therapy, psychology, education, or related discipline

Additional Qualifications:
o 800 hrs of relevant course work in principles of recreation therapy, child development, learning theory, positive behavioral support techniques, and/or behavioral analysis. May be included as part of the degree program.
o One year of relevant experience in designing and/or implementing comprehensive therapies for children with developmental disabilities and challenging behavior
o 50 hrs every 5 years continuing education related to children with developmental disabilities and behavior

Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Individual

Provider Type:
Audiologist

Provider Qualifications

License *(specify):*
RCW 18.35.040 (Washington state law concerning minimum qualifications for an applicant for licensure as an audiologist or speech-language pathologist)

RCW 18.35.080 (Washington state law concerning licenses for audiology and speech-language pathology)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

WAC 246-828-095 (Department of Health administrative rule concerning minimum standards of practice for audiology)

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:

Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Individual

Provider Type:
Licensed Practical Nurse

Provider Qualifications

License *(specify):*
Chapter 246-840 WAC (Washington state law governing practical and registered nursing, including licensure)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Therapeutic Equipment and Supplies

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Equipment and supplies, not available through Medicaid or EPSDT benefits, incorporated in a behavioral support plan or other therapeutic plan, such as a sensory integration or communication therapy plan, and necessary in order to fully implement the therapy or intervention. Included are items such as a weighted blanket, supplies that assist to calm or redirect the child to a constructive activity, or a vestibular swing. Items included under this expanded definition of equipment and supplies do not meet the four-part definition of durable medical equipment under the waiver service of Specialized Medical Equipment and Supplies, but are integral to supporting positive behavior in a child and are of medical or remedial benefit.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Therapeutic Equipment and Supplies may be authorized as a waiver service
only after the individual has accessed what is available to her/him under
Medicaid, EPSDT, and any other private health insurance plan;

The department does not pay for equipment and supplies determined by DSHS to be experimental;

Recommendation required from a treating or other relevant health professional who has assessed the client and determined individual need for the service.

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

The department will require evidence that participants have accessed the full benefits of Medicaid, EPSDT, and private insurance before authorizing this waiver service. Initial denial of funding or other evidence that the service is not covered by another source will suffice.

Rates are based upon the usual and customary charges for the therapeutic equipment and/or supplies. All payments are made directly by the Single State Agency (DDA) to the provider of the equipment/supplies.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Therapeutic Equipment and Supply Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapeutic Equipment and Supplies

Provider Category:
Agency
Provider Type:
Therapeutic Equipment and Supply Vendor
Provider Qualifications
License *(specify):*
Chapter 19.02 RCW (Washington state law concerning business licenses)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:
Every 3 years.
The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Transportation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

Service Definition *(Scope):*
Reimbursement for transporting a participant to and from waiver funded services specified in the participant's Individual Support Plan. Waiver transportation services cannot duplicate other types of transportation available through Medicaid, EPSDT, or included in a provider's contract. Waiver transportation is provided in order for the CIIBS participant to access a waiver service, such as summer camp (respite service), when without the transportation they would not be able to participate. Waiver transportation is different from Personal Care transportation in that it does not provide transportation to and from shopping or medical appointments.

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

(1) Transportation to/from medical or medically related appointments is a Medicaid transportation service, and is to be considered and used first. This includes benefits under EPSDT.
(2) Transportation is offered in addition to medical transportation but cannot replace or duplicate Medicaid transportation services.
(3) Transportation is limited to travel to and from a waiver service.
(4) Transportation does not include the purchase of a bus pass.
(5) Reimbursement for provider mileage requires prior approval by DDA and is paid according to contract.
(6) This service does not cover the purchase or lease of vehicles.
(7) Reimbursement for provider travel time is not included in this service.
(8) Reimbursement to the provider is limited to transportation that occurs when the individual is with the provider.
(9) The individual is not eligible for transportation services if the cost and responsibility for transportation is already included in the provider's contract and payment.
(10)Transportation services require prior approval by the DDA regional administrator or designee.
(11)If the waiver enrollee's personal care provider uses his/her own vehicle to provide transportation to the waiver enrollee for essential shopping and medical appointments as a part of the personal care service, the provider may receive up to sixty miles per month in mileage reimbursement. If the waiver enrollee works with more than one individual personal care provider, the waiver enrollee's limit is still a total of sixty miles per month.

The rate per mile is based upon historical reimbursement to state staff for transportation to and from meetings or on the rate negotiated for individual providers by the SEIU. All payments are made directly by the Single State Agency (DDA) to the provider of transportation.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Transportation Provider
Agency	Transportation Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:
Individual

Provider Type:
Transportation Provider

Provider Qualifications

License *(specify):*
Chapter 308-104 WAC (Department of Licensing administrative code concerning drivers' licenses)

Certificate *(specify):*

Other Standard *(specify):*
Includes contracted Individual Respite or Personal Care Providers.

Chapter 308-106 WAC (Department of Licensing administrative code concerning mandatory motor vehicle insurance)

Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:
Agency

Provider Type:
Transportation Provider

Provider Qualifications

License *(specify):*
Chapter 308-104 WAC (Department of Licensing administrative code concerning drivers' licenses)

Certificate *(specify):*

Other Standard *(specify):*
Chapter 308-106 WAC (Department of Licensing administrative code concerning mandatory motor vehicle insurance)

Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Vehicle Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Adaptations or alterations to a vehicle that is the participant's primary means of transportation in order to accommodate the unique needs of the individual, enable full integration into the community, and ensure the health, welfare, and safety of the individual and/or family members.

The following are specifically excluded: Purchase or lease of a vehicle and regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
(1) Prior approval by the regional administrator or designee is required.
(2) Vehicle modifications are excluded if they are of general utility without direct medical or remedial benefit to the individual.
(3) Vehicle modifications must be the most cost effective modification based upon a comparison of contractor bids as determined by DDA.

(4) The need for vehicle modifications must be identified in the individual's ISP.

Rates are based upon bids received from potential contractors. All payments are made directly by the Single State Agency (DDA) to the contractor.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vehicle Manufacturer
Agency	Vehicle Service Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:
Agency
Provider Type:
Vehicle Manufacturer
Provider Qualifications
License *(specify):*
Chapter 19.02 RCW (Washington state law concerning business licenses)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Vehicle Modifications

Provider Category:
Agency
Provider Type:
Vehicle Service Provider
Provider Qualifications
License *(specify):*
Chapter 19.02 RCW (Washington state law concerning business licenses)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g. license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

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

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

Check each that applies:

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

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

Case management services will be provided by employees of the Developmental Disabilities Administration, Department of Social and Health Services that are employed as a DDA case/resource manager or a social worker 3 and therefore meet the following qualifications:

DDA Case/Resource Manager

A Bachelor's degree in social sciences, social services, human services, behavioral sciences or an allied field and two years of experience providing social services to people with developmental disabilities, graduate training in social science, social services, human services, behavioral sciences or an allied field will substitute, year for year, for one year of the experience providing social services to people with developmental disabilities.

Social Worker 3

One year as a Social Worker 2 since July 1, 1988.

OR

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

OR

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

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

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

NOTE: Equivalent social service experience would include the previous classes of Caseworker 3 or higher.

OR

For Promotion Only: A Bachelor's degree and three years of experience as a Caseworker 3, Social Worker 1A or B, Social Worker 2, Casework Supervisor Trainee, Casework Supervisor, Juvenile Rehabilitation Supervisor 1 or 2, or Juvenile Rehabilitation Counselor 2 in State service.

Appendix C: Participant Services

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

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

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

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

(a) Anyone who has unsupervised access to individuals with developmental disabilities and children. This includes volunteers, students, interns, or contracted or licensed staff and state staff.

(b) All department applicants and contracted providers meeting the criteria above are subject to a DSHS Background unit check that includes a Washington State Patrol criminal history check; a check of licensing actions taken by the Dept of Health; and all abuse and neglect registries maintained by Residential Care Services, Adult Protective Services and Children's Administration. Additionally, contracted providers and their staff who have resided in Washington less than three years are required to have fingerprint based FBI checks.

State and federal (FBI) background checks are required on all long-term care workers (as defined in RCW 74.39A.009) for the elderly or persons with disabilities hired or contracted after January 1, 2012.

Children's Administration - Child Protective Services (CPS) investigates all reports of child abuse and neglect when there is an allegation that a child has been abused or neglected by a parent, legal custodian, or guardian of the child; in a DSHS licensed, certified, or state-operated facility; or by persons or agencies subject to childcare licensing, including individuals employed by or volunteers of such facilities. All other investigations are referred to law enforcement.

(c) The state completes a criminal history background investigation prior to directly hiring or contracting with any provider that may have unsupervised contact with a child or vulnerable adult. (DDA Policy 5.01, Background Checks). A copy of the cleared criminal history background investigation must be received by the Department and placed in the contractor file. Contracted agency providers are required to conduct background checks on all of their employees, including all administrators, employees, volunteers, and subcontractors who may have unsupervised access to clients, pursuant to WAC 388-101-3250 and RCW 43.43.830. As part of contract renewal, no less than every 3 years, the Department verifies that contracted individuals continue to pass criminal history background investigations and that contracted agencies are in compliance with the State's background investigation requirements. The DDA employees responsible for conducting criminal history background checks for all individual service providers is limited to six (6) regional contracts managers monitored by the Central Office Contracts Program Manager, which contributes to statewide consistency. The Division of Licensed Resources (DLR) reviews the compliance with this requirement for all licensed residential settings, including those providing respite.
The DSHS entity responsible for retrieving this information and determining whether an applicant's history places them on the Secretary's List of disqualifying crimes is the Background Check Centralized Unit (BCCU). Ultimately, the program or hiring authority will make a decision based on the information that they have received through the BCCU.

The Administration is audited periodically by a number of entities, including the Washington State Auditor's Office, and DSHS Operations Review. The requirement to conduct criminal history background investigations is monitored by these entities due to its importance in reducing risk to clients of the Administration.

(d) Relevant state laws, regulations and policies are:
- RCW 43.43.830 (Washington State Patrol state law concerning definitions of key terms related to background checks)
- RCW 43.43.832 (Washington State Patrol state law concerning disclosure of information related to background checks)
- RCW 43.43.833 (Washington State Patrol state law concerning state immunity for providing background check information)
- RCW 43.43.834 (Washington State Patrol state law concerning liability limits for background checks by business, organizations, or insurance companies)
- RCW 74.15.030 (DSHS state law concerning the powers and duties of the Secretary, including background checks)
- WAC 388-06 (DSHS administrative code concerning background check requirements)
- DSHS Administrative Policy 18.63 (concerning employee background check requirements)

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

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

◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings

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

(a) The entities responsible for maintaining the abuse registry:

Under state authority, RCW 26.44 (state law concerning abuse of children), Child Protective Services (CPS) within the Children's Administration (CA) of the Department of Social and Health Services (DSHS) is responsible for receiving and investigating reports of suspected child abuse and neglect.

Under state authority, RCW 74.34 (state law concerning abuse of vulnerable adults), DDA receives reports and conducts investigations of abuse, neglect, exploitation and abandonment for clients enrolled with the administration. Residential Care Services (RCS) investigates abuse and neglect occurring in nursing homes, adult residential care facilities, adult family homes, & supported living programs. Adult Protective Services (APS) investigates abuse and neglect involving adults residing in their own homes. Both APS and RCS forward final findings of abuse, neglect and exploitation to the DSHS Background Check Central Unit (BCCU).

The BCCU enters the information into their database used to screen all names submitted for a background check.

(b) The types of positions for which abuse registry screenings must be conducted:

Pursuant to WAC 388-06-0110 (concerning who must have background checks) and RCW 74.15.030 (state law concerning the powers and duties of the Secretary of DSHS, including backgound checks), all DDA direct hires and direct contracts which may involve unsupervised access to children or people with developmental disabilities require a background check through the BCCU which includes abuse registry screening.

Prior to providing contracted waiver services, the DSHS requires screening of individuals through the BCCU which includes the abuse registry findings. Per RCW 74.39A.050(8)(state law concerning quality improvement of long-term care services), no provider or staff, or prospective provider or staff, entered into a state registry finding him or her guilty of abuse, neglect, exploitation, or abandonment of a minor or a vulnerable adult as defined in Chapter 74.34 RCW (state law concerning abuse of vulnerable adults) shall be employed in the care of and have unsupervised access to vulnerable adults.

(c) The process for ensuring that mandatory screenings have been conducted:

As part of the background check process, the BCCU cross-checks all potential employees with a CA database that contains information on all individuals with a "found finding" of child abuse and/or neglect. DDA does not directly hire or contract with any provider that may have unsupervised contact with a child or vulnerable adult until a background check is cleared and placed into the individual’s file (DDA Policy 5.01, Background Checks). Contracted agency providers are required to conduct background checks on all of their employees, including all administrators, employees, volunteers, and subcontractors who may have unsupervised access to clients, pursuant to WAC 388-101-3250 (concerning background checks for the staff of certified provides of community residential services and supports) and RCW 43.43.830 (which is state law covering the Washington State Patrol which concerns background checks for those with access to children or vulnerable adults). This is checked again by the state during contract renewal no less than every 3 years.

Appendix C: Participant Services

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

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

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

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

Facility Type	
Child Foster Home	
Licensed Staff Residential	
Child Foster Group Care	

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

The only use of community residential facilities for individuals on this waiver is to provide respite and crisis diversion. These services are temporary in nature. Any facility in which they are provided is not the permanent residence of the individual. Clients' rights are safeguarded through State policy and contractual requirements as well as provider policies. The Individual Support Plan developed for each waiver participant identifies goals for community living. This information is provided to respite agencies to ensure continuity of care.

Licensed staffed residential, child foster homes, and child foster group care facilities serve children and youth and are typical homes located in residential neighborhoods which provide an atmosphere reflective of each individual residents care needs and personality. Requirements to provide individualized and specialized supports, appropriate social and recreational activities within integrated community settings, and maintenance of a home environment reflective of each child's individual preferences are all components contained in the statement of work in each of the above contracts.

Licensed providers work in conjunction with the families to provide a shared parenting model, outlining how the needs of the child will best be met collectively by each participant on the child's team. Children continue to participate in school as their support needs are identified in their Individualized Educational Programs. It is expected that children continue to have access to and are participating members of the community in which they live. Children continue to celebrate all life events that are important to them, much like they would if they were residing in their family home. Parents, siblings, and extended family members are welcome to visit and all homes are located with access to community resources and activities.

Licensed staffed residential, child foster homes, and child foster group care facilities provide full access to typical facilities in a home such as a kitchen with cooking facilities. In addition, children/youth attend school in their local district. The capacity in each of the homes is small and often does not exceed four. In the Child Foster Home and Licensed Staffed Residential Settings, all children/youth have their own bedrooms. Children/youth access medical, dental, and any additional treatment/therapy needs in their community. Children/youth participate in activities in their community (e.g., YMCA, basketball at the school, Special Olympics, concerts, camping, shopping). Staff Provide age appropriate therapeutic instruction and support services for all children and youth to learn ADL's and develop skills towards becoming independent adults. And the child/youth's bedrooms are reflective of things that are important to her/him.

Children/youth in child foster homes and licensed staffed residential settings have their own bedrooms. Children/youth in child foster group care settings do not make choices about who their roommates will be. Parent and/or guardians do have choice in where their son/daughter will receive respite services. Parents and/or guardians have the opportunity to visit available homes based upon location, educational needs, the child's needs, and the needs of the other children in the home. Additionally, there is a regional process that involves collaboration between department staff and paid providers to determine the most appropriate setting that can best support the child and meet her/his individualized needs.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Child Foster Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Personal Care	☐
Specialized Clothing	☐
Behavioral Health Crisis Stabilization Services-Specialized Psychiatric Services	☐
Behavioral Health Stabilization Services-Behavior Support and Consultation	☐
Behavioral Health Stabilization Services-Crisis Diversion Bed Services	☐
Specialized Nutrition	☐
Specialized Psychiatric Services	☐
Respite	☑
Behavior Support and Consultation	☐
Sexual Deviancy Evaluation	☐
Physical therapy	☐
Speech, Hearing, and Language Services	☐
Transportation	☐
Assistive Technology	☐
Specialized Medical Equipment and Supplies	☐
Occupational Therapy	☐
Vehicle Modifications	☐
Staff/Family Consultation and Training	☐
Therapeutic Equipment and Supplies	☐
Nurse Delegation	☐
Environmental Accessibility Adaptations	☐

Facility Capacity Limit:

Capacity is dependent on multiple factors in the home but does not exceed 6.

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑

Standard	Topic Addressed
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed Staff Residential

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Personal Care	☐
Specialized Clothing	☐
Behavioral Health Crisis Stabilization Services-Specialized Psychiatric Services	☐
Behavioral Health Stabilization Services-Behavior Support and Consultation	☐
Behavioral Health Stabilization Services-Crisis Diversion Bed Services	☐
Specialized Nutrition	☐
Specialized Psychiatric Services	☐
Respite	☑
Behavior Support and Consultation	☐
Sexual Deviancy Evaluation	☐
Physical therapy	☐
Speech, Hearing, and Language Services	☐
Transportation	☐
Assistive Technology	☐
Specialized Medical Equipment and Supplies	☐
Occupational Therapy	☐

Waiver Service	Provided in Facility
Vehicle Modifications	☐
Staff/Family Consultation and Training	☐
Therapeutic Equipment and Supplies	☐
Nurse Delegation	☐
Environmental Accessibility Adaptations	☐

Facility Capacity Limit:

Licensing will allow up to 6. DDA contract limits to 4.

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Child Foster Group Care

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Personal Care	☐
Specialized Clothing	☐
Behavioral Health Crisis Stabilization Services-Specialized Psychiatric Services	☐

Waiver Service	Provided in Facility
Behavioral Health Stabilization Services-Behavior Support and Consultation	☐
Behavioral Health Stabilization Services-Crisis Diversion Bed Services	☐
Specialized Nutrition	☐
Specialized Psychiatric Services	☐
Respite	☑
Behavior Support and Consultation	☐
Sexual Deviancy Evaluation	☐
Physical therapy	☐
Speech, Hearing, and Language Services	☐
Transportation	☐
Assistive Technology	☐
Specialized Medical Equipment and Supplies	☐
Occupational Therapy	☐
Vehicle Modifications	☐
Staff/Family Consultation and Training	☐
Therapeutic Equipment and Supplies	☐
Nurse Delegation	☐
Environmental Accessibility Adaptations	☐

Facility Capacity Limit:

Capacity is dependent on facility size. The largest is licensed for 20.

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

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

Appendix C: Participant Services

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

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

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

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

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

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

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

The following limitations apply to natural, step, or adoptive parent providers for CIIBS waiver services:
(1) If the client is under age eighteen, their natural, step, or adoptive parent cannot be their paid provider for any waiver service.
(2) If the client is age eighteen or older, their natural, step, or adoptive parent cannot be their paid provider for any waiver service with the exception of:
(a) Personal care;
(b) Transportation to a waiver service; or
(d) Respite care for the individual if they and their parent live in separate households.

Other relatives and legal guardians are limited to the paid provision of personal care, respite, and transportation. Personal care and respite limits are determined by the assessment. A guardian would not be paid to provide his/her own respite. Transportation limits are determined by need after available state plan and EPSDT benefits are first utilized. Medical transportation for children is not waiver funded, as the state has determined that it is the responsibility of the parent/guardian to transport a minor child to medical appointments.

For these specific services, it is often in the best interest of the client for a relative or guardian to be the paid provider. Guardians possess detailed knowledge of the child/youth in their care and have stepped in when a parent has been unable for any number of reasons to provide this care. The provision of personal care and transportation services by the guardian or relative allows a person familiar with the client to perform personal and familiar tasks, assists to stabilize the household, and ensures that the child is able to access waiver services when other means of transportation are unavailable. Guardians and relatives fill an important personal care provider niche when sufficient provider resources are lacking.

The following controls are in place to ensure payments are made only for services rendered:
• Annual Individual Support Plans
• CRM monitoring of plan
• Annual ISP audits
• National Core Indicator interviews
• Individual Support Plan surveys

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

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

○ **Other policy.**

Specify:

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

The State of Washington allows for continuous open enrollment of qualified providers. Provider qualifications are available to the public on-line per Washington Administrative code (WAC). Waiver enrollees may select providers at any time during the waiver year.
Qualified providers will be able to enroll at any time during the waiver year and on an ongoing basis. Providers contracted for CIIBS service providers will also be eligible to work with children and youth served by other federal and state programs. Qualifying and enrolling a provider typically takes from 30 to 90 days.

The state's strategy for recruiting providers includes: publicizing information about the program through the internet; networking through advocacy groups; distributing public flyers and a public podcast; giving community presentations; publishing a request for information in newspapers around the state, at colleges and universities, and other community settings.

In addition, the Home Care Quality Authority (HCQA-an agency of Washington State government) operates the Home Care Referral Registry to match the needs of Washington State residents who are eligible for Medicaid in-home care services with pre-screened and pre-qualified providers. In support of the Registry, the HCQA operates Home Care Referral Registry Centers, which are actual offices across Washington State that a client or potential provider can visit or contact by telephone or e-mail. Individuals that wish to become providers can register and be on the Home Care Referral Registry, and clients can use the Registry to find qualified providers.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
C.a.1: The percentage of residential service providers requiring licensure that have initially met and continue to meet licensing requirements prior to the provision of waiver services, as verified by Children's Administration. Numerator: Providers that initially met and continue to meet licensing requirements Denominator: All residential service providers that require licensing

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

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

DSHS/Children's Administration/Division of Licensed Resources		Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
C.a.2 The percentage of supported living providers requiring certification, who initially met and continued to meet DDA contract standards, which include appropriate certification. N= All supported living providers that met certification standards. D= All supported living providers.

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

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

☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Compliance Coordinator (QCC) Team within DDA.	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Comparison of claims data and contract records

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
C.b.1 The percentage of waiver files reviewed for which all authorized providers met DDA contract standards. N= All files reviewed for which 100% of authorized providers met contract standards. D: All files reviewed for compliance with contract standards.

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

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

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Compliance Coordinator (QCC) Team within DDA.	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Comparison of claims data and contract records

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

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

Data Aggregation and Analysis:

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

Performance Measure:
C.b.2: The percentage of non-licensed/non-certified waiver service providers who initially met and continued to meet DDA contract standards. N= All non-licensed/non-certified waiver service providers who initially met and continued to meet DDA contract standards. D= All non-licensed/non-certified waiver service providers.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
C.b.3 The percentage of waiver participants and family members responding to the National Core Indicators survey who indicated satisfaction with the performance of their service providers. N: Waiver participants responding to the NCI survey with provider performance satisfaction D: Waiver participants responding to the NCI survey

Data Source (Select one):

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Performance Measure:
C.c.1: The percentage of case file reviews, for which authorized providers met state training requirements as verified by valid licenses and contracts. N= Files reviewed for which an authorized provider met state training requirements. D= All files reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Compliance Cordinator (QCC) Team within DDA.	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
C.c.2 The percentage of licensed waiver service providers who meet state training requirements as verified by valid licenses and contracts. N= Waiver service providers requiring licensure who meet state training requirements. D= Waiver service providers requiring licensure and training.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Agency Contract Database

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

Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
C.c.3: The percentage of waiver service providers who don't require licensure who meet state training requirements as verified by valid contracts. N= All providers of waiver services who don't require licensure who meet state training requirements as verified by valid contracts. D= All providers of waiver services who don't require licensure.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Agency Contract Database

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

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
C.a.1; C.a.2; C.b.2; and C.c.3: The Contracts Program Manager produces an annual report comparing claims data against the Agency Contracts Database (ACD) to verify that providers of service to all waiver participants meet contract standards, including licensure and other requirements, as verified by a valid contract.

C.c.2 and C.c.3: DDA maintains provider contract records in the Agency Contracts Database (ACD) that verifies providers have met ongoing training requirements prior to contract renewal. ACD reports are run annually to verify completion of training requirements.

C.b.1. and C.c.1: The Quality Compliance Coordinator (QCC) Team completes a review of randomly selected files across all waivers on an annual basis. The list for the QCC Team review is generated to produce a random sample with a 95% confidence level and a confidence interval of +/-5%. The findings from these reviews are collected in a database. All findings are expected to be corrected within 90 days. Corrections are monitored by QCC Team members.

As a part of the QCC review, the team checks to see that providers of service to waiver participants continue to meet contract standards, which include appropriate licensure, certification and other standards including training requirements, as verified by a valid contract in the Agency Contracts Database.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Contract Reports:
C.a.1; C.a.2; C.b.2; C.c.2; and C.c.3:
The results of the annual report comparing claims data against the ACD are shared with the regions for immediate follow up. Providers without a valid contract or the necessary training requirements are reviewed to determine the appropriate course of contract action. Services are terminated for those without valid contracts.

QCC Waiver File Reviews:
C.b.1. and C.c.1:
Individual findings are expected to be corrected within 90 days. Regional management and QCC are available to provide individualized support and assistance with these corrections. QCC staff monitors to ensure corrections occur.

Next, findings are analyzed by DDA management. Based on the analyses, additional necessary steps are taken. For example:
- *Annual staff Waiver Training curriculum is developed and/or modified.
- *Policies are clarified.
- *Personnel issues are identified and addressed.
- *Form format and instructions are modified.
- *Waiver administrative code (WAC) is revised.
- *Regional processes are revised.

C.b.3: The National Core Indicators Survey:

Washington State's Developmental Disabilities Administration (DDA) participates in a national study that assesses performance and outcome indicators for state developmental disabilities service systems. This study allows the division to compare its performance to service systems in other states and within our state from year to year.
There are currently 60 performance and outcome indicators to be assessed covering the following domains:
- Consumer Outcomes
- System Performance
- Health, Welfare, & Rights
- Service Delivery System Strength & Stability

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making

exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

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

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

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

1. Washington State submitted their Statewide Transition Plan for New HCBS Rules on March 6th, 2015. In the Transition Plan, the state documented the results of the state assessment of HCBS settings. From the Transition plan:

"ALTSA and DDA reviewed the requirements for HCBS settings and identified settings that fully comply with the requirements, settings that will comply with the requirements after implementing changes, and settings that do not or cannot meet the HCBS requirements. The review included (1) an analysis of (a) state laws, (b) rules, (c) policies, (d) processes, and (e) forms/tools in relation to the new federal HCBS requirements and (2) an identification of changes that are necessary to achieve and maintain compliance with the federal HCBS requirements. The state solicited input from the state Long-Term Care Ombuds, stakeholders, and clients as part of this analysis. The state conducted on site visits of all adult day service centers, all settings presumed to be institutional, all group training homes, and one residential setting identified by a stakeholder as potentially not meeting the characteristics of an HCB setting. The review details are in the appendices."

Settings that fully comply with HCBS Characteristics for participants on the CIIBS Waiver: (1) in home; (2) community healthcare providers; (3) dental providers; (4) behavioral health crisis bed diversion services; (5) specialized psychiatric services; (6) behavior support and consultation; (7) community crisis stabilization services; (8) vehicle modification

providers; and (9) transportation providers

Each setting was evaluated against the HCBS characteristics including: (1) The setting is integrated in, and supports full access of individuals receiving Medicaid HCBS to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS; (2) The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting; (3)An individual's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected; (4) Individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented; (5) Individual choice regarding services and supports, and who provides them, is facilitated; (6) Individuals have a choice of roommates in the setting; (7) Individuals have the freedom to furnish and decorate their sleeping or living units; (8) Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time; (9) Individuals are able to have visitors of their choosing at any time; (10) The setting is physically accessible to the individual; (11) The unit or room is a specific physical place that can be owned, rented or occupied under another legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law of the State, county, city or other designated entity.

2. The State reviews these settings at least annually during the LOC assessment to ensure that services are being delivered in an environment that meets State and federal HCBS requirements.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Individual Support Plan (ISP)

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

- ☐ **Registered nurse, licensed to practice in the State**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☑ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

  Specify qualifications:

- ☑ **Social Worker**

  Specify qualifications:

  Please see B-6-c.
- ☐ **Other**

  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Approximately 60 days prior to the Individual Support Plan the Case Resource Manager(CRM)/Social Service Specialist contacts the individual and his/her representative by phone and letter. To aid them in their assessment planning and scheduling, case managers and their supervisors run monthly caseload reports that show each individual's next ISP date.

During the phone conversation the CRM/Social Service Specialist describes the Individual Support Plan process and confirms per policy 5.02 (Necessary Supplemental Accommodation) the individual has an identified representative. In addition, the individual is asked who else they would like to have participate and/or contribute and where they would like the face-to-face ISP meeting to be held. Support is provided as needed to ensure the service plan development process is driven by the waiver participant.

The letter the CRM/Social Service Specialist sends serves to confirm the date, time and location of the meeting and includes the DDA HCBS Waiver Brochure. The DDA HCBS Waiver Brochure includes information about waiver services, eligibility criteria and administrative hearing rights. The CRM/Social Service Specialist also extends invitations by phone and/or letter to individuals who the waiver participant has asked to participate in the ISP process. In addition, the waiver participant is provided access to person centered planning tools that they can review and use prior to the meeting. Support is available to assist the individual to review and/or use those tools.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The Individual Support Plan (ISP) is the planning document produced for all clients receiving paid services, including waiver participants.

The DDA Assessment provides:

-An integrated, comprehensive tool to measure support needs for adults and children.

-A work process to support case management services because the system:

- o Identifies The level of support needed by a client;
- o Indicates whether a service level assessment is needed; and
- o Documents the paid and unpaid services the waiver participant will receive.

-Detailed information regarding client needs in many life domains.

This allows ase managers to make more effective service referrals.
-Documentation of health and welfare needs which are automatically populated in the ISP as needs that must be addressed.
-Clearer information for executive management and legislators on the overall needs of people with developmental disabilities.
-A nationally normed assessment for adults developed by the AAIDD.
-A mechanism to identify and record the individual's personal goals.

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

-The individual waiver participant directs the overall process of ISP development.
-Development of the Individual Support Plan (ISP) is facilitated by the DDA Case Resource Manager (CRM)/ Social Service Specialist.
-Participants or contributors to the plan in addition to the individual and the individual's representative may consist of
anyone else the individual would like to have participate or contribute (family, friends, providers, etc...)
-The ISP is completed at least once every 12 months. Planning for the ISP begins 60 days in advance of the due date.

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

The DDA Assessment which is administered by the DDA CRM/Social Service Specialist provides the internal assessment and contains the following modules which assess for participant needs, preferences, goals and health status.

1. The Support Assessment module contains:
   a. The Supports Intensity Scale Assessment (which includes the ICF/ID Level of Care for individuals age 16 and above);
   b. ICF/ID Level of Care Assessment for individual age 15 and under;
   c. Protective Supervision Scale;
   d. Caregiver Status Scale;
   e. Current Services Scale;
   f. SIS Behavior Scale; and
   g. SIS Medical Scale.

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

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

4. The Supports Intensity Scale (SIS) Assessment contains the following scales:

a. Support needs;
b. Supplemental protection and advocacy;
c. Exceptional medical support needs; and
d. Exceptional behavioral support needs.

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

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

Participants are informed of services available under the Waiver by:
1. The DDA HCBS Waiver Brochure which is enclosed with the letter confirming the ISP meeting. The letter and brochure are sent approximately 60 days prior to the ISP meeting. The DDA HCBS Waiver Brochure identifies waiver services.
2. During the course of the ISP meeting service options are discussed and described.
3. Washington Administrative Code (WAC) fully defines services available under the waiver and is made available upon request and via the DDA internet Website.

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

 Participant goals:
o There is a screen in the DDA assessment that requires the documentation of participant goals, if those goals are shared with the CRM/Social Service Specialist.

Participant needs (including health care needs):
o Health and welfare needs are identified throughout the course of the assessment on multiple screens (please see section b above). Health and welfare needs are also identified by additional documentation submitted as part of the ISP process (i.e. medical reports).

Preferences:
o Participant preferences are identified throughout the assessment and planning process. These are documented in the body of the assessment and in the ISP.

(e) How Waiver and other services are coordinated:

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

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

 The assessment identifies health and welfare needs.
o The identified needs populate the ISP.
- Business rules require each identified need is addressed by a waiver, non-waiver, and/or non-paid service.
o When an identified need requires a Waiver funded service the

CRM/Social Service Specialist is required to identify the specific provider and the service type that will address this need.
- The CRM/Social Service Specialist is required to provide sufficient documentation to allow the provider and the participant to know what the provider responsibilities are.

o When an identified need is addressed by a non-paid service, the CRM/Social Service Specialist identifies the responsiblse party in the ISP.
o When a provider or service to address specific needs has not been identified, the plan reflects the steps in place to identify either the service or the provider.
- Whenever the service or provider is identified the ISP is amended to reflect the updated plan.

The CRM/Social Service Specialist provides oversight and monitoring of the ISP, including both paid and non-paid services.

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

o An individual may request a review of his/her ISP at any time by calling his/her case manager. If there is a significant change in conditions or circumstances, DDA must reassess the plan and amend the plan to reflect any significant changes. This reassessment does not affect the end date of the annual ISP.

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

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

ISP amendment With new assessment
o Change in status of client in key domain (behavior, medical, caregiver, ADL, etc.)
o Change of provider for residential service (the individual's residence changes)
o Change in a paid service

ISP amendment without new assessment
o Change in demographic information only.
o Change in the assistance available.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

The DDA Assessment evaluates risk by assessing for the following:
- *Unstable/potentially unstable diagnosis
- *Caregiver training required
- *Medication regimen affecting plan
- *Immobility issues affecting plan
- *Nutritional status affecting plan
- *Current or potential skin problems
- *Skin Observation Protocol
- *Alcohol/Substance Abuse
- *Depression
- *Suicide
- *Pain
- *Mental Health
- *Legal
- *Environmental
- *Financial
- *Community Protection
  - Community Protection criteria have been developed to identify clients not already on the CP waiver, but who are exhibiting some extreme behaviors that could pose a public safety threat.

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

Emergency planning is an required component of the ISP. Back up caregivers and emergency contacts are identified during the waiver participant's assessment and can be updated at any time. Back up and emergency plans are required in WAC for all residential providers. Arrangements for back-up plans vary from individual to individual. In some situations a back-up plan may be a family member. In others, a back up plan may include a paid provider stepping in to assure health and welfare needs are addressed during times of crisis.

WAC 388-828-1640
What are the mandatory panels in your DDA assessment?
After DDA has determined your client group, DDA determines the mandatory panels in your DDA assessment using the following tables. An "X" indicates that the panel is mandatory; an "O" indicates the panel is optional. If it is blank, the panel is not used.

(1) DDA "Assessment main" and client details information

	Client Group			
	Waiver and State	Other Medicaid	State Only	
DDA Assessment Panel Name	No Paid Services	Only Residential	Paid Services	Paid Services
Assessment Main	X	X	X	X
Demographics	X	X	X	X
Overview	X	X	X	X
Addresses	X	X	X	X
Collateral Contacts	X	X	X	X
Financials	X	X	X	X

(2) Supports intensity scale assessment

	Client Group			
	Waiver and State	Other Medicaid	State Only	
DDA Assement Panel Name	No Paid Services	Only Residential	Paid Services	Paid Services
Home Living	X	X	X	X
Community Living	X	X	X	X
Lifelong Learning	X	X	X	X

Employment	X	X	X	X
Health & Safety	X	X	X	X
Social Activities	X	X	X	X
Protection & Advocacy	X	X	X	X

(3) Support assessment for children

	Client Group			
	Waiver and State	Other Medicaid	State Only	
DDA Assessment Panel Name	No Paid Services	Only Residential	Paid Services	Paid Services
Activities of Daily Living	X	X	X	X
IADLs (Instrumental Activities of Daily Living)	X	X	X	X
Family Supports	X	X	X	X
Peer Relationships	X	X	X	X
Safety & Interactions	X	X	X	X

(4) Common support assessment panels

	Waiver and State	Other Medicaid	State Only	
DDA Assessmentd Panel Name	No Paid Services	Only Residential	Paid Services	Paid Services
Medical Supports	X	X	X	X
Behavioral Supports	X	X	X	X
Protective Supervision	X	X	X	X
DDA Caregiver Status*	X	X	X	X
Programs and Services	X	X	X	X

*Information on the DDA Caregiver Status panel is not mandatory for clients receiving paid services in an AFH, BH, SL, GH, SOLA, or RHC.

(5) Service level assessment panels

	Waiver and State	Other Medicaid	State Only	
DDA Assessment Panel Name	No Paid Services	Only Residential	Paid Services	Paid Services
Environment	X	X	O	
Medical Main	O	X	O	
Medications	X	X	X	
Diagnosis	X	X	X	
Seizures	X	X	X	
Medication Management	X	X	X	
Treatments/programs	X	X	X	
ADH (Adult Day Health)	O	O	O	
Pain	X	X	X	
Indicators-Main	O	X	O	
Allergies	X	X	X	
Indicators/Hospital	X	X	X	
Foot	X	X	O	
Skin	X	X	O	
Skin Observation	O	O	O	
Vitals/Preventative	X	X	O	
Comments	O	O	O	
Communication-Main	O	X	O	
Speech/Hearing	O	X	O	
Psych/Social	O	X	O	
MMSE (Mini-Mental Status Exam)	O	X	O	
Memory	O	X	O	
Behavior	O	X	O	
Depression	O	X	O	
Suicide	O	O	O	
Sleep	O	O	O	
Relationships & Interests	O	O	O	
Decision Making	O	X	O	

Goals	X	O	O	
Legal Issues	O	O	O	
Alcohol	O	O	O	
Substance Abuse	O	O	O	
Tobacco	O	X	O	
Mobility Main	O	X	O	
Locomotion In Room	O	X	O	
Locomotion Outside Room	O	X	O	
Walk in Room	O	X	O	
Bed Mobility	O	X	O	
Transfers	O	X	O	
Falls	O	O	O	
Toileting-Main	O	X	O	
Bladder/Bowel	O	X	O	
Toilet Use	O	X	O	
Eating-Main	O	X	O	
Nutritional/Oral	O	X	O	
Eating	O	X	O	
Meal Preparation	O	X	O	
Hygiene-Main	O	X	O	
Bathing	O	X	O	
Dressing	O	X	O	
Personal Hygiene	O	X	O	
Household Tasks	O	X	O	
Transportation	O	X	O	
Essential Shopping	O	X	O	
Wood Supply	O	X	O	
Housework	O	X	O	
Finances	O	O	O	
Pet Care	O	O	O	
Functional Status	O	O	O	
Employment Support*	X*	X*	X*	
Mental Health	X	X	X	
DDA Sleep*	X*	O	O	

*Indicates that:

(a) The "Employment Support" panel is mandatory only for clients age twenty-one and older who are on or being considered for one of the county services listed in WAC 388-828-1440(2).

(b) The "DDA Sleep" panel is mandatory only for clients who are age eighteen or older and who are receiving:

(i) DDA HCBS Core or Community Protection waiver services; or

(ii) State-Only residential services.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Participants are given free choice of all qualified/approved providers of each service approved in his/her plan. During the course of the ISP process the waiver participant is advised s/he have a choice of providers. The assessment meeting includes an Asessment Wrap-up checklist that the client and/or her/his representative signs. One of the items on the checklist is a statement verifying that the individual understands that s/he has a choice of and can change provider(s). Also, at the time of the annual individual support plan (ISP) update, participants have an opportunity to select alterantive providers. Waiver participants can also select alterantive providers at any time by requesting an update of their ISP.

The Case Resource Manager (CRM)/Social Service Specialist provides information to access appropriate referral registries, contract database list and/or websites to facilitate access to provider lists and assist with the contracting process.

In-home Respite:

All individual's can contact the Home Care Referral Registry to access an individual respite provider. DDA provides waiver participant's the contact information to the Referal registry or information can be accessed from the internet Home Care Referral Registry website @http://www.hcrr.wa.gov/

- *The Home Care Referral Registry is maintained by the Home Care Quality Authority. The Registry provides information about available Individual providers (IPs) in a geographic areas who are interested in beinginterviewed for potential hire.
- *DDA provides lists of agencies contracted to provide in-home services and families choosing an agency, work with agency staff to select individuals to work in their homes.

- *Other Provider types
  - o Lists of provider of specific services can be generated out of the Agency Contracts Data Base (ACD) maintained by DSHS. Provider recruitment is ongoing and contract referrals are accepted on a continual basis.
  - o The ALTSA Internet page maintains provider lists for Adult Family Home and Adult Residential Care Facilities.
  - o The DDA Internet page maintains a supported living provider locator.
  - o Contractors for Environmental Adaptations are listed by Labor & Industries, along with information about their licenses and any actions taken against them. Families may choose from this broad list of contractors and refer them to DDA for contracting. DDA also maintains a list of contractors.
  - o ProviderOne maintains an online search engine open to the public for providers of therapy, counseling, and other services.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The Developmental Disabilities Aadministration (DDA) operates a number of quality assurance (QA) processes that ensures that person-centered individual service plans meet the needs of waiver participants. At the end of each QA review cycle, a final report is generated which includes detailed data on a statewide level. These results are analyzed and incorporated into a statewide quality improvement plan. The State Medicaid Agency receives annual QA review reports and meets with the operating agency at the conclusion of the QA cycle to review results and provide input into the quality improvement plan. The quality improvement plan is then reviewed and approved for implementation by DDA executive management. This is part of a total Quality Improvement Strategy (QIS), which includes surveys, file reviews, performance measures, ternary evaluations of performance measures, and staff training.

More detail on QA processes as they relate to the individual support plan is provided below.

The mechanism for ongoing oversight of waiver operation by the Single State Medicaid Agency is the HCA Medicaid Agency Waiver Management Committee, which includes representatives from administrations and divisions within the operating agency, Home and Community Services and Residential Care Services, which are divisions within the operating agency, as well as the Developmental Disabilities Administration (DDA) and the Behavioral Health and Service Integration Administration (BHSIA). The Committee meets at least quarterly to review all functions delegated to the operating agency, current quality assurance activity, pending waiver activity (e.g. amendments, renewals, etc.), potential waiver policy and rule changes and quality improvement activities.

The Developmental Disabilities Administration is an administration within the Department of Social and Health Services (DSHS), which is the operating agency. The individual case manager/Social Service Specialist is an employee of DDA. DDA determines client eligiblity and requires the use of the administration's electronic assessment and service planning tool. DDA case managers/Social Service Specialists directly authorize all initial service plans and supervisors conduct quality assurance activities on service plans. DDA has direct electronic access to all service plans.

DDA has a comprehensive monitoring process to oversee the planning process and the individual support plan (ISP). In addition, DDA participates in the National Core Indicators Survey and initiates an ISP survey. Data is gathered and analyzed and necessary steps are taken to correct areas of concern.

DDA monitoring process:

The DDA Quality Compliance Coordinator(QCC) Team completes an annual audit of randomly selected files. The list for the QCC team audit is generated to produce a random sample with a 95% confidence level and a +/- 5 confidence interval. Included in the review are items concerning the person-centered planning process and content of the ISP.

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

- * Annual Waiver Training curriculum is developed in part to address review findings.
- * Policy clarifications are issued.
- * Personnel issues are identified.
- * The format of and instructions on forms are modified.
- * Waiver WAC is revised to clarify rule.
- * Regional processses are updated.

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

There are currently 47 performance and outcome indicators to be assessed covering the following domains:

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

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

An Assessment meeting wrap-up form is given to each waiver participant at the conclusion of the ISP planning meeting. This form gives participants an opportunity to respond to a series of questions about the ISP process.

A ISP Meeting survey is mailed to waiver participants within one month of the ISP planning meeting. This survey gives participants an opportunity to respond to a series of questions about the ISP process. The survey is mailed from Central Office based on a random sample representative of each waiver with a 95% confidence level and a confidence interval of +/-5%. Information collected is analyzed annually by the HCA Medicaid Agency Waiver Management Committee.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

- [x] **Medicaid agency**
- [x] **Operating agency**
- [x] **Case manager**
- [ ] **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

The regional DDA Case Resource Manager (CRM) or Social Service Specialist provides the primary oversight and monitoring of the ISP. The DDA CRM or Social Service Specialist authorizes the Waiver Services identified as necessary to meet health and welfare needs in the ISP. The DDA CRM or Social Service Specialist monitors service provision no less than two times per year by at least one face to face client visit and an additional contact with the waiver participant/legal representative which can be completed by telephone, e-mail or face to face. Continuous monitoring also occurs by contacting providers; reviewing progress reports submitted by providers and reviewing additional assessments (e.g. IEP□s, psychological evaluations, Occupational Therapy evaluations etc.). If the DDA CRM or Social Service Specialist finds that the ISP is not meeting the individual's needs the ISP will be revised/amended. All monitoring is documented in either the Service Episode Record section of the electronic DDA Assessment or the Waiver Screen.

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

In addition to DDA CRM/Social Service Specialist monitoring activities, the following occur:

* A sample of waiver case files is reviewed by Quality Compliance Coordinators.
  - o Quality Compliance Coordinators review annually a statewide random sample of waiver files.
  - o Waiver case files are reviewed for the following evidence:

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

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

Currently 47 performance and outcome indicators are assessed that cover the following domains:

□ * Consumer Outcomes
□ * System Performance
□ * Health, Welfare, & Rights

- * Service Delivery System Strength & Stability

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

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

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

Assessment Meeting Wrap-up and ISP Survey:
An Assessment Meeting Wrap-up is given to each waiver participant at the conclusion of the ISP planning meeting. The Wrap-up survey gives participants an opportunity to respond to a series of questions about the ISP process. And after the assessment is finalized, Central Office sends an ISP survey to a stastically-valid random sample of waiver participant with a return envelope to allow for an anonymous submission to Central Office.

Questions on the ISP survey:
- * Did you get to choose who came to your meeting?
- * Did your Case Manager discuss any concerns you have with your current services?
- * Were your concerns addressed in your new support plan?
- * Did you receive information about what services are available in your waiver to meet your assessed needs?
- * Were you given a choice of services that are available in your waiver to meet your identified needs?
- * Were you given a choice of service providers?
- * Were your personal goals discussed in developing your plan?
- * Do you feel like your health concerns are addressed to your satisfaction?
- * Do you feel like your safety concerns are addresssed adequately?
- * Did you receive information regarding planning for emergencies, such as an earthquake or other natural disaster?
- * Do you know who to contact if your needs change before the next assessment?
- * Do you know you have a right to appeal decisions made by DDA?
- * Did your case manager explain how to use your Planned Action Notice (PAN) to appeal a service decision in your support plan if you disagree with that decision?

Residential Care Services (RCS) certifies DDA residential providers and licenses adult family homes and boarding (broup)homes, all of which are qualified providers of respite services.
- o These providers are evaluated at a minimum of every two years.
- o A component of the RCS evaluation process is a review of the ISP to ensure the agency is implementing the plan as written.

b. Monitoring Safeguards. *Select one:*

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

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
D.a.1: The percentage of Individual Support Plans (ISPs) conducted for waiver participants that address their assessed health and welfare needs through the provision of wvr svcs or other means. Numerator: Waiver participants' ISPs reviewed that address all assessed health and welfare needs through the provision of waiver svcs or other means. Denom: Reviewed waiver participants' ISPs.

Data Source (Select one):
Other
If 'Other' is selected, specify:
This requirement is system-enforced by CARE.

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D.a.2: The percentage of Individual Support Plans (ISPs) conducted for waiver participants that personal goals are identified. Numerator: Waiver participants with identified personal goals addressed in their service plan. Denominator: Total number of waiver participants.

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

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

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D.a.3 To monitor ongoing waiver eligibility, the percentage of ISPs with monthly waiver service provision or monitoring by the case manager during a break in service. N= Waiver ISPs reviewed with monthly waiver service provision or monitoring by the case manager during a break in service. D= All Waiver ISPs reviewed.

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

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

collection/generation *(check each that applies):*		
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Compliance Coordinators (QCC) Team	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

D.a.4 The percentage of waiver recipients' ISPs with critical indicators triggered in the assessment that were addressed in the ISP. N= Number of ISPs in which all identified critical indicators were addressed. D= Total number of waiver recipients ISPs.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
D.a.5: The percentage of all waiver ISPs which include emergency planning. N= All waiver ISPs with evidence of emergency planning present. D= All waiver IPSs reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Compliance Coordinators (QCC) Team	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D.a.6: The percentage of families reporting through NCI surveys that they are involved in the creation of their waiver participant's ISP. N= All waiver participants or family members responding to the NCI survey and reporting involvement in the creation of the ISP. D= All waiver participants or waiver participant family members responding to the NCI survey.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: National Core Indicators Survey	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

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

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

Performance Measure:
D.c.1: The percentage of annual Individual Support Plans (ISPs)for waiver participants that are completed before the end of the twelfth month following the initial ISP or the last annual ISP. Numerator: All ISPs for waiver participants completed before the end of the twelfth month. Denominator: All waiver ISPs completed.

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

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

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

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

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Compliance Coordinator (QCC) Team within DDA.	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D.c.2: The percentage of waiver participants and family members responding to the ISP Meeting Survey who report knowing what to do if their needs change before the next annual ISP meeting. Num: All ISP Meeting Survey respondents

who report knowing what to do if their needs change before the next ISP Denom: All waiver participants and family members responding to the ISP Meeting Survey

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

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
D.d.1 The percentage of waiver participants and family members responding to the NCI survey who report satisfaction with the development and implementation of their ISPs. Numerator: All waiver participants reporting satisfaction regarding the development and implementation of their ISPs. Denominator: All waiver participants and family members responding to the NCI surveys

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other**	☐ **Annually**	

Specify: Quality Assurance Team within DDA.		☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D.d.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. Numerator: All waiver ISPs with services delivered in accordance with the ISP specifications Denominator: All waiver ISPs reviewed

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

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

☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Compliance Coordinator (QCC) Team within DDA.	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D.d.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. Numerator: All waiver ISPs with services delivered within 90 days or as specified in the ISP Denominator: All waiver ISPs reviewed

Data Source (Select one):

Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Compliance Coordinator (QCC) Team within DDA.	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
D.d.4: The percentage of waiver ISPs with service authorizations in place for waiver funded services that should have occurred in the last 3 months. Numerator: All waiver ISPs with service authorizations for waiver funded services that should have occurred in the last 3 months Denominator: All waiver ISPs reviewed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Compliance Coordinator (QCC) Team within DDA.	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
D.e.1: The percentage of waiver participant records that contain the annually updated ISP Wrap-up, which includes verification that the waiver participant accepts waiver services in the community in lieu of an institution. Numerator: All waiver participant records reviewed that included the annual ISP Wrap-Up. Denominator: All waiver participant records reviewed.

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

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

		Confidence Interval = 95%
☑ **Other** Specify: Quality Compliance Cordinator (QCC) Team within DDA.	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D.e.2: The percentage of waiver participant records that contain the annually updated ISP Wrap-up, which includes verification that the waiver participant had a choice of qualified providers and if not satisfied was able to select another qualified provider. Numerator: All waiver participant records reviewed that included the annual ISP Wrap-Up. Denominator: All wvr participant records reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Compliance Coordinator (QCC) Team within DDA.	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

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

		Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 100% of those responding to the ISP Meeting Survey
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
D.a.1; D.a.3; D.a.4; D.a.5; D.c.1; D.d.1; D.d.2; D.d.3; D.d.4; D.e.1; D.e.2
The QCC Team completes an audit of randomly selected files on a waiver-specific basis across a two-year period. The list for the QCC Team audit is generated to produce a random sample representative of each waiver with a 95% confidence level and a confidence interval of +/-5%. The findings from these reviews are collected in a database. All findings are expected to be corrected within 90 days. Corrections are monitored by QCC Team members.

A valid sample is produced for the QCC audit. The remaining file review is strictly an additional measure to assist with ongoing quality assurance.

The audit protocol includes (among others) the following questions with a target of 100% compliance.

"Have all identified waiver funded services been provided within 90 days of the annual ISP effective date?"
"Is there a SSPS or County authorization for all Waiver funded services identified in the current ISP that should have occurred in the three (3) months prior to this review?"
"Are all the current services authorized in SSPS or CMIS/County Services Screen identified in the ISP?"
(Authorizations are audited as a proxy for claims data. The SSPS electronically prevents a provider from claiming payment for an amount and rate higher than what is authorized.)
"Are the authorized service amounts equal or less than the amounts identified in the ISP?"
"Is the effective date of this year's annual ISP no later than the last day of the 12th month of the previous annual ISP effective date?"
"Is there evidence that the Wrap-Up discussion occurred at the DDA annual or initial assessment?
"Is there a signed Voluntary Participation statement from the annual or initial assessment in the client file?"

D.a.2: The DDA assessment allows for entry and addressing of personal goals. An annual report is generated at Central Office to identify assessments with one or more personal goals to verify personal goals are acknowledged and addressed.

Data are available in a computer-based system which provide 100% analysis of individual results.
D.a.5: An annual report is created to verify that emergency plans are documented in waiver participants' ISPs.
D.a.6: DDA compares data on response rates to NCI questions and responses from waiver year to waiver year. DDA constructs pie charts for questions and analyzes the outcome of the survey with the HCA Medicaid Agency Waiver Management Committee and stakeholders. DDA uses this information to assist with the development of the Waiver training curriculum as well as to develop needed policy changes.

D.c.1: Monthly reports are prepared for a review of the progress toward achieving 100% timely assessments of need. The data is analyzed by comparing the actual number of assessments completed on time to the regional monthly targets and to the assessments that were due. Regional Waiver Coordinators review Assessment Activity Reports on a monthly basis and send information to case managers for follow-up to promote timeliness of assessments.

D.c.2: ISP Meeting Survey:
A ISP Meeting survey is mailed to waiver participants within one month of the ISP planning meeting. This survey gives participants an opportunity to respond to a series of questions about the ISP process. The survey is mailed from Central Office based on a random sample representative of each waiver with a 95% confidence level and a confidence interval of +/-5%. Information collected is analyzed annually at the HCA Medicaid Agency Waiver Management Committee.
Question: "Do you know who to contact if your needs change before the next assessment?

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Waiver File Reviews (Annual QCC audit):
D.a.1; D.a.3; D.a.4; D.a.5; D.c.1; D.d.1; D.d.2; D.d.3; D.d.4; D.e.1; D.e.2
Findings from QCC Team and Supervisor file reviews are analyzed by management, and based on the analysis necessary steps are taken to increase compliance. For example:
- Annual Waiver Training curriculum is developed in part to address audit findings.
- Policy clarifications occur as a result of audit findings.
- Analyses of findings assist regions to recognize personnel issues.
- Analysis of audit finding may impact format and instructions on forms.
- Analysis of findings has led to revision in Waiver WAC to clarify rule.
- Analysis of findings has led regions to revise regional processes.

The National Core Indicators Survey:
D.a.6;
Washington State's Developmental Disabilities Administration (DDA) participates in a national study that assesses performance and outcome indicators for state developmental disabilities service systems. This study allows the administration to compare its performance to service systems in other states and within our state from year to year.

There are currently 60 performance and outcome indicators to be assessed covering the following domains:
• Consumer Outcomes
• System Performance
• Health, Welfare, & Rights
• Service Delivery System Strength & Stability

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

ISP Meeting Survey:
D.c.2:
DDA compares data on response rates to the ISP Meeting Survey and responses from waiver year to waiver year. DDA constructs pie charts for questions and analyzes the outcome of the survey with the HCA Medicaid Agency Waiver Management Committee and stakeholders. DDA uses this information to assist with the development of the Waiver training curriculum as well as to develop needed policy changes.

• Annual Waiver Training curriculum is developed in part to address audit findings.
• Policy clarifications occur as a result of audit findings.
• Analysis of audit finding may impact format and instructions on forms.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

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

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

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

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

- ( ) **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

a) The nature of the opportunities afforded to participants:

 Participants who receive personal care services have employer authority and are considered the common law employer.

(b) How participants may take advantage of these opportunities:

 All participants have the option of accessing agency services or becoming the employer of record for an individual provider. If the waiver recipient chooses to hire an individual provider they are considered the common law employer.

(c)The entities that support individuals who direct their services and the supports that they provide:

 The Home Care Referral Registry (HCRR) of Washington State was established to improve the quality of long term In-Home services provided by In-Home providers through improved regulations, higher standards, increased accountability, and the enhanced ability of consumers to obtain services. In addition, the Registry was created to encourage stability in the In-Home provider work force. The HCRR of Washington State provides the following services/resources:

- o A referral Registry used to connect waiver participants to providers and staff to assist.
- o Assistance with hiring and employee management.

 The Aging and Long Term Support Administration (ALTSA) provides:

- o Training for Individual Providers
- o Background checks
- o Contract assistance
- o Financial management services
- o Case Management services.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

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

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

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

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

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

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant

direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

(a) The information about participant direction opportunities:

During service plan development, the Case Resource Manager/ Social Service Specialist is responsible for informing the waiver participant of their ability to choose an individual provider or an agency provider. If waiver participants choose individual providers, they are informed they will become the employer of record and are given a form entitled "Acknowledgement of my responsibilities as the employer of my individual providers". This document provides the waiver participant with:

* Information about being an employer and resources for related skill development
* Information about the financial management role of DSHS
* Information about the role of the Health Care Referral Registry (HCRR) of Washington State

(b) The entity or entities responsible for furnishing this information:

The Case Resource Manager/Social Service Specialist is responsible for furnishing the information to the waiver participant.

(c) How and when this information is provided on a timely basis:

Information is provided at the time of service plan development.

Information is also available on the ADSA internet and through the HCRR of Washington State.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

- ○ **The State does not provide for the direction of waiver services by a representative.**
- ◉ **The State provides for the direction of waiver services by representatives.**

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

- ☑ **Waiver services may be directed by a legal representative of the participant.**
- ☐ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Waiver Service	Employer Authority	Budget Authority
Personal Care	☑	☐

Waiver Service	Employer Authority	Budget Authority
Respite	☑	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

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

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

☑ **Governmental entities**
☐ **Private entities**

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

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

The waiver service entitled:

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

Provide the following information

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

The State Operating Agency.

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

Per the CMS-approved cost allocation plan.

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

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

☑ **Assist participant in verifying support worker citizenship status**
☑ **Collect and process timesheets of support workers**
☑ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
☐ **Other**

Specify:

Supports furnished when the participant exercises budget authority:

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

Specify:

Additional functions/activities:

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

Specify:

Execute and hold Medicaid provider agreements.

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

(a) Monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform:

* The State Operating agency performs the FMS functions. Routine methods to assure accuracy of payments and client satisfaction are as follows:
  * Regional staff (inlcuding supervisors) contact individual waiver participants to verify services are provided as indicated in the payment authorization and ISP.
  * Case Resource Managers/Social Service Specialist verify services were provided as planned.
  * The State Auditors Office and Operations Review and Consultation conduct routine audits of agency payments.

(b) The entity (or entities) responsible for this monitoring:

* The State Auditors Offce and Operations Review and Consultation conduct routine adutis of agency payments.

(c) How frequently performance is assessed:

* Performance is assessed by the Case Resource Manager/Social Service Specialist at least annually at the time of plan review.
* The State Auditors Offcie performs annual audits of the State Operating agency.
* Operations Review and Consultation (an internal DSHS office) performs periodic audits of state programs.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

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

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

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

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Personal Care	☐
Specialized Clothing	☐
Behavioral Health Crisis Stabilization Services-Specialized Psychiatric Services	☐
Behavioral Health Stabilization Services-Behavior Support and Consultation	☐
Behavioral Health Stabilization Services-Crisis Diversion Bed Services	☐
Specialized Nutrition	☐
Specialized Psychiatric Services	☐
Respite	☐
Behavior Support and Consultation	☐
Sexual Deviancy Evaluation	☐
Physical therapy	☐
Speech, Hearing, and Language Services	☐
Transportation	☐
Assistive Technology	☐
Specialized Medical Equipment and Supplies	☐
Occupational Therapy	☐
Vehicle Modifications	☐
Staff/Family Consultation and Training	☐
Therapeutic Equipment and Supplies	☐
Nurse Delegation	☐
Environmental Accessibility Adaptations	☐

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

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

(a) the types of entities that furnish these supports:
- Case Resource Manager/Social Service Specialist
- Health Care Referral Registry (HCRR)

(b) how the supports are procured and compensated:
- Case Resource Manager/Social Service Specialists are state employees for whom we receive Medicaid administrative match.
- HCRR is a state agency funded by legislative appropriation.

(c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver:
- During service plan development the Case Resource Manager/ Social Service Specialist is responsible for informing the waiver participant of their ability to choose and individual provider or an agency provider. If the waiver participant chooses an individual provider they are informed they will become the employer of record and are given a form entitled Acknowledgement of my responsibilities as the employer of my individual providers. This document provides the waiver participant with:
  - Information about being an employer and resources for related skill development
  - Information about the financial management role of DSHS
  - Information about the role of the Health Care Referral Registry (HCRR) of Washington State
- The HCRR of Washington State provides:
  - A referral Registry used to connect waiver participants to providers and staff to assist.
  - Assistance with hiring and employee management.

(d) the methods and frequency of assessing the performance of the entities that furnish these supports:

- Case Resource Managers/Social Service Specialists receive yearly performance evaluations per state personnel policies.
- HCRR is funded directly by the Legislature and answers directly to the legislature and the public.

e) the entity or entities responsible for assessing performance:

- The Department of Social and Health Services and the Legislature

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

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

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Participants are able to switch to agency provided personal care at any time. The Case Resource Manager/Social Service Specialist facilitates the transition and assures no break in service.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

The state does not have a mechanism for involuntary termination of participant direction. The state may terminate an individual provider for cause. In this case, the Case Resource Manager/Social Service Specialist assures continuity of care.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	30	
Year 2	30	
Year 3	30	
Year 4	30	
Year 5	30	

Appendix E: Participant Direction of Services

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

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

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

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law

employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

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

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

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

- ☑ **Recruit staff**
- ☐ **Refer staff to agency for hiring (co-employer)**
- ☑ **Select staff from worker registry**
- ☑ **Hire staff common law employer**
- ☐ **Verify staff qualifications**
- ☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

- ☑ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- ☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- ☐ **Determine staff wages and benefits subject to State limits**
- ☑ **Schedule staff**
- ☑ **Orient and instruct staff in duties**
- ☑ **Supervise staff**
- ☑ **Evaluate staff performance**
- ☑ **Verify time worked by staff and approve time sheets**
- ☑ **Discharge staff (common law employer)**
- ☐ **Discharge staff from providing services (co-employer)**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

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

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

- ☐ **Reallocate funds among services included in the budget**
- ☐ **Determine the amount paid for services within the State's established limits**
- ☐ **Substitute service providers**
- ☐ **Schedule the provision of services**
- ☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☐ **Identify service providers and refer for provider enrollment**
- ☐ **Authorize payment for waiver goods and services**
- ☐ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

Waiver participants have rights under Medicaid law, state law (RCW) and state rules (WAC) to appeal any decision of DDA affecting eligiblity, service, or choice of provider.

During entrance to a waiver, an individual is given administrative hearing rights via the DDA HCBS Waiver Brochure (DSHS #22-605). The CRM/Social Service Specialist discusses administrative hearing rights at the time of the initial and annual ISP meeting, and Planned Action Notices (PAN) are attached to the ISP when it is sent to the individual and their designee (the individual who has been designated to assist the client with understanding and exercising their administrative hearing rights) for signature.

When the department makes a decision affecting eligibility, level of service or denial or termination of provider, a Planned Action Notice (PAN) must be sent within 5 working days of the decision. The notice is sent to the client and their designee. The PAN provides the effective date of the action, the reason and applicable WAC, appeal rights, and time lines for filing appeals. Individuals have up to 90 days to appeal a department decision. If an individual wishes to maintain services during the appeal process, they must ask for an administrative hearing within the ten-day notice period. If the tenth

day falls on a weekend or holiday, they have until the next business day to ask for an administrative hearing. If the tenth day happens before the end of the month, they have until the end of the month to ask for an administrative hearing and still be able to get continued benefits.

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

PANs are contained electronically in the DDA Assessment on the CARE platform. If the PAN was modified then a copy of the modified PANs are maintained in client files. Service Episode Records (SERs) document when a PAN was sent. SERs are contained electronically in the DDA Assessment on the CARE platform.

DDA uses a variety of PANs to communicate decisions. All PANs include relevant administrative hearing rights and comply with Medicaid requirements.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

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

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

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

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

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

DDA operates the grievance/complaint system.

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

DDA provides participants with administrative hearing rights and a complaints/grievance process. The Complaints/Grievance process is not a pre-requisite to an administrative hearing, rather this policy provides participants with an opportunity to address those issues that are not dealt with through the administrative hearing process. DDA policy 5.03 Client Complaint/Grievances clearly delineates those issues that may be addressed in this manner and those issues that should be addressed through processes such as the administrative hearing

process. Participants are informed of both processes via brochures, DVDs, WAC, policy and their Case Resource Manager.

DDA policy 5.03 Client Complaint/Grievances provides waiver participants an opportunity to address problems outside the scope of the adminitrative hearing process. DDA has also worked with the Developmental Disabilities Council to produce a video to assist individuals and their representatives with understanding how to work with the department to resolve complaints/grievances.

This policy applies to all DDA Field Services offices, State Operated Living Alternatives (SOLA), and Residential Habilitation Centers (RHC).

POLICY

A. DDA staff will strive to address grievances/complaints at the lowest level possible. Complaints can be received and addressed at any level of the organization. However, the complaint will be referred back to the Case Resource Manager/Social Service Specialist (CRM/SSS) for action unless the complainant specifically requests it not be.

B. Legal authorization from the client or a personal representative is required to share information with persons outside of DSHS unless otherwise authorized by law. Authorization from the individual is not required when responding to correspondence assignments or inquiries from the Governor□s Office as part of administration of DSHS programs.

C. Communication to complainants will be made in their primary language if needed.

D. DDA will maintain an complaint tracking database to log and track complaints as specified in the Procedures section of this policy. DDA also tracks complaints in service episode records (SERs) in the CARE system.

PROCEDURES

A. The following procedures describe the handling of client complaints at four levels:

1. Case Resource Manager/Social Service Specialist Level;
2. Supervisor Level;
3. Regional Administrator (RA) Level; and
4. Central Office Level

B. Complaints concerning services in the DDA Residential Habilitation Centers (RHCs) and State Operated Living Alternatives (SOLA) will be directed to the Regional Administrator in the respective region.

C. Case Resource Manager/Social Service Specialist Level

1. Case Resource Managers (CRM) and Social Service Specialists (SSS) solve problems and resolve complaints as a daily part of their regular case management activities. This activity will be documented in the client record as appropriate in SER's. The Complaint SER's code will be used to identify Complaints and any resolution to the complaint.

2. If the complainant does not feel that the complaint or problem has been resolved, and he/she wants to

have the complaint reviewed by a supervisor, the CRM/SSS will give his/her supervisor□s name and telephone number to the complainant.

D. Supervisor Level

1. Upon receipt of an unresolved complaint at the CRM/SSS level, the supervisor has ten (10) working days to attempt to resolve the issue. If the response will take longer than 10 days, the supervisor will make an interim contact with the complainant and give a reasonable estimated date of response.

2. If resolution is reached, the supervisor will document the outcome in the client record.

3. If the complainant still does not feel that the complaint/problem has been resolved, and he/she wants to have the complaint reviewed by the RA, the supervisor will give the RA□s name and telephone number to the complainant. The supervisor will also enter the complaint information in the automated DDA Complaint Tracking (CT) database.

E. Regional Administrator Level

1. Upon receipt of an unresolved complaint, the RA will assign a staff to investigate and resolve the issue within 10 working days. If the response will take longer than 10 working days, the RA or designee will make an interim contact with the complainant and give a reasonable estimated date of response.

2. If resolution is achieved, the assigned Regional staff will:

a. Document the outcome in the CT database and the client record; and

b. Notify the complainant and all parties involved and document the notification in the client record.

3. If the matter is not resolved, and the complainant wants a review by DDA Central Office, the RA or designee will document the outcome in the CT database and give the name and telephone number of the Chief, Office of Quality Programs and Services (OQPS) to the complainant. The RA should also notify the OPQS Chief by phone or email of the potential contact.

F. Central Office Level

1. Upon receipt of an unresolved complaint, the OQPS Chief or designee will ensure the complaint has been entered in the database and has ten (10) working days to investigate and resolve the issue. If the response will take longer than ten (10) days, the OQPS Chief will make an interim contact with the complainant and give a reasonable estimated date of

response.

2. The OQPS Chief will document the outcome in the CT database and notify the complainant and all parties involved. The OQPS Chief will send a written summary to the Region for inclusion in the client record.

G. Complaint Tracking Database

1. Entries in the CT database must include:
a. Date the complaint was received;
b. Name and phone number of person receiving the complaint;
c. Complainant name, contact number, and relationship to client;
d. Client name and identification number;
e. The specific complaint;
f. Who the complaint was assigned to;
g. Due date; and
h. Outcome.

2. The OQPS will review complaints entered in the CT database during its monitoring review cycle. Regional Quality Assurance Managers will conduct periodic regional reviews of complaints and status.

The following types of complaints are outside the scope of this policy as they are addressed through separate processes:

1. Allegations of abuse, neglect, exploitation, abandonment, financial exploitation of a child or vulnerable adult. These must be directed immediately to Adult Protective Services (APS), the Complaint Resolution Unit (CRU), or Child Protective Services (CPS), as appropriate.

2. Client disputes about services that have been denied, reduced, suspended, or terminated. These are resolved through the Fair Hearing procedure.

3. Client disputes about services that have been requested or authorized through an exception to rule (ETR) that have been denied, reduced, or terminated.

4. Complaints received from DSHS Constituent Services. These will be handled according to the requirements of DSHS Administrative Policy 8.11, Complaint Resolution and Response Standards.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

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

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

Several state laws require Department of Social and Health Services (DSHS) employees, volunteers, and contractors to report suspected abandonment, abuse, neglect, exploitation, and financial exploitation of children and vulnerable adults:

• Chapter 26.44 RCW mandates the reporting of any suspected abuse or neglect of a child to either DSHS or law enforcement.

• Chapter 74.34 RCW mandates an immediate report to DSHS of suspected abuse, neglect, abandonment, or financial exploitation of a vulnerable adult. When there is suspected sexual or physical assault of a vulnerable adult, it must be reported to DSHS and to law enforcement.

• RCW 70.124.030 mandates the reporting of suspected abuse or neglect of state hospital patients.

Chapter 74.34 RCW divides reporters into two types: mandated and permissive. Per RCW 74.34.020, "Mandated reporter" is an employee of the department; law enforcement officer; social worker; professional school personnel; individual provider; an employee of a facility; an operator of a facility; an employee of a social service, welfare, mental health, adult day health, adult day care, home health, home care, or hospice agency; county coroner or medical examiner; Christian Science practitioner; or health care provider subject to chapter 18.130 RCW (Regulation of health professions-Uniform disciplinary act).

Under state law, volunteers at a facility or program providing services to vulnerable adults fall into the permissive category. However, in order for contractors, volunteers, interns, and work study students to work in regional Field Services offices, Residential Habilitation Centers (RHC), and State Operated Living Alternatives (SOLA), they must agree to follow mandatory reporting requirements

The Developmental Disabilities Administration (DDA) requires all contracted residential providers to report a broader scope of serious and emergent incidents to the Administration per DDA Policy 6.12 (Residential Reporting Requirements). Serious and emergent incidents are reported to DDA via fax, telephone and e-mail.

More detail is provided below and is broken out by incidents concerning children, incidents concerning adults, and the incidents that must be reported and entered into DDA's Electronic Incident Reporting System.

Children

The State requires that "abuse" and "neglect" be reported for review and follow-up action by an appropriate authority.

Per RCW 26.44.020(1): "Abuse or neglect" means sexual abuse, sexual exploitation, or injury of a child by any person under circumstances which cause harm to the child's health, welfare, or safety, excluding conduct permitted under RCW 9A.16.100 (Use of force on children-Policy-Actions presumed unreasonable); or the negligent treatment or maltreatment of a child by a person responsible for or providing care to the child. An abused child is a child who has been subjected to child abuse or neglect as defined in this section.

Who must report instances of suspected child abuse and neglect and the timelines associated with reporting are contained in RCW 26.44.030 (Reports-Duty and authority to make-Duty of receiving agency....).

(1)(a) When any practitioner, county coroner or medical examiner, law enforcement officer, professional school personnel, registered or licensed nurse, social service counselor, psychologist, pharmacist, employee of the

department of early learning, licensed or certified child care providers or their employees, employee of the department, juvenile probation officer, placement and liaison specialist, responsible living skills program staff, HOPE center staff, or state family and children's ombuds or any volunteer in the ombuds's office has reasonable cause to believe that a child has suffered abuse or neglect, he or she shall report such incident, or cause a report to be made, to the proper law enforcement agency or to the department as provided in RCW 26.44.040 (Reports-Oral, written-Contents).

(b) When any person, in his or her official supervisory capacity with a nonprofit or for-profit organization, has reasonable cause to believe that a child has suffered abuse or neglect caused by a person over whom he or she regularly exercises supervisory authority, he or she shall report such incident, or cause a report to be made, to the proper law enforcement agency, provided that the person alleged to have caused the abuse or neglect is employed by, contracted by, or volunteers with the organization and coaches, trains, educates, or counsels a child or children or regularly has unsupervised access to a child or children as part of the employment, contract, or voluntary service. No one shall be required to report under this section when he or she obtains the information solely as a result of a privileged communication as provided in RCW 5.60.060 (Witnesses-Competency-Who is disqualified-Privileged communications).

Nothing in this subsection (1)(b) shall limit a person's duty to report under (a) of this subsection.

(c) The reporting requirement also applies to department of corrections personnel who, in the course of their employment, observe offenders or the children with whom the offenders are in contact. If, as a result of observations or information received in the course of his or her employment, any department of corrections personnel has reasonable cause to believe that a child has suffered abuse or neglect, he or she shall report the incident, or cause a report to be made, to the proper law enforcement agency or to the department as provided in RCW 26.44.040.

(d) The reporting requirement shall also apply to any adult who has reasonable cause to believe that a child who resides with them, has suffered severe abuse, and is able or capable of making a report. For the purposes of this subsection, "severe abuse" means any of the following: Any single act of abuse that causes physical trauma of sufficient severity that, if left untreated, could cause death; any single act of sexual abuse that causes significant bleeding, deep bruising, or significant external or internal swelling; or more than one act of physical abuse, each of which causes bleeding, deep bruising, significant external or internal swelling, bone fracture, or unconsciousness.

(e) The reporting requirement also applies to guardians ad litem, including court-appointed special advocates, appointed under Titles 11, 13, and 26 RCW, who in the course of their representation of children in these actions have reasonable cause to believe a child has been abused or neglected.

(f) The reporting requirement in (a) of this subsection also applies to administrative and academic or athletic department employees, including student employees, of institutions of higher education, as defined in RCW 28B.10.016 (Colleges and universities generally-Definitions), and of private institutions of higher education.

(g) The report must be made at the first opportunity, but in no case longer than forty-eight hours after there is reasonable cause to believe that the child has suffered abuse or neglect. The report must include the identity of the accused if known.

(2) The reporting requirement of subsection (1) of this section does not apply to the discovery of abuse or neglect that occurred during childhood if it is discovered after the child has become an adult. However, if there is reasonable cause to believe other children are or may be at risk of abuse or neglect by the accused, the reporting requirement of subsection (1) of this section does apply.

(3) Any other person who has reasonable cause to believe that a child has suffered abuse or neglect may report such incident to the proper law enforcement agency or to the department of social and health services as provided in RCW 26.44.040.

(4) The department, upon receiving a report of an incident of alleged abuse or neglect pursuant to this chapter, involving a child who has died or has had physical injury or injuries inflicted upon him or her other than by accidental means or who has been subjected to alleged sexual abuse, shall report such incident to the proper law enforcement agency. In emergency cases, where the child's welfare is endangered, the department shall notify the proper law enforcement agency within twenty-four hours after a report is received by the department. In all other cases, the department shall notify the law enforcement agency within seventy-two hours after a report is received by the department. If the department makes an oral report, a written report must also be made to the proper law enforcement agency within five days thereafter.

(5) Any law enforcement agency receiving a report of an incident of alleged abuse or neglect pursuant to this chapter, involving a child who has died or has had physical injury or injuries inflicted upon him or her other than by accidental means, or who has been subjected to alleged sexual abuse, shall report such incident in writing as provided in RCW 26.44.040 to the proper county prosecutor or city attorney for appropriate action whenever the law enforcement agency's investigation reveals that a crime may have been committed. The law enforcement agency shall also notify the department of all reports received and the law enforcement agency's disposition of them. In emergency cases, where the child's welfare is endangered, the law enforcement agency shall notify the department within twenty-four hours. In all other cases, the law enforcement agency shall notify the department within seventy-two hours after a report is received by the law enforcement agency.

(6) Any county prosecutor or city attorney receiving a report under subsection (5) of this section shall notify the victim, any persons the victim requests, and the local office of the department, of the decision to charge or decline to charge a crime, within five days of making the decision.

Adults

The State requires the following types of critical events or incidents be immediately reported for review and follow-up action by an appropriate authority:

-Abandonment
-Abuse (including sexual, physical and mental)
-Exploitation
-Financial exploitation
-Neglect
-Self-neglect

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

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

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

b. Physical abuse means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to: striking with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or the use of chemical restraints or physical restraints unless the restraints are consistent with licensing requirements, and includes restraints that are otherwise being used inappropriately.

c. Mental abuse means any willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to: coercion, harassment, inappropriately isolating a vulnerable adult from family, friends, or regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing.

d. Exploitation means an act of forcing, compelling, or exerting undue influence over a vulnerable adult causing the vulnerable adult to act in a way that is inconsistent with relevant past behavior, or causing the vulnerable adult to perform services for the benefit of another.
(1) Financial exploitation means the illegal or improper use of the property, income, resources, or trust funds of the vulnerable adult by any person for any person's profit or advantage.

3. Neglect means a pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; or an act or omission by a person or entity with a duty of care

that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100.

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

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

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

Required reporting of allegations involving waiver participants: What, when and to whom:

RCW 74.34.035 Reports (excerpt):

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

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

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

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

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

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

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

(b) There is a fracture;

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

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

DDA Electronic Incident Reporting System.

Per DDA Policy 12.01 (Incident Management and Reporting), DDA staff are required to input Serious and Emergent incidents into an Electronic Incident Reporting System. Policy 12.01 applies to all DDA employees, including State Operated Living Alternatives (SOLA) programs, Residential Habilitation Centers (RHC), and all DDA volunteers, interns, and work study students.

DDA Policy 12.01 describes the process the Developmental Disabilities Administration (DDA) will use to protect, to

the extent possible, the health, safety, and well-being of Administration clients, and to ensure that abandonment, abuse, exploitation, financial exploitation, neglect and self-neglect is reported, investigated, and resolved; and to ensure that procedures are in place to prevent abuse.

Incident types reported and tracked by DDA per Policy 12.01 include:

- * Abuse
- * Neglect
- * Exploitation
- * Abandonment
- * Death
- * Medication Errors
- * Emergency Use of Restrictive Procedures
- * Serious Injuries
- * Criminal Activity
- * Hospitalizations
- * Missing clients
- * Mental Health Crisis
- * Serious Property Destruction

Timelines established by DDA Policy 12.01 are:

A. Phone call to Central Office within 1 Hour followed by Electronic IR within 1 working day.

1. Known media Interest or litigation must also be reported to Regional Administrator & HQ within 1 hour.
2. Death of a RHC or SOLA client.
3. Death of a client (suspicious or unusual).
4. Natural disaster or other conditions threatening the operations of the program or facility.
5. Alleged sexual abuse of a client by a DSHS employee, volunteer, licensee or contractor.
6. Clients missing from SOLA or RHC in cases where a missing person report is being filed with law enforcement.
7. Injuries resulting from abuse/neglect or of unknown origin requiring hospital admission.
8. Client arrested with charges or pending charges for a violent crime.

B. Electronic IR Database within 1 working day

1. Alleged or suspected abandonment, abuse, neglect, exploitation, or financial exploitation of a client by a DSHS employee, volunteer, licensee or contractor.
2. Client injury of unknown origin when the injury raises suspicions of possible abuse or neglect.
3. Known criminal activity perpetrated by a DSHS employee, volunteer, licensee or contractor that may impact the person's ability to perform the duties required of their position.
4. Criminal activity by clients resulting in a case number being assigned by law enforcement.
5. Sexual abuse of a client not subject to report within 1 hour.
6. Injuries resulting from alleged or suspected client to client abuse requiring medical treatment beyond First Aid.
7. Injuries of known cause (other than abuse/neglect) that result in hospital admission.
8. Missing person.
9. Death of client (not suspicious or unusual).
10. Inpatient admission to state or local psychiatric hospitals.
11. Alleged or suspected abuse, abandonment, neglect, exploitation, or financial exploitation by other non-client/non-staff screened in by APS or CPS for investigation.
12. Criminal activity against clients by others resulting in a case number being assigned by law enforcement
13. Restrictive procedures implemented under emergency guidelines

14. Medication error which causes or is likely to cause injury/
harm as assessed by a medical or nursing professional
15. Emergency medical hospitalizations
16. Awareness that a client and/or the individual's legal representative are contemplating permanent sterilization procedures.

References:
-RCW 5.60.060: Witnesses-Competency-Who is disqualified-privileged communications
-RCW 9A.42.100: Endangerment with a controlled substance
-Chapter 26.44 RCW: Abuse of Children
-RCW 26.44.030: Reports-Duty and authority to make-Duty of receiving agency....
-RCW 26.44.040: Reports-Oral, written-Contents
-RCW 28B.10.016: Colleges and universities generally-Definitions
-DDA Policy 12.01: Incident Management and Reporting
-DDA Policy 5.13: Protection from Abuse: Mandatory Reporting
Chapter 71A.12 RCW: Developmental Disaiblities-State Services
-Chapter 74.34 RCW: Abuse of Vulnerable Adults statute
-RCW 74.34.020: Abuse of vulnerabvle adults-Definitions
-WAC 388-71-0100 through 01280: Adult Protective Services
-HCS Long-Term Care Manual, Chapter 6, policies and procedures of the Adult Protective Services Program

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

The Developmental Disabilities Administration (DDA) works with the Aging and Long-Term Support Administration (ALTSA), Children's Administration (CA), and the DSHS Communications Division on education efforts for clients, families and providers associated with DSHS. Washington State has designated November as Vulnerable Adult Awareness Month.

DSHS also started an End Harm campaign a number of years ago. DDA participates in this campaign which is aimed at shedding light on abuse and educating the general public as well as DSHS staff and consumers. A statewide number (1-866-EndHarm) was implemented several years ago. Anyone can call this number to report any type of abuse or neglect against a vulnerable person 24 hours per day and 7 days per week. The End Harm toll free number is promoted via news releases, the internet, DDA's Director's Corner and ALTSA publications. Participants receive information at least annually during their annual assessment about how to report any type of abuse or neglect of a vulnerable adult or child. The End Harm number is identified on the Meeting Wrap up form that is reviewed at the end of each annual assessment.

All providers receive mandatory reporter training. Individual and AFH/ARC providers receive training via the Fundamentals of Caregiver training. DDA residential program employees receive training from their employer. In addition, residential programs post contact information to report abuse and neglect in the participant's home.

Every DDA CRM/Social Service Specialist receives mandatory reporter/incident management training as a component of DDA Core Training.

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

Investigations of abuse, neglect, and exploitation of adults are conducted by two investigative bodies: Residential Care Services (RCS) and Adult Protective Services (APS). Investigations regarding children are conducted by Child Protective Services (CPS).

Residential Care Services: Under state authority, Residential Care Services (RCS) is the designated DSHS authority to investigate incidents of abuse (physical, mental, sexual and exploitation of person), abandonment, neglect, self-neglect and financial exploitation in residential programs.

RCS reviews provider systems to see if a failed practice contributed to any finding of abuse, neglect, abandonment, self-neglect, and financial exploitation. If failed provider practice is identified, RCS will issue a citation to the

provider under the appropriate section of Certified Community Residential Services and Supports WAC 388-101, Adult Family Home WAC 388-76 and Assisted Living Facility Licensing Rules 388-78A. The provider must submit and implement a corrective action plan, which is subject to on-site verification by RCS.

RCS documents their conclusion of their investigations in TIVA (Tracking Incidents for Vulnerable Adults). RCS sends the Statement of Deficiencies to providers within 10 days and will document their conclusion of their investigations in TIVA within 15 days of the last day of data collection. For each allegation, the RCS investigators complete data entry into the RCS complaint investigation tracking systems and are required to record a data-qualifier in relation to the decision of the substantiated or unsubstantiated finding.

Those qualifiers are as follows for substantiated investigations:
 * Federal deficiencies related to the allegation are cited
 * State deficiencies related to the allegation are cited
 * No deficiencies related to the allegation are cited, or
 * Referral to appropriate agency

For unsubstantiated investigations, the following qualifiers are used:
 * Allegation did not occur
 * Lack of sufficient evidence
 * Referral to appropriate agency

When a provider practice investigation is completed, RCS determines whether:
 * The allegations are substantiated or unsubstantiated;
 * The facility or provider failed to meet any of the regulatory requirements; and,
 * The provider practice or procedure that contributed to the complaint has been changed to achieve and/or maintain compliance.

RCS utilizes a centralized statewide intake unit for the purpose of receiving reports of alleged abuse, neglect and financial exploitation for all licensed and certified Long Term Care residential providers. Referrals from the DDA incident reporting system, reports from the public and reports from mandated reporters are received and processed through this unit. RCS Field investigators receive prioritized referrals from the centralized intake unit and respond by conducting on-site investigations

RCS is centrally located in Olympia. RCS investigates licensed or certified residential providers. RCS prioritizes reports for investigation based upon on the severity and immediacy of actual or potential harm. Complaint investigation response times are 2 days, 10 days, 20 days, 45 days, or 90 days and Quality Reviews. All of these categories require an on-site investigation, except for the Quality Review category. Any situation that involves imminent danger is reported to law enforcement immediately. Any report received from a public caller is assigned an on-site investigative response time.

Adult Protective Services: Under state authority, Adult Protective Services (APS) receives reports and conducts investigations of alleged abuse (physical, mental, sexual and exploitation of person), abandonment, neglect, self-neglect and financial exploitation in order to determine whether the alleged abuse, etc. occurred and if so who was/were the perpetrator(s).

APS is located in Olympia and APS investigators are located in regional offices throughout the state. Investigations are prioritized based on the severity and immediacy of actual or potential harm. Emergent issues are referred to 911. The APS investigator meets face to face with the alleged victim within 24 hours for all reports categorized as high; within five working days for a medium priority report; and within ten working days for a low priority report. A shorter response time may be assigned on a case by case basis.

APS investigations are completed within 90 days of assignment unless necessary investigation or protective services activity continues. If a case remains in "investigating" or "investigation pending" status 90 days after intake, APS supervisors review the case at least every 30 days thereafter for the duration of the case.

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

Child Protective Services: Under state authority, Child Protective Services (CPS) within the Children's Administration (CA) of the Department of Social and Health Services (DSHS) is responsible for receiving and investigating reports of suspected child abuse and neglect.

The primary purpose of the CPS program is to assess risk of child maltreatment rather than to substantiate specific allegations of child abuse and neglect. Any referral received from a commissioned law enforcement officer stating a parent has been arrested for Criminal Mistreatment in the fourth degree under RCW 9A.42 is screened in and assigned for investigation.

When someone reports that a child may be abused or neglected, CPS is required by law to investigate. A report of suspected child abuse or neglect could be made to CPS or the police. Even though CPS staff and the police work together, they make separate investigations. CPS conducts family assessments, and the police conduct criminal investigations.

Upon receipt of a report concerning the possible occurrence of abuse and/or neglect, CPS begins a risk assessment. The risk assessment begins with a review of the information with the reporter to determine if there is sufficient information to locate the child; identify the perpetrator as a parent or caretaker; and determine whether the allegation is a situation of child abuse or neglect or there is a risk of harm to the child. Referrals which are determined to contain sufficient information may be assigned for investigation or other community response.

CPS workers must complete the intake process with referral information recorded in the FamLink within:

a. 4 hours from the date and time CA receives the following referrals:
   1. Emergent CPS or DLR (Division of Licensed Resources)/CPS
   2. Family Reconciliation Services (FRS)
b. 4 business hours (business hours are 8:00 a.m. to 5:00 p.m., Monday through Friday) from the date and time CA receives Non-Emergent CPS or DLR/CPS referrals.
c. 2 business days from the date and time CA receives the following referrals:
   1. Information Only
   2. CPS - Alternate Intervention
   3. Third Party
   4. Child Welfare Services (CWS)
   5. Licensing Complaint
   6. Home Study

If additional victims identified during the course of an investigation are determined:

a. To be at risk of imminent harm, a social worker will have face to face contact within 24 hours from the date and time they are identified.
b. NOT to be at risk of imminent harm, a social worker will have face to face contact within 72 hours of the date and time they are identified.

The assigned social worker must:

a. Contact the referrer if the intake information is insufficient or unclear and may provide information about the outcome of the case to mandated referrers.
b. Conduct a face-to-face investigative interview with child victims within 10 calendar days from date of referral.

CPS is a continuum of protection consisting of different but complementary functions. Intervention designed to protect children from abuse and neglect must include permanency planning goals from the onset of the case and must be updated at 90-day intervals.

When it appears that a child is in danger of being harmed, or has already been seriously abused or neglected, a police officer can place the child in protective custody. Custody of the child is then transferred to CPS, which places the child with a relative or in foster care. By law, a child can be kept in protective custody for no more than 72 hours, excluding weekends and legal holidays. If the child is not returned to the parents or some other voluntary arrangement made within 72 hours, the matter must be reviewed by a court.

In very serious cases of abuse and neglect, a child can be removed permanently from the parents (i.e., termination of parental rights). When this happens the child becomes legally free through a court procedure. The parent no longer has any rights or responsibilities toward the child. If a parent voluntarily gives up a child for adoption, this is called relinquishing parental rights.

Child Welfare Services (CWS) within the CA provides services to children and families with long-standing abuse and neglect problems. Typically these children have been removed from the family home and are in the foster care system. The focus of CWS is to achieve a permanent plan and placement for these children as soon as possible.

CPS seeks to complete investigations within 45 days, but it may take up to 90 days if law enforcement is involved. Outcome notices are sent to relevant parties upon investigation completion.

CPS, RCS and APS are using the FamLink and TIVA systems to document investigation activites including intake of complaints and outcome reports. There is an electronic connection between FamLink/TIVA and the CARE system to notify case managers of a) complaints that are referred for investigations and b) investigation outcomes. This is an electronic notification that is identified in the individual's CARE record.

The Aging and Long-Term Care Administration receives nightly data feeds from the new TIVA (Tracking Incidents for Vulnerable Adults) system that are used in this ALTSA/DDA reporting system. TIVA information is reviewed to determine if client information matches DDA waiver participants who are identified in CARE. DDA uses this reporting system to address specific programmatic and provider issues from the outcomes of the waiver clients who were involved in investigations by Residential Care Services (RCS), Adult Protective Services (APS) and/or Child Protection Services (CPS) for whom a report of abuse, neglect, abandonment, or financial exploitation was substantiated. The data are broken out by type of incident and provider type.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Under state authority, Child Protective Services (CPS) within the Children's Administration (CA) of the Department of Social and Health Services (DSHS) is responsible for receiving and investigating reports of suspected child abuse and neglect.

When someone reports that a child may be abused or neglected, CPS is required by law to investigate. A report of suspected child abuse or neglect could be made to CPS or the police. Even though CPS staff and the police work together, they make separate investigations. CPS conducts family assessments, and the police conduct criminal investigations.

Residential Care Services is responsible for overseeing the certification of all certified residential programs. Mandatory reporting, and mandatory reporter training are among the standards they evaluate per Washington Administrative Code. Certification occur a minimum of every two years, but the certification length can be reduced depending on the regulatory concerns.

RCS Field Managers (supervisors) review prioritized complaints assigned from the centralized intake unit. As needed, supervisors work directly with investigative staff in developing investigative plans and may assist investigators with coordination activities.

The RCS Assistant Director and the Quality Assurance (QA) Administrator receive copies of serious and immediate complaint intakes at the same time that the initial referrals are sent from CRU to the field. Both of these individuals monitor the progress of investigative response to these incidents.

RCS Field Managers review the results of all investigated complaints; ensure that investigation activities were thorough and complete and that no follow-up activities are required. Field Managers also make recommendations to HQ and assist with coordination of enforcement activities.

RCS provider practice substantiation rates are monitored by DDA through data pulled from the TIVA (Tracking Incidents for Vulnerable Adults) system. Intakes and investigations can be reviewed by program, by type, and by facility. Trends and patterns are identified and analyzed to determine if substantiated areas of non-compliance negatively impacted waiver clients living in the licensed or certified setting. Analyses include a review of the general scope and severity of the non-compliance, and whether or not RCS enforcement processes resulted.

RCS and the Aging and Long-Term Support Administration are using the TIVA system to document investigation activities including intake of complaints and outcome reports. There is an electronic connection between the TIVA and the CARE system to notify case managers of a) complaints that are referred for investigations and b) investigation outcomes. This is an electronic notification that is identified in the individual's CARE record. Data from the TIVA system is used to develop statewide training for case managers and the community on adult protective services and how to recognize and prevent instances or reoccurrences of abuse, neglect, and financial exploitation.

DDA requires serious and emergent incidents to be entered into a statewide electronic incident reporting system per DDA Policy. Incidents are entered into the system by DDA CRMs and Social Service Specialists with notification sent to appropriate staff.

Adult Protective Services (APS) is a state wide program within the operating agency. The intakes, investigations and protective services performed by APS are continuously monitored at both the state and the regional levels. For example:

-Regional supervisors and program managers conduct on-going quality assurance audits of APS case records.

-The APS program has implemented a statewide QA monitoring process that includes record reviews and a formal in-person skills evaluation conducted by a supervisor during an actual APS investigation.

-Several reports based on data pulled from the statewide APS data base are routinely generated and evaluated at least annually by program managers and upper management at the state office.

-The regions use a report system tool that enables them to create customized reports pulled from the statewide data base to track, monitor and evaluate implementation of APS in their region.

-Data is used to develop statewide training for case managers and the community on APS and how to recognize and prevent instances or re-occurrences of abuse, neglect and exploitation.

DDA Regional Quality Assurance staff in all three regions provides ongoing monitoring of the Incident Reporting system. The Central Office Incident Program Manager is responsible for the monitoring and oversight of all significant incidents. A Central Office Incident Report team meets monthly to review aggregate data, trends and patterns and staff incidents of particular concern.

Aggregate data analyzed by DDA Central Office is also sent out to the regions for follow up. Regional analysis is tracked and discussed at the Regional Quarterly Quality Assurance Meeting. Best practices and significant issues are presented to the Full Management Team four times per year.

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

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Introduction:

The following information is applicable to paid providers and licensed/certified settings that are available to waiver participants for respite care and to in-home Behavior Support and Consultation providers. DDA safeguards concerning the use of each type of restraint do not apply to family members (e.g., parents, siblings, relatives) unless they are paid providers of the Department of Social and Health Services.

Protections against the inappropriate use of restraints and restrictive procedures are contained in state law and rules concerning abuse and neglect (i.e., as described in Appendix G-1).

The Positive Behavior Support Plan:

The basic tool used by the DDA to address challenging behaviors is the Positive Behavior Support Plan (PBSP). PBSPs are in addition to the individualized person-centered plan.

A PBSP consists of the following sections:
a. Prevention Strategies;
b. Teaching/Training Supports;
c. Strategies for Responding to Challenging Behaviors; and
d. Data Collection and Monitoring.

PBSPs are specifically required when:

1. The use of certain restrictive interventions is planned or used. DDA Policies 5.15, 5.19, and 5.20 provide more information regarding PBSPs.
2. An indiviudal is taking psychoactive medications to reduce challenging behavior or treat a mental illness. DDA Policy 5.16 provides more information.
3. Certain restrictive physical interventions are planned or used. DDA Policies 5.17 and 5.20 contain more information.
.
When challenging behaviors are identified, a written Functional Assessment and PBSP must be completed within ninety (90) days. All PBSPs must be agreed to by the individual or legally responsible individual.

Conditions under which a restraint may be applied:

Physical restraints, mechanical devices used as a restraint and chemical restraints may be used solely to treat a participant's behavior that poses a safety or health risk. Per DDA policy, restraints may not be used for the purposes of discipline or convenience.

The use of mechanical or physical restraints during medical and dental treatment is acceptable if under the direction of a physician or dentist and consistent with standard medical/dental practices. DDA Policy 5.17 provides additional detail.

Identification of a specific and individualized assessed need:

If a restraint is to be used to treat challenging behavior, it must be supported by a functional assessment as described in DDA Policy 5.14, Attachment A. All Functional Assessments must contain four major sections:

- Description and Pertinent History;
- Definition of Challenging Behavior(s);
- Data Analysis/Assessment Procedures; and
- Summary Statements.

Based on the Functional Assessment, a written Positive Behavior Support Plan is implemented to reduce or eliminate the indiviudal's need to engage in the challenging behavior(s).

Informed Consent:

The use of restraints is voluntary and the participant or representative must give informed consent, which is documented in the individual's ISP and PBSP. The participant or representative is always included in the development of the person centered care plan, as well as a PBSP. The participant or representative is made aware of the risks and the right to refuse the restraint. The participant or legal guardian has the right to refuse any service (including the use of restraints) or medication at any time.

Positive interventions, supports and less intrusive methods must be employed prior to the use of restraints:

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

When a waiver participant receives psychoactive medication, non-pharmaceutical supports used to assist in the treatment of the individual's symptoms or behaviors must be documented in the individual's Positive Behavior Support Plan.

Participants must have an assessed need proportionate to the use of restraints:

The need for a restraint must be assessed by a specialist in challenging behaviors. This information must then be incorporated into the participant's ISP, the Functional Assessment that details the challenging behaviors and their precursors, and the PBSP. The conditions under which a restraint may be used must be documented in the participant's ISP and PBSP. Documentation must reflect the symptom related to behavior for which a restraint is being used, when a restraint may be used, and how the restraint should be used.

The use of chemical restraints is governed by DDA Policies 5.15 and 5.16. If the waiver participant appears to be displaying symptoms of mental illness and/or persistent challenging behavior, any physical, medical, or dental conditions that may be causing or contributing to the behavior must first be considered.

If no physical or other medical condition is identified, then a psychiatric assessment is conducted. After the assessment, if the treatment professional recommends psychoactive medication, the prescribing professional or agency staff documents this in a Psychoactive Medication Treatment Plan (PMTP). The plan must include the following:

a. A description of the behaviors, symptoms or conditions for which the medication is prescribed;
b. The name, dosage, and frequency of the medication;
c. The length of time considered sufficient to determine if the medication is effective;
d. The behavioral criteria to determine whether the medication is effective; and
e. The anticipated schedule of visits with the prescribing professional.

Collection and review of data to measure the ongoing effectiveness of the restraint:

Per DDA Policy 5.14, the PBSP must:
- Operationally define the goals of the PBSP in terms of specific, observable behaviors.
- Indicate what data is needed to evaluate success (e.g., frequency, intensity and duration of target behaviors).
- Provide instructions to staff or caregivers on how to collect this data (e.g., forms, procedures) i.e., frequency, intensity and duration.
- List who will monitor outcomes, need for revisions, and evaluate success and process for monitoring.
- Recommend displaying data in a graph over time for easy analysis.

Per DDA Policies 5.15 and 5.20, the program staff responsible for PBSPs must review the plan at least every thirty (30) days. If the data indicates progress is not occurring after a reasonable period, but no longer than six (6) months, the PBSP must be reviewed and revisions implemented as needed.

Per DDA Policy 5.16, with respect to psychoactive medication the prescribing professional should see the individual at least every three (3) months. The continued need for the medication and possible reduction in medication is assessed at least annually by the prescribing professional.

Periodic review of restraint usage:

The ISP and PBSP must be reviewed at least annually (and in the case of behavior support and consultation provider to children and youth in the family home, providers must submit quarterly progress reports) and updated at any time the use of a restraint (including psychoactive medication) becomes ineffective, is no longer needed or becomes unsafe.

When challenging behaviors are identified, a written Functional Assessment and PBSP must be completed within ninety (90) days. If the data indicates progress is not occurring after a reasonable period, but no longer than six (6) months, the FA and the PBSP must be reviewed and revisions implemented as needed.

Restraints may not cause harm:

The use of restraints must be deemed safe and appropriate per DDA policies concerning the use of restraints and restrictive procedures. The waiver participant or representative is informed of any risks and may choose to decline the use of restraints at any time.

Education and training requirements for providers involved in the use of restraints:

All staff using physical interventions must have prior training in the use of such techniques according to the facility or agency's policy and procedures. Staff must also receive training in crisis prevention techniques and positive behavior support. Staff receiving physical intervention techniques training must complete the course of instruction and demonstrate competency before being authorized to use the techniques with waiver participants. All residential service providers must have documentation of prior training in the use of physical intervention techniques.

A review of de-escalation techniques and physical intervention techniques with all service providers and members of a child/youth’s support team must occur annually before continuing to be used with the child/youth.

Regarding the use of psychoactive medications, staff and family members are informed of the anticipated impact of the medication and its potential side effects. Staff and/or family members monitor the waiver participant to determine if the medication is being effective and communicate when it is not effective to the prescribing professional.

References:

- DDA Policy 5.14: Positive Behavior Support
- DDA Policy 5.15: Use of Restrictive Procedures
- DDA Policy 5.16: Use of Psychoactive Medications
- DDA Policy 5.17: Physical Intervention Techniques
- DDA Policy 5.19: Positive Behavior Support for Children and Youth
- DDA Policy 5.20: Restrictive Procedures and Physical Interventions with Children and Youth

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The Department of Social and Health Services (DSHS) through the Aging and Long-Term Support Administration (ALTSA) and through Child Protective Services (CPS) is responsible for investigating the unauthorized use of restraints.

Under state authority RCW 74.34, the ALTSA receives reports and conducts investigations of abuse, neglect, exploitation and abandonment for individuals enrolled with the Developmental Disabilities Administration. ALTSA Adult Protective Services (APS) investigates the perpetrators of abuse and neglect occurring in nursing homes, adult residential care facilities, adult family homes, supported living programs and adults residing in their own homes.

Under state authority contained in Chapter 26.44 RCW, CPS within the Children's Administration (CA) of DSHS is responsible for receiving and investigating reports of suspected child abuse and neglect.

DDA monitors the use of unauthorized restraints and takes corrective action through:
* Reports received in the DDA Incident Reporting system,
* Reports submitted to APS,
* Reports submitted to RCS,
* Reports submitted to CPS,
* The face to face DDA Assessment process conducted yearly and at times of significant change,
* The DDA grievance process, and
* DDA Quality Assurance activities that include face to face interviews of clients and review of complaints.

RCS and APS are using the TIVA system to document investigation activities including a) intake of complaints and b) outcome reports. There is an electronic connection between the FamLink and the CARE system to notify case managers of a) complaints concerning treatment of children that are referred for investigations and b) investigation outcomes. This is an electronic notification that is included in the individual's CARE record.

DDA Policies 5.14, 5.15, 5.16, 5.17, 5.19 and 5.20 (see G-2.b.i) specify the requirements for the use and documentation of any type of restraint (mechanical or pharmacological). Only the least restrictive intervention needed to adequately protect the individual, others, or property may be used, and must be terminated as soon as the need for protection is over. Approved restraint use must be fully documented and reviewed at least monthly by the residential provider and at least quarterly by the waiver participant’s interdisciplinary team. Any emergency use of a restraint requires an incident report to DDA headquarters where it is reviewed by the Incident Management Program Manager.

RCS has contracted evaluators who evaluate the residential agencies/programs at least once every two years. Their review always includes any use of restraints, restrictive procedures, or use of psychoactive medications.

Quality Compliance Coordinator (QCC) staff review yearly the positive behavior support plans (PBSPs) of a sample of waiver participants. One focus is on instances in which the PBSP includes a restraint that requires approval through an exception to rule (ETR). When the QCC team identifies PBSPs requiring an ETR that did not have an ETR, the QCC team verifies that individual corrective action was completed within 90 days and reports to DDA management on any systems issues.

References:
-Chapter 26.44 RCW: Abuse of Children
-Chapter 74.34 RCW: Abuse of Vulnerable Adults
-DDA Policy 5.14: Positive Behavior Support
-DDA Policy 5.15: Use of Restrictive Procedures
-DDA Policy 5.16: Use of Psychoactive Medications
-DDA Policy 5.17: Physical Intervention Techniques
-DDA Policy 5.19: Positive Behavior Support for Children and Youth
-DDA Policy 5.20: Restrictive Procedures and Physical Interventions with Children and Youth

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

The State does not permit or prohibits the use of restrictive interventions

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The use of restrictive interventions is permitted during the course of the delivery of waiver services
Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Introduction:

The following information is applicable to paid providers and licensed/certified settings that are available to waiver participants for respite care, as well as to providers of in-home Behavior Support and Consultation. DDA safeguards concerning the use of restrictive interventions do not apply to family members (e.g., parents, siblings, relatives) unless they are paid providers of the Department of Social and Health Services.

Protections against the inappropriate use of restraints and restrictive interventions are contained in state law and rules concerning abuse and neglect (i.e., as described in Appendix G-1).

The Positive Behavior Support Plan:

The basic tool used by the DDA to address challenging behaviors is the Positive Behavior Support Plan (PBSP). PBSP's are in addition to the individualized person-centered plan.

A written PBSP must have the following sections:
a. Prevention Strategies;
b. Teaching/Training Supports;
c. Strategies for Responding to Challenging Behaviors; and
d. Data Collection and Monitoring.

PBSPs are specifically required when:

1. The use of certain restrictive interventions is planned or used. DDA Policy 5.15, Use of Restrictive Procedures, DDA Policy 5.19, Positive Behavior Support for Children & Youth, and DDA Policy 5.20, Restrictive Procedures and Physical Interventions with Children and Youth, provide more information and requirements regarding PBSPs.
3. Certain restrictive physical interventions are planned or used. DDA Policy 5.17, Physical Intervention Techniques, and DDA Policy 5.20, Restrictive Procedures and Physical Interventions with Children and Youth, contain more information and related requirements.
.
When challenging behaviors are identified, a written Functional Assessment and PBSP must be completed within ninety (90) days. If the data indicates progress is not occurring after a reasonable period, but no longer than six (6) months, the FA and the PBSP must be reviewed and revisions implemented as needed.

All PBSPs must be agreed to by the individual or legally responsible individual.

Conditions under which a restrictive intervention may be applied:

As listed in DDA Policy 5.15, Use of Restrictive Procedures, the following are not permitted under any circumstances:

a. Corporal/physical punishment;

b. The application of any electric shock or stimulus to a client's body;
c. Forced compliance, including exercise, when it is not for protection;
d. Locking a client alone in a room;
e. Overcorrection;
f. Physical or mechanical restraint in a prone position (i.e., the individual is lying on their stomach);
g. Physical restraint in a supine position (i.e., the individual is lying on their back);
h. Removing, withholding, or taking away money, tokens, points, or activities that a client has previously earned;
i. Requiring an individual to re-earn money or items purchased previously; and
j. Withholding or modifying food as a consequence for behavior (e.g., withholding dessert because the client was aggressive).

Per DDA Policy 5.15, restrictive interventions may only be used for the purpose of protection, and may not be used for the purpose of changing behavior in situations where no need for protection is present. The participant or legal guardian has the right to refuse any service (including the use of restrictive interventions) at any time.

Identification of a specific and individualized assessed need:

If a restraint is to be used to treat challenging behavior, it must be supported by a functional assessment as described in DDA Policy 5.14 (Positive Behavior Support), Attachment A (Recommended Guidelines for Developing Functional Assessments and Positive Behavior Support Plans). All Functional Assessments must contain four major sections:

・Description and Pertinent History;
・Definition of Challenging Behavior(s);
・Data Analysis/Assessment Procedures; and
・Summary Statements.

Based on the Functional Assessment, a written Positive Behavior Support Plan is implemented to reduce or eliminate the client's need to engage in the challenging behavior(s).

Informed Consent:

The use of restrictive interventions is voluntary and the participant or representative must give informed consent, which is documented in the individual's ISP and PBSP. The participant or representative is always included in the development of the person-centered care plan, as well as a PBSP. The participant or representative is made aware of the risks and the right to refuse the restrictive intervention. The participant or legal guardian has the right to refuse any service (including the use of restrictive interventions) or medication at any time.

Positive interventions, supports and less intrusive methods must be employed prior to the use of restrictive interventions:

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

Participants must have an assessed need proportionate to the use of restrictive interventions:

The need for a restrictive intervention must be assessed by a specialist in challenging behaviors. This information must then be incorporated into the participant's ISP, the Functional Assessment that details the challenging behaviors and their precursors, and the PBSP. The conditions under which a restrictive intervention may be used must be documented in the participant's ISP and in the PBSP. Documentation must reflect the symptom related to behavior for which a restrictive intervention is being used, when a restrictive intervention may be used, and how the restrictive intervention should be used.

Restrictive interventions must be used only as provided for in DDA Policy 5.15., Use of Restrictive Procedures, DDA Policy 5.17, Physical Intervention Techniques, and DDA Policy 5.20, Restrictive Procedures and Physical Interventions with Children and Youth.
• Restrictive interventions must be used only when positive or less restrictive techniques or procedures have been tried and are determined to be insufficient to protect the client, others, or damage to the property of others.
• Restrictive interventions may only be used for the purpose of protection and may not be used for the purpose of changing behavior in situations where no need for protection is present.
• Only the least restrictive intervention needed to adequately protect the client, others, or property must be used, and terminated as soon as the need for protection is over.

Collection and review of data to measure the ongoing effectiveness of the restrictive intervention:

Per DDA Policy 5.14, Positive Behavior Support, the PBSP must address the following:

• Operationally define the goals of the PBSP in terms of specific, observable behaviors.
• Indicate what data is needed to evaluate success (e.g., frequency, intensity and duration of target behaviors).
• Provide instructions to staff or caregivers on how to collect this data (e.g., forms, procedures) i.e., frequency, intensity and duration.
• List who will monitor outcomes, need for revisions, and evaluate success and process for monitoring.
• Recommend displaying data in a graph over time for easy analysis.

Per DDA Policy 5.15, Use of Restrictive Procedures, and DDA Policy 5.20, Restrictive Procedures and Physical Interventions with Children and Youth, program staff responsible for PBSPs must review the plan at least every thirty (30) days. If the data indicates progress is not occurring after a reasonable period, but no longer than six (6) months, the PBSP must be reviewed and revisions implemented as needed.

Periodic review of restrictive intervention usage:

The ISP and PBSP must be reviewed at least annually (and in the case of behavior support and consultation provider to children and youth in the family home, providers must submit quarterly progress reports) and updated at any time the use of a restrictive intervention becomes ineffective, is no longer needed or becomes unsafe.

A post-analysis (i.e., a debriefing to review the incident and assess what could have been done differently) must take place whenever restrictive interventions are implemented in emergencies or when the frequency of use of the intervention is increasing. The child/youth, service providers involved, supervisor (in residential settings), parent/guardian, and other team members must participate, as appropriate. The DDA case manager must document the post-analysis in a service episode record (SER) in the client's record.

Restrictive interventions may not cause harm:

The use of restrictive interventions must be deemed safe and appropriate per DDA policies concerning the use of restrictive procedures. The waiver participant or representative is informed of any risks and may choose to decline the use of restrictive interventions at any time.

Education and training requirements for providers involved in the use of restrictive interventions:

All staff using restrictive interventions must have prior training in the use of such techniques according to the facility or agency's policy and procedures. With all training on the use of restrictive interventions, staff must also receive training in crisis prevention techniques and positive behavior support. Staff receiving restrictive intervention techniques training must complete the course of instruction and demonstrate competency before being authorized to use the techniques with waiver participants. All residential service providers must have documentation of prior training in the use of restrictive intervention techniques.

A review of de-escalation techniques and physical intervention techniques with all service providers and members of a child/youth's support team must occur annually before continuing to be used with the

child/youth.

Restrictive intervention systems must include, at a minimum, the following training components:
1. Principles of positive behavior support, including respect and dignity;
2. Communication techniques to assist a child/youth to calm down and resolve problems in a constructive manner;
3. Techniques to prevent or avoid escalation of behavior;
4. Techniques for providers and parents/guardians to use in response to their own feelings or expressions of fear, anger, or aggression;
5. Techniques for providers and parents/guardians to use in response to the child/youth's feelings of fear or anger;
6. Instruction that restrictive intervention techniques may not be modified except as necessary in consideration of individual disabilities, medical, health, and safety issues. An appropriate medical/health professional and a certified trainer or behavioral specialist must approve all modifications;
7. Evaluation of the safety of the physical environment at the time of the intervention;
8. Use of the least restrictive interventions depending upon the situation;
9. Clear presentation and identification of prohibited and permitted restrictive intervention techniques as outlined in this policy;
10.Discussion of the need to release a child/youth from any physical restraint as soon as possible;
11.Instruction on how to support restrictive interventions as an observer and recognize signs of distress by the child/youth and fatigue by the staff; and
12.Discussion of the importance of complete and accurate documentation by service providers.

References:

-DDA Policy 5.14: Positive Behavior Support
-DDA Policy 5.15: Use of Restrictive Procedures
-DDA Policy 5.16: Use of Psychoactive Medications
-DDA Policy 5.17: Physical Intervention Techniques
-DDA Policy 5.19: Positive Behavior Support for Children and Youth
-DDA Policy 5.20: Restrictive Procedures and Physical Interventions with Children and Youth

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The Department of Social and Health Services (DSHS) through the Aging and Long-Term Support Administration (ALTSA) and through Child Protective Services (CPS) is responsible for detecting the unauthorized use of restrictive interventions.

Under state authority RCW 74.34, the ALTSA receives reports and conducts investigations of abuse, neglect, exploitation and abandonment for clients enrolled with the Developmental Disabilities Administration. ALTSA Residential Care Services (RCS) investigates the role of provider systemic issues regarding abuse and neglect occurring in nursing homes, adult residential care facilities, adult family homes, & supported living programs. ALTSA Adult Protective Services (APS) investigates the perpetrators of abuse and neglect involving adults.

Under state authority contained in Chapter 26.44 RCW, Child Protective Services (CPS) within the Children's Administration (CA) of the Department of Social and Health Services (DSHS) is responsible for receiving and investigating reports of suspected child abuse and neglect.

DDA detects use of unauthorized restrictive intervention through:
- * Reports submitted to APS,
- * Reports submitted to RCS,
- * Reports submitted to CPS,
- * Reports received in the DDA Incident Reporting system,
- * The face to face DDA Assessment process conducted yearly and at times of significant change,
- * The DDA grievance process, and
- * DDA Quality Assurance activities that include face to face interviews of clients and review of complaints.

RCS and APS are using the TIVA system to document investigation activities including a) intake of complaints and b) outcome reports. There is an electronic connection between the FamLink and the CARE system to notify case managers of a) complaints concerning treatment of children that are referred for investigations and b) investigation outcomes. This is an electronic notification that is iincluded in the individual's CARE record.

DDA Policies 5.14, 5.15, 5.16, 5.17, 5.19 and 5.20 (see G-2.b.i) specify the requirements for using and documenting use of any type of restrictive intervention. Only the least restrictive intervention needed to adequately protect the client, others, or property may be used, and terminated as soon as the need for protection is over. The use of approved restrictive interventions must be fully documented and reviewed at least monthly by the residential provider and at least quarterly by the waiver participant's interdisciplinary team. Any emergency use of a restrictive interventions requires an incident report to DDA headquarters where it is reviewed by the Incident Management Program Manager.

Residential Care Services (RCS) Division has contracted evaluators who evaluate the residential agencies/programs at least once every two years. Their review always includes any use of restraints, restrictive interventions, or use of psychoactive medications.

Quality Compliance Coordinator (QCC) staff yearly review the positive behavior support plans (PBSPs) of a sample of waiver participants. One focus is on instances when the PBSP includes a restraint that requires approval through an exception to rule (ETR). When the QCC team identifies PBSPs requiring an ETR that did not have an ETR, the QCC team verifies that individual corrective action was completed within 90 days and reports to management on systems issues.

References:

-Chapter 26.44 RCW: Abuse of Children
-Chapter 74.34 RCW: Abuse of Vulnerable Adults
-DDA Policy 5.14: Positive Behavior Support
-DDA Policy 5.15: Use of Restrictive Procedures
-DDA Policy 5.16: Use of Psychoactive Medications
-DDA Policy 5.17: Physical Intervention Techniques
-DDA Policy 5.19: Positive Behavior Support for Children and Youth
-DDA Policy 5.20: Restrictive Procedures and Physical Interventions with Children and Youth

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The Department of Social and Health Services:
- *Developmental Disabilities Administration (DDA)
- *Aging and Long-Term Support Administration/Residential Care Services (RCS)
- *Aging and Long-Term Support Administration/Adult Protective Services (APS)
- *Childrens' Administration/Child Protective Services (CPS)

Under state authority RCW 74.34, the Aging and Long-Term Support Administration (ALTSA) receives reports and conducts investigations of abuse, neglect, exploitation and abandonment for clients enrolled with the Developmental Disabilities Administration. ALTSA's Residential Care Services (RCS) investigates the role of provider systemic issues in abuse and neglect occurring in nursing homes, adult residential care facilities, adult family homes, & supported living programs. ALTSA's Adult Protective Services (APS) investigates the perpetrators of abuse and neglect involving adults.

The DDA detects use of unauthorized restrictive intervention through:

- *Reports submitted to APS,
- *Reports submitted to RCS,
- *Reports submitted to CPS,
- *Reports received in the DDA Incident Reporting system,
- *The face to face DDA Assessment process conducted yearly and at times of significant change,
- *The DDA complaint/grievance process, and
- *DDA Quality Assurance activities that include face to face interviews of clients and review of complaints.

Residential Care Services Division has contracted evaluators who evaluate the residential agencies/programs at least once every two years. Their review always includes any use of restraints, restrictive procedures, or use of psychoactive medications.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c -i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Waiver participants are served in their family homes with the exception of out-of-home respite services. In-home respite providers may be delegated the task of medication administration by an RN. Outside of the service of respite, families are responsible for medication administration and management.

DSHS/DDA assists families to monitor their child's medications through an emphasis on collaboration between all persons, including healthcare providers, who support the child. Collaboration across systems is monitored as a part of the case manager follow-up visits, which occur every 30-90 days. This collected

information is analyzed at least annually by the Program Manager, Senior Researcher, and HCBS Medicaid Waiver Management Committee.

Medication management is a component of the DDA assessment. The DDA assessment will trigger a referral requirement if medication risk factors are identified. Once this requirement is triggered the CRM must address the risk identified in the ISP. How the risk is addressed depends on the concern identified. It could result in a medication evaluation referral, additional family or provider training, nurse oversight visits, and consultation with the healthcare provider or any of a number of measures.

The Health Care Authority (HCA) utilizes the standardized guidelines for psychoactive medication in children and youth when approving medication coverage requests. Requests for subscriptions outside the guidelines trigger a second opinion review. Safety limit parameters, including dosage and medication combinations, were established by a review of the literature, expert review, and community practice consensus. The program was then created for second opinion review of prescriptions that appear to be given outside of these safety standards.

Examples of dosage and medication combination parameters that trigger a DSHS medication review:
• Prescription of stimulant beyond 60mg amphetamines, 120mg methylphenidates, 120mg atomoxetine/day, or 70mg of lisdexamfetamine
• Prescription of stimulant to children • Combination prescription of >1 stimulant class
• Combination prescription of both atomoxetine and stimulant, without failing monotherapy of each first
• Five (5) or more psychotropic medications prescribed concomitantly after 60 days
• Two (2) or more concomitant antipsychotic medications after 60 days
• Absence of a DSM-IV diagnosis in the child's claim record

Protections against the use of chemical restraints are included in DDA Policies 5.14 (Positive Behavior Support), Policy 5.15 (Use of Restrictive Procedures), Policy 5.16 (Use of Psychoactive Medications), Policy 5.19 (Positive Behavior Support for Children and Youth), and Policy 6.19 (Residential Medicaid Management) with respect to the use of psychoactive medications. If psychoactive medications are used, informed consent must be obtained, a functional assessment must be completed, a positive behavior support plan must be developed and implemented, and a Psychoactive Medication Treatment Plan must be in place. Psychoactive medications can only be used as prescribed."

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

The Department of Social and Health Services:

- *Developmental Disabilities Administration (DDA)
- *Aging and Long-Term Support Administration/Residential Care Services (RCS)Division
- *Aging and Long-Term Support Administration/Adult Protective Services (APS)
- *Childrens' Administration/Child Protective Services (CPS)

DSHS/CA/DLR (Division of Licensed Resources within Children's Administration) is responsible for monitoring medication administration as a part of overall performance monitoring in licensed residential settings for children. The Children's Administration Management Information System (CAMIS) database containing the record of licensing inspections and required provider training is maintained and monitored by Children's Administration/Division of Licensed Resources (DLR). As part of the ongoing performance monitoring, a schedule of unannounced visits is established for all Foster Home and Staffed Residential providers. The licensed providers are reviewed at least every 36 months to assess performance against ongoing licensing requirements. The schedule is continually monitored and updated by DLR for compliance. Outcomes of the licensing process, such as statements of deficiency and corrective actions, are documented in the database and are used to determine whether or not licensure will continue or establish the frequency of unannounced visits. Communication regarding the licensing process occurs at the regional level.

DDA Policy 6.19 (see G-3-b-i) specifies the requirements for residential medication management. Residential Care Services Division has contracted evaluators who evaluate the residential agencies/programs at least once every two years.

Issues with medication management are also identified if errors result in allegations of abuse, neglect, exploitation. Under authority provided via RCW 74.34 (public assistance Washington state law concerning abuse of vulnerable adults), the Aging and Long-Term Support Administration (ALTSA) receives reports and conducts investigations of abuse, neglect, and exploitation for individuals enrolled with the Developmental Disabilities Administration. ALTSA's Residential Care Services (RCS) investigates provider systemic issues regarding abuse and neglect occurring in nursing homes, adult residential care facilities, adult family homes, & supported living programs. ALTSA's Adult Protective Services (APS) investigates the perpetrators of abuse and neglect involving adults.

Under authority provided via RCW 26.44 (Washington state law concerning abuse of children), Child Protective Services (CPS) investigates all allegations of abuse, neglect, and exploitation of children living in their parents home and/or licensed facility or foster care. Substantiations are forwarded to the BCCU.

CPS, RCS and APS are using TIVA and FamLink to document investigation activites including intake of complaints and outcome reports. There is an electronic connection between TIVA/FamLink and the CARE system to notify case managers of a) complaints that are referred for investigations and b) investigation outcomes. This is an electronic notification that will be included in the individual's CARE record.

ALTSA receives nightly data feeds from FamLink that are used in this ALTSA reporting system. FamLink information is reviewed to determine if client information matches DDA waiver participants who are identified in CARE. DDA usea the ALTSA reporting system to address specific programmatic and provider issues from the outcomes of the waiver participants who were involved in investigations by Residential Care Services (RCS) and/or Children's Protection Services (CPS) for whom a report of abuse, neglect, abandonment, or financial exploitation was substantiated. The data are broken out by type of incident and provider type.

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

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DDA Administration Policy 6.19 (Residential Medication Management, please see G-3-b-i) specifies the requirements for residential medication management. Residential Care Services (RCS) has contracted staff who evaluate the residential agencies/programs at least once every two years to ensure they are in compliance with these requirements.

iii. Medication Error Reporting. *Select one of the following:*

- ◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  Complete the following three items:

  (a) Specify State agency (or agencies) to which errors are reported:

The Developmental Disabilities Administration (DDA) within the Department of Social and Health Services (DSHS).

(b) Specify the types of medication errors that providers are required to *record:*

Providers are required to record all medication errors.

WAC 388-101-3720 ("Medications--Documentation") indicates the service provider must maintain a written record of all medications administered to, assisted with, monitored, or refused by the individual.

WAC 388-101-3690 ("Medication Refusal") indicates
(1) When an individual who is receiving medication support from the service provider chooses to not take his or her medications, the service provider must:

(a) Respect the individual's right to choose not to take the medication(s) including psychoactive medication(s); and

(b) Document the time, date and medication the individual did not take.

(2) The service provider must take the appropriate action, including notifying the prescriber or primary care practitioner, when the individual chooses to not take his or her medications and the individual's refusal could cause harm to the individual or others.

(c) Specify the types of medication errors that providers must *report* to the State:

Providers are required to report medication errors causing injury/harm, or a pattern of errors.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Department of Social and Health Services:
- * Developmental Disabilities Administration (DDA)
- * Aging and Long-Term Support Administration/Residential Care Services (RCS)
- * Children's Administration/Child Protective Services (CPS)

DDA Policy 6.19 (Residential Medication Management, please see G-3-b-i) specifies the requirements for residential medication management. RCS has contracted staff who evaluate the residential agencies/programs at least once every two years.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
G.a.1: The % of incidents alleging abuse, neglect, abandonment, and/or financial exploit of waiver clients that were reported by DDA, per policy, to Adult Protective Services (APS), Child Protective Services (CPS), or Residential Care Services (RCS). N= # of incidents where CRMs reported allegations to APS, CPS or RCS. D= Total # of incidents requiring notification by DDA to APS, CPS or RCS.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Incident Review Committee	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.2: The number of allegations of abuse, neglect, abandonment, or financial exploitation substantiated by APS, by type of incident. N= The number of substantiated allegations of abuse, neglect, abandonment, or financial exploitation by APS, by incident type. D= The total number of allegations substantiated by APS.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
Tracking Investigations of Vulnerable Adults (TIVA) and Famlink

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.3: The number of waiver clients for whom a report of abuse, neglect, abandonment, or financial exploitation was substantiated by Child Protection Services (CPS)by type of incident. N=The number of substantiated allegations of abuse, neglect, abandonment, or financial exploitation by CPS, by incident type. D= The total number of allegations substantiated by CPS .

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
TIVA (Tracking Investigations of Vulnerable Adults) and Famlink

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
G.a.4: The total number of completed RCS investigations with an enforcement activity by type of enforcement activities. N=The number of investigations resulting in an enforcement activity by type of enforcement activity. D=The total number of completed RCS investigations involving waiver recipients with an enforcement activity.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
TIVA (Tracking Investigations of Vulnerable Adults) and Famlink

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Incident Review Committee	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.5: The percentage of families responding to the NCI Survey who report that they know how to report a concern or make a complaint about services. N= All families of waiver participants who respond to the NCI Survey and report they know how to report a concern or make a complaint about services. D= All families of waiver participants who respond to the NCI Survey.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.6: The percentage of waiver participants whose death was subject to review that were reviewed by the DDA Mortality Review Team (MRT). N= The number of waiver participants whose death was reviewed. D= The number of waiver participants whose death was subject to review.

Data Source (Select one):
Mortality reviews
If 'Other' is selected, specify:
Mortality Review Team Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☑ **Other** Specify: Mortality Review Team	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.7: The number of waiver recipients deaths reviewed by the Mortality Review Team (MRT) by cause of death. N= The number of waiver recipient deaths reviewed by the MRT by cause of death. D= The total number of waiver recipient deaths reviewed by the MRT.

Data Source (Select one):
Mortality reviews
If 'Other' is selected, specify:
Mortality Review Team Database

Responsible Party for data	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*		
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.8: The percentage of closed critical incident reports for which appropriate follow up occurred. N: The number of closed critical incidents for which appropriate follow up occurred. D = The total number of closed critical incident reports.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
Incident Management Review Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.9: The % of incidents of alleged abuse, neglect, exploit or abandonment in which the wvr partic. and/or legal rep. was contacted within 30 days to ensure safety plans were developed/appropriately implemented. N:# of reviewed incidents in which the waiver participants and/or legal rep was contacted within 30 days. D: # of reviewed incidents of alleged abuse, neglect, exploit or abandonment.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Compliance Coordinators (QCC) Team	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G.b.1: The percentage of waiver participants with three or more incident reports during the calendar quarter that was reviewed by QA managers to verify appropriate actions were taken. N=The number of waiver participants with three or more incident reports during the quarter with appropriate action taken. D=the total number of waiver participants with three or more incidents during the quarter.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☑ **Other** Specify: Quality Compliance Coordinators (QCC) team	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.b.2: The percentage of waiver recipients with a critical incident report whose ISP was amended when it should have been amended. N= The number of waiver participants with a critical incident report whose ISP was amended when it

should have been amended. D= The total number of waiver participants with a critical incident whose ISP should have been amended.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
incident Management Review Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Incident Review Team	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 40 individuals (across all waivers) per year.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G.c.1: The Percentage of Positive Behavior Support Plans requiring an Exception to Policy (ETP) with an ETP in the CARE system. N=the number of waiver client files reviewed with a PBSP which had the required ETP. The D=the number of waiver client files reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☑ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

Quality Compliance Coordinators (QCC) Team		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G.d.1: The % of waiver participants who visited the dentist during the year.
Numerator= The # of individuals who visited a dentist during the waiver year.
Denominator= The total # of waiver participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Compliance Coordinators (QCC) Team within DDA	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
G.a.1: Alleged incidents of abuse, neglect, abandonment and exploitation are recorded in the DDA Incident Reporting (IR) Database. The database also documents contacts and follow-up referrals. A report is compiled based on incident type and other agencies contacted to document whether or not APS, CPS, or RCS was notified.

G.a.2. and G.a.3: The TIVA (Tracking Investigations of Vulnerable Adults) and Famlink (children) provide data for reports that lists clients for whom a report of abuse, neglect, abandonment, or financial exploitation was substantiated. The data are broken out by type of incident.

G.a.1, G.a.4. and G.c.1: The QCC Team completes a review of randomly selected files across all waivers annually. The list for the QCC Team review is based on a random sample representative of of the waiver program with a 95% confidence level and a confidence interval of +/-5%. The findings from these reviews are collected in a database. All findings are expected to be corrected within 90 days. Corrections are monitored by QCC Team members. The review protocol addresses (among other things) the following areas with a target of 100% compliance:
1. If there has been an Incident Report of alleged/suspected abuse, neglect, exploitation, or abandonment submitted within the last 12 months, did DDA notify appropriate Department (APS,CPS,RCS) and Law Enforcement agencies?
2. If there has been an Incident Report of alleged/suspected abuse, neglect, exploitation, or abandonment submitted within the last 12 months, is there evidence the case manager contacted the client/legal representative within 30 days of the Incident Report date to ensure safety plans were developed/appropriately implemented?
3. If the Positive Behavior Support Plan includes restrictions requiring an Exception to Policy (ETP), was there an approved ETP?

G.a.6 and G.a.7: The Mortality Review Team (MRT) reviews waiver recipients whose death occurred while receiving residential services, medically intensive children's program services or whose death was unusual or unexplained to identify factors that may have contributed to the deaths and to recommend measures to improve client supports and services.

G.b.1: Each of the three DDA Regions has a designated Quality Assurance (QA) Manager. Every four months those managers review individuals with three or more reports in the DDA Incident Reporting database. A report is provided by each regional QA Manager to Executive Management listing all waiver recipients with three or more incident reports that were reviewed during that four-month period.

G.b.2: Every month members of the Central Office Incident Review Team (IRT) review a sample of individuals for which a critical incident was reported during the waiver year. Each member reviews the information contained in CARE to verify that the response to the incident was appropriate, including whether there should have been (and was or was not) an amendment to the ISP.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
G.a.1, G.a.2; G.a.3; G.a.4; G.a.9: If the review determines specific allegations of abuse, neglect, abandonment and exploitation were not referred to APS, CPS, or RCS, an immediate referral to the appropriate entity is made.

G.a.1, G.a.4. and G.c.1: If a pattern of critical incidents is identified with respect to a specific individual or a

specific provider, the quality Assurance Office Chief works with the appropriate HQ and/or regional staff to take appropriate steps to prevent future occurrences of such incidents. For example, client ISPs or positive behavior support plans might be updated, provider reviews and/or certification might be adjusted to target the underlying factors resulting in the incidents, and provider alerts might be developed if a pattern across providers is detected. In addition, case manager training might focus on prevention, detection, and remediation of critical incidents.

G.a.9: If following notification of an incident the waiver participant/legal representative was not contacted within 30 days, the supervisor and case manager are reminded that this is required. If no contact was made at all, follow-up with the waiver participant/legal representative is required.

G.a.6 and G.a.7: Changes implemented as a result of information gained from MRT reviews include caregiver alerts, curriculum for providers and case managers, and changes in DSHS administrative rules (WAC). For example, topics of caregiver alerts include "How hot is your water?", "Aspiration", "Seizures and Bathing", and "Type 2 Diabetes".

G.b.1: QA Managers review any client with three or more incidents in each four-month period and report findings to central office. The Incident Review Team (Central Office) reviews QA reports and makes recommendations for corrective actions if needed.

G.b.2: In the review of the IR information, if amendments to the ISP or PBSP are determined necessary but were not made or were insufficient, the case manager and/or regional management are notified to ensure that the participant's needs are being addressed and that necessary changes are included in the ISP or PBSP.

G.c.1:
When the QCC team identifies Positive Behavior Support Plans requiring an ETP that did not have an ETP, the QCC team verifies each individual corrective action was completed within 90 days and reports to management on systems issues.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Developmental Disabilities Administration (DDA) has managed at least one HCBS waiver since 1983. In 2003 a statewide effort was launched to coordinate the implementation of Quality Improvement in all agencies. We have developed multiple processes for trending, prioritizing, and implementing system improvements that have been prompted as a result of data analysis.

Internal DDA Systems
DDA uses several data systems that are vital to the implementation of the Waiver.

DDA Assessment:
- o The DDA Assessment is designed to discover the individual support needs of each individual who is assessed. It is a tool to help case managers plan for services and supports to meet the needs of individuals with developmental disabilities.
- o All Waiver participants will be assessed using this tool, which includes an assessment of caregiver stress, behavior issues, critical medical issues, and protective supervision needs.
  - * Data is pulled as needed by program managers, waiver manager, quality assurance staff and management.
  - * Data is analyzed by the appropriate entity who is using the information for system improvement activities.

Comprehensive Assessment Reporting and Evaluation (CARE):
- o Assists case managers to provide effective monitoring of case status and service plans.
- o Provides a system of ticklers or alerts to cue case resource manager action at specific intervals based upon client need.
- o Provides an automated process for Exception to Rule (ETR), Prior Approvals and Waiver Requests.
- o Delivers a consistent, reliable and automated process.
- o Provides client demographic and waiver status in real time.
- o Provides management reports to look for trends and patterns in the Waiver caseload.
  - * Data is pulled as needed by program managers, regional staff, quality assurance staff and management.
  - * Data is analyzed by the appropriate entity who is using the information for system improvement activities.

Quality Compliance Coordinator (QCC) Review database:
- o Is used to collect audit data to insure that the processes and procedures required in delivering waiver services are according to requirements.
- o Is used to develop regional and statewide corrective action plans.
  - * Data is developed by the Office of Compliance and Monitoring.
  - * Reports are created at least annually.
  - * Data is analyzed by DDA staff at a minimum annually.

DDA Incident Reporting system (IR):
- o The IR system provides management information concerning significant incidents occurring in client's lives.
- o Individual incidents come first to the CRM for input into the IR system.
- o DDA has developed protocols and procedures to respond to incidents that have been reported.
- o Analysis processes are in place to review and monitor the

health and welfare of DDA clients.
 * Data is pulled by the Incident Program Manager.
 * Data is pulled three times a year.
 * Data is analyzed by the Incident Reporting Team and as requested by DDA management.

Individual Support Plan Meeting Survey:
o A ISP Meeting survey is mailed to waiver participants within one month of the ISP planning meeting. This survey gives
participants an opportunity to respond to a series of questions about the ISP process. The survey is mailed from Central
Office based on a random sample across all waivers with a 95% confidence level and a confidence interval of +/-5%.
Information collected is analyzed annually by DDA staff.
o Information regarding trends or patterns that is gathered from that data is acted upon, through additional training for case managers, clarification of information for participants, etc.
* Data is pulled by the Research Specialist.
* Data is pulled at least annually.
* Data is analyzed by DDA staff at a minimum annually.

Complaint Data Base:
o DDA maintains a Complaint data base that is the repository for complaints that rise above the standard issues that case managers or supervisors handle each day as a normal business practice.
 * Data is pulled by the Research Specialist.
 * Data is pulled at least annually.
 * Data is analyzed by DDA staff at a minimum annually.

DSHS systems external to DDA:

Social Service Payment System:
o DDA audits information from this system to verify services identified in the Individual Support Plan as necessary to meet health and welfare needs have been authorized.
o DDA also audits information from this system to ensure that services are only authorized after first being identified in the Individual Support Plan.
 * Data is pulled by the SSPS Program Manager.
 * Data is pulled at least annually.
 * Data is analyzed by DDA staff at a minimum annually.

Child Protective Services (CPS):
o CPS is responsible for investigating and making official findings on any accusations of abuse or neglect of a minor child.
o DDA refers all such incidents to CPS for investigation and works cooperatively with them to provide information about the incident and to protect the child during the investigation.
 * Data is pulled by the Research Specialist.
 * Data is pulled at the request of the Program Manager.
 * Data is analyzed by DDA staff at a minimum annually.

Adult Protective Services (APS):
o APS is responsible for investigating and making official findings on any accusations of abuse, neglect or exploitation of a vulnerable adult, who does not live in either a licensed setting or is served by a certified residential service.

- o DDA refers all such incidents to them for investigation and works cooperatively with them to provide information about the incident and to protect the adult during the investigation.
  - * Data is pulled by the Research Specialist.
  - * Data is pulled at least annually.
  - * Data is analyzed by the Regional Quality Assurance Managers and as requested by DDA management.

Division of Licensing Resources (DLR):

- o Monitors and licenses Children's Foster Homes, Group Homes and Staffed Residential Homes, which are utilized as respite resources in the waiver program.
- o DDA works cooperatively with DLR to ensure homes are licensed and appropriate care is provided.
  - * Data is pulled by DLR.
  - * Data is pulled at the request of the Program Manager.
  - * Data is analyzed by the Program Manager and as requested by management.

Residential Care Services (RCS):

- o RCS is responsible for investigating provider practices in instances of abuse, neglect or exploitation of a vulnerable adult who receives services from either a licensed setting or is served by a certified residential agency.
- o DDA refers incidents to them for investigation and works cooperatively with them to provide information about the incident.
  - * Data is pulled by the DDA Incident Program Manager.
  - * Data is pulled at least annually.
  - * Data is analyzed by DDA staff at a minimum annually.

FamLink/TIVA are electronic systems that maintains notifications, investigative and outcome information for CPS, APS and RCS. Data from FAMLINK/TIVA is used to track and trend inforamtion related to allegations of abuse, neglect, abandonment and financial exploitation.

Administrative Hearing Data Base:

- o The Administrative Hearings data base tracks requests for administrative hearings requested by waiver clients who disagree with decisions made by DDA.
- o DDA uses data from this data base to review the concerns of persons on the waivers and determine if there are system issues that need to be addressed.
  - * Data is pulled by the Research Specialist.
  - * Data is pulled at least annually.
  - * Data is analyzed by DDA staff and as requested by DDA management.

Agency Contracts Database (ACD):

- o The ACD is an important tool in assuring that waiver service providers have contracts in place that meet requirements.
- o The tool is used by DSHS to monitor all state contracts.
- o The system monitors compliance with background check requirements, training requirements, evidence of any required licensure, and timeliness of contracts.
  - * Data is pulled at least annually by the Contracts Program Manager.
  - * Data is analyzed by DDA staff and as requested by DDA management.

External Non Governmental Systems:

National Core Indicators (NCI) Survey:

o DDA has been participating in the NCI Survey since 2000.
o DDA has adapted the survey to do a face-to-face survey in the home that addresses satisfaction with DDA services, providers and other key life indicators.
o Additional questions have been added about waiver services.
o This data is reviewed with stakeholders and state staff.
 * Data is pulled at least annually by the Research Specialist.
 * Data is analyzed by DDA staff and as requested by DDA management.
o Recommendations for needed changes are developed from this process and necessary action is taken.

Developmental Disabilities Council (DDC):
o The DDC partners with the state to conduct focus groups that look at the NCI data and make recommendations to the state.
o Reports are developed by the DDC and submitted to the state for action.
 * Reports are delivered to DDA upon completion.
 * DDA responds with appropriate action.

Information from the above data systems is gathered and analyzed in order to continually monitor and make changes to our delivery system when the need is demonstrated. DDA utilizes a variety of methods to analyze data. Some examples include identifying trigger points that require more in-depth analysis using control charts and other types of analysis; or in-depth work focused on the occurrence of a serious incident.

Once the need for change has been determined through the analysis of data, DDA prioritizes quality improvement steps based on a risk management strategy that considers health and safety, best practices, legislative requirements, and CMS recommendations.

DDA then implements needed system improvements through a variety of methods, such as training and re-training; resource allocation; studies; policy or rule changes; and funding requests. DDA identifies who is responsible for implementation of the needed change, how that will be accomplished and timelines for accomplishing the needed change.

Strategies for improvement are specific to the type of improvement that is indicated by the data that has been reviewed. However the process is generally the same:
1. We review and analyze data;
2. We strategize to find solutions to any problems identified from the data;
3. Action plans are developed; and
4. Progress is reviewed until goals are accomplished.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **State Medicaid Agency**	☑ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☑ **Other** Specify: 2 times per year. 3 times per year. 6 times per year during the first year of the biennium.

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The Developmental Disabilities Administration (DDA) uses a discovery and monitoring process to analyze the effectiveness of our current systems. All collected data is identified by waiver type in order to evaluate and monitor each individualized waiver program. Performance is measured in terms of outcomes. DDA uses both internal and external groups to analyze this data. DDA reviews data from multiple data sources to discover whether trends and patterns meet expected outcomes. DDA begins an improvement process if they do not. DDA's Quality Improvement (QI) process has been part of the Administration's activities for decades.

The goal of Quality Improvement in DDA is to promote, encourage, empower and support continuous quality improvement. Major areas of focus:

Surveys
- *ISP surveys give individuals/guardians an opportunity to provide anonymous feedback on the planning process. Information collected from these surveys is used to analyze the effectiveness of the planning process.

Reviews
- *Reviews ensure that processes and procedures required in delivering waiver services are according to requirements.
- *Waiver review findings are analyzed and shared with regional and statewide management teams for corrective action and system improvement.

Quarterly evaluations of performance measures
- *Quarterly DDA Regional management reports on waiver performance.
- *The report contains data such as the number of waiver assessments due with respect to the number that were completed, the regional progress on correction related to QCC audit findings, and many other key indicators of operational performance.

Training
- *Training is a significant focus to ensure that administraion's employees are equipped with the skills and knowledge to carry out their waiver responsibilities.
- *Annual Waiver training is provided for ongoing improvement.

There are many entities that play a critical role and are essential to DDA's Quality Management Strategy:

Internal (within DSHS)

Incident Review Team (IRT):
- *This team meets monthly to review aggregate data from the Electronic Incident Reporting System and make recommendations to prevent incidents.
- *Team members include:
  - Waiver Program Managers (PM), Waiver Requirements PM, RHC PM, Incident PM, Mental Health PM, Vocational PM, Quality Assurance PM, Compliance and Monitoring Unit Office Chief, Quality Programs and Services Office Chief, Special Investigation Unit PM and Data Analyst

for RHC investigation unit.

Mortality Review Team (MRT):
- *Meets monthly to review deaths of participants and monitor and make recommendations on trends and patterns.
- *Team members are:
  - RHC PM, Mental Health PM, Residential PMs, Compliance and Monitoring Unit Office Chief, Quality Programs and Services Office Chief, Waiver PM, Special Investigation Unit PM and Nursing Services PM.

Nursing Care Consultants (NCC):
- *Assigned to Regions to review and monitor health and safety concerns.
- *Nurses consult with case managers on health and welfare concerns.

State Waiver Program Manager and Regional Waiver Specialists:
- *The primary responsibility for the implementation of this waiver resides with the Waiver Program Manager
- *Regional Waiver Specialists work collaboratively with the Waiver Program Manager to ensure proper implementation at the regional level.
- *The Waiver Program Manager and Waiver Specialists meet monthly to monitor waiver implementation and recommend necessary waiver changes.

Regional Quality Assurance (QA) staff:
- *Provide quarterly reports which contain quality assurance information on incidents and other QA activities in the region.

Children's Administration:
- *Division of Licensing Resources(DLR) monitors and licenses Children's Foster Homes, Group Homes and Staffed Residential Homes.
- *Child Protective Services (CPS) provides investigation of incidents of abuse, neglect, abandonment and exploitation involving children.

External

HCA Medicaid Agency Waiver Management Committee:
- *This committee meets four times per year and is comprised of representatives from the Health Care Authority (the single State Medicaid Agency), Home and Community Services. the Behavioral Health and Service Integration Administration, and the Developmental Disailities Administration.
- *The Committee presents information to the single State Medicaid Agency in the following areas:
  - Annual reports from the three administrations
  - QCC reviews
  - National Core Indicators
  - Fiscal reports

The HCA provides recommendations and feedback based on the information provided.

Stakeholder input and review of waiver programs:
- *A web site offers stakeholders an opportunity to:
  - Review annual reports.
  - Review quality assurance activities.
  - Provide suggestions for ways to better serve waiver clients.

Developmental Disabilities Council (DDC):
- *The DDC is comprised of self-advocates, family members

and department representatives.
- o The DDC analyzes and provides recommendations for improvement using the National Core Indicators Survey as its' tool.

The HCBS (DDA) Waivers Quality Assurance Committee:
- *Sponsored by the DDC and comprised of self-advocates, family members, providers and Department representatives.
  - o Meets four times a year, with provision for more frequent sub-committee meetings on select topics as needed.
  - o Provides a forum for active, open and continuous dialogue between stakeholders and the DDA for implementing, mornitoring and improving the delivery of waiver services to best meet the needs of people with intellectual and developmental disabilities.

Various reports are disseminated to both external and internal groups. These groups are involved in evaluating the performance and progress of the Waiver program. Through this review process these groups also provide feedback on opportunities for improvement.

Included in the distribution cycle are:

Internal:

- *DDA Assistant Secretary, HQ Management Team and Regional Management Team reviews:
  - o Quarterly Regional management reports on the waiver performance.
  - o The report contains data such as the number of waiver assessments due against the number that were completed, the regional progress on correction related to QCC review findings, and many other key indicators of operational performance.

- *DDA Assistant Secretary, HQ Management Team and all Regional Management Teams reviews:
  - o The Quarterly Regional Quality Assurance Managers reports are compiled into one final report.
  - o Each regional QA report, also in a PowerPoint format contains 8 control charts from the key incident types, a detailed analysis of any waiver participant with 3 or more incidents, analysis of deaths, and information/ data on many other QA activities in the region.
  - o When the final report is compiled best practices and concerns are reviewed and necessary action is taken.

QCC reviews:
- *Statewide analysis of rview findings. The report includes data and recommendations from the annual review cycle. This report is then shared with the Medicaid Agency Waiver Oversight Committee and the Statewide Management Team.
- *Regional review findings. The regional reports are specific to the regional review. Each report provides an analysis of the data from the most current review and compares historical data (when available).

DDA Assistant Secretary Reviews:
- Monthly fiscal reports provided by Management Services Division (MSD).
  - o These reports provide detailed analysis of the waiver expenditures and individuals served.

External

A web site offers stakeholders an opportunity to review:
- *Annual waiver progress/performance reports.
- The reports are often PowerPoint presentations with control charts or Pareto charts constructed from data related to performance measures.

Washington State Developmental Disabilities Council (DDC):
- *Annual NCI Core Indicator reports are provided to the DDC for their recommendation and feedback.
- *The NCI reports focus on participant satisfaction or areas of concern.
- *The DDC invites families and self-advocates to review the data from the National Core Indicator survey report. Their feedback and recommendations are then shared with DDA management after every evaluation.

The HCBS Medicaid Agency Waiver Management Committee:
- *Includes representatives from the Health Care Authority (the Single State Medicaid Agency) and Administrations/Divisions within the operating agency: DDA, HCS, RCS, and BHSIA.
- *Meets at least quarterly to review:
  - All functions delegated to the operating agency
  - Current quality assurance activity
  - Pending waiver activity (e.g., amendments, renewals)
  - Potential waiver policy and rule changes
  - Quality improvement activities

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Developmental Disabilities Administration (DDA) believes that the quality of programs and services delivered to people with developmental disabilities in Washington State is everyone s business. The evaluation and improvement of processes and systems are ongoing. All collected data is identified by each waiver type in order to evaluate and monitor individualized waiver program effectiveness.

Each year DDA improves services to waiver clients by using the numerous data collection points, appropriate analysis and prioritization techniques, evaluation and feedback from differing groups.

DDA also seeks the assistance of CMS and other entities through grants, conferences, or Best Practices information, to continue to refine benchmarks for improvement and evaluate the system against those benchmarks.

The Quality Improvement Strategy will be re-evaluated at least once during the five year approval period. The following process will be followed in reviewing and updating the Quality Improvement Strategy:
- DDA will maintain a waiver management strategy.
- All processes and strategies will be continuously improved through the various methods of evaluation, monitoring, analysis and actions taken.
- DDA will work with participants, families, advocates, and providers to identify opportunities for performance improvement and report the progress being made back to stakeholders.
- State staff, providers and stakeholders will provide ongoing monitoring of the system. Changes may be recommended by any of the above entities.

Explanation and Examples of Types of Data Analysis Used:

Charting Data: Using charts and graphs, often provides greater insight and interpretation of data. Data charts provide a powerful tool to help observe and analyze the behavior of processes and the effects of trial

solutions. They are the best way to present data to others helping them to quickly grasp the information.

Chart Selection Guide: The information below summarizes several chart types that are useful in Quality Improvement and suggests possible applications:

A pie chart presents data as a percentage of a total. Examples of application include sources of errors and make up of a budget.

A bar chart presents comparisons of data categories. These can be categories at a point in time or changes in categories over a period of time. Examples of application include the number of errors over time, process output by month or by department, and comparison of results using different methods.

Pareto charts present data relative to the size of categories in order. Examples of application include customer quality characteristics in order of importance, and types of customer complaints.

Histo-grams present a distribution of a set of data (how frequently the given values occur) and shows the stability of a process. One example of application is variation of complaint resolution times.

Line charts represent behavior over time, same data collection frequency, and X charts. Examples of application include time to complete inspections over time, and the number of customer complaints over time.

Control charts present the common cause and special cause variation based on 3 sigma of the average, X bar and R, X and mr charts. Examples of application include time to fulfill customer requests, and the number of IRs per month.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

a) Providers are not required to have an independent financial audit of their financial statements. Agency providers are required to submit a cost report. If the department has reason to be concerned, the department will request an audit by Operations Review and Consultation or the State Auditors Office. Operations Review and Consultation is within DSHS. The State Auditor's Office is a state agency outside the Department of Social and Health Services.

b) The Office of Rates Management conducts desk audits on all annual cost reports submitted by providers. The revenues reported by providers are reconciled to the payments made through SSPS (later, ProviderOne) for services and the provider's contract(s) in place during the period. The Offce of Rates Management may require additional information from the provider (payroll records, other financial records, etc.) if there are concerns about the integrity of the cost report information. The Office of Rates Management may also conduct on-site reviews of provider financial records to ensure that the cost report is accurate and completed in accordance with contract requirements.

c) The state agencies responsible for conducting the financial audit program are the DSHS Operations Review and Consultation Services and/or the State Auditors Office.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance*

read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
I.a.1: The percentage of waiver participants who initially met financial eligibility for waiver enrollment. N= All waiver participants who initially met financial eligibility for waiver enrollment D= All waiver participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☑ **Other** Specify: Quality Compliance Cordinator (QCC) Team within DDA.	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
I.a.2:The percentage of waiver participants who continued to meet financial eligibility for waiver enrollment. N= All waiver participants who continued to meet financial eligibility for waiver enrollment. D= All waiver participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☑ **Other** Specify: Quality Compliance Coordinator (QCC) Team within DDA.	☑ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
I.a.3: The percentage of waiver participants whose authorized service amounts are equal to or less than the amount identified in the ISP. N= All waiver participants whose authorized service amounts are equal to or less than the amount identified in the ISP. D= All waiver participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	

		☑ **Representative Sample** Confidence Interval = 5%
☑ **Other** Specify: Quality Compliance Coordinator (QCC) Team within DDA.	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
I.a.4:The percentage of waiver participants who initially met disability criteria as established in the Social Security Act. N= All waiver participants who initially met disability criteria as established in the Social Security Act. Denominator: All waiver participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☑ **Other** Specify: Quality Compliance Coordinators (QCC) Team	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
I.a.5:The percentage of waiver participants who continued to meet disability criteria as established in the Social Security Act. N= All waiver participants who continued to meet disability criteria as established in the Social Security Act. D= All waiver participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
I.a.6:The percentage of all payments claimed under the CIIBS Waiver that are made for CIIBS Waiver recipients. N= All payments appropriately claimed under the CIIBS Waiver for CIIBS Waiver participants. D= All payments claimed under the CIIBS Waiver.

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*		
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
I.b.1: The percentage of payments in which the payment rate for Nurse Delegation was consistent with the rate methodology in the approved waiver application. N: the total # of payments for Nurse Delegation in which the payment rate was consistent with the rate methodology in the approved waiver. D: the total # of payments for Nurse Delegation reviewed.

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*		
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
I.a.1; I.a.2; I.a.3; I.a.4; I.a.5:
The QCC Team completes a review of randomly selected files across all waivers annually. The list for the QCC Team review is generated to produce a random sample representative of the waiver program with a 95% confidence level and a confidence interval of +/-5%. The findings from these reviews are collected in a database. All findings are expected to be corrected within 90 days. Corrections are monitored by QCC Team members.

A valid sample is produced for the QCC review. The review protocol includes (among others) the following questions with a target of 100% compliance.
*Are all the current authorized services identified in the ISP?
*Are the authorized service amounts equal or less than the amounts identified in the ISP?
*Are the payment rates for respite services consistent with the established rates for individual providers and agency providers?

I.a.6 and I.b.1:
A claims data report is run annually to verify that all claims made for FFP are for waiver participants and to verify the use of the proper rate methodology for Nurse Delegation Service..

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Waiver File Reviews (Annual QCC audit):
I.a.1; I.a.2; I.a.3; I.a.4; I.a.5:
Findings from QCC Team and Supervisor file reviews are analyzed by management, and based on the analysis necessary steps are taken to increase compliance. For example:.
• Annual Waiver Training curriculum is developed in part to address audit findings
• Annual Automated Client Eligibility System (ACES) training addresses financial and disability eligibility determination issues reflected in annual audits
• Policy clarifications occur as a result of audit findings.
• Analyses of findings assist regions to recognize personnel issues.
• Analysis of audit finding may impact format and instructions on forms.
• Analysis of findings has led to revision in Waiver WAC to clarify rule.
• Analysis of findings has led regions to revise regional processes.

Providers whose service authorization included a rate higher than the contracted rate are reviewed to determine the appropriate course of action. Overpayments are processed as necessary.

I.a.6: Claims that are made for nonwaiver participants are removed from the claim for FFP.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The goal of all CIIBS Waiver payment rates is to ensure waiver recipient access to cost-efficient services. Staff of the Developmental Disabilities Administration (DDA) within the Department of Social and Health Services are employees of the State Operating Agency. The CIIBS Waiver will have two dedicated resource managers (one stationed in Western Washington, the other stationed in Eastern Washington) to execute contracts with providers that serve waiver recipients. Their training and supervision will focus in part upon contract rates, the processes whereby rates are established and appropriate rate parameters (e.g., minimum and maximum rates) for each service. Unit rates and maximum expenditure amounts are part of the contracting process and are contained in service contracts. All contracts are reviewed and approved by Regional Business Managers who are also employees of DSHS/ DDA.
For those rates that have been pre-established based on Union negotiations and/or established benchmarks (personal care, respite, transportation, nurse delegation), Social Services Payment System (SSPS) edits ensure that the unit rate and total of number of units paid do not exceed the amounts authorized. Standardized unit rates are entered into SSPS based on the service code.

Oversight of rates based on provider-specific negotiations (behavior management and consultation, staff/family consultation and training, sexual deviancy evaluation, occupational therapy, speech, hearing and language services, physical therapy), contractor bids (environmental accessibility adaptations, vehicle modifications), and usual and customary charges (specialized medical equipment and supplies, assistive technology, specialized nutrition and specialized clothing, therapeutic equipment and supplies) is maintained by the CIIBS Waiver program manager, Regional Business Managers, and the DSHS Contract Manager. Benchmarks for all of these services already exist. Many of these services are covered under other DDA HCBS Waivers. Those services that are unique to the CIIBS Waiver (assistive technology, specialized nutrition and specialized clothing, therapeutic equipment and supplies, vehicle modifications) are either covered under other programs or are off-shoots of current services. Proposed rates that vary greatly from established benchmarks will undergo increased scrutiny.

For waiver services other than those with union negotiated rates, regional staff negotiate rates within ranges established and published for each service. The CIIBS Program has designated Resource Managers who negotiate rates with CIIBS providers. These Resource Managers are supervised by the CIIBS Program Manager at Central Office. Payment cannot exceed 1) the prevailing charges in the locality for comparable services under comparable circumstances, or 2) the rates charged for comparable services funded by other sources. Methods for determining

reasonable rates include periodic market surveys; cost analysis; price comparison; and competitive bidding (for environmental accessibility adaptations and vehicle modifications).

Rates for CIIBS Service contracts are negotiated by the designated CIIBS Resource Managers and reviewed by Regional Management and the CIIBS Program Manager at Central Office. As a result, the frequency of statewide oversight is continuous and ongoing and includes monthly conference calls to review service proposals, new contracts, and negotiated rates to assure that the rate negotiation process is applied uniformly across all regions. Contracted provider and rate information is maintained by the Resource Managers and shared with families who are selecting providers for service.

Rate determination methods for each service are as follows:

- Personal Care
  - o Provider rates are standardized based on negotiations with the Service Employees International Union (SEIU) and funding provided by the Legislature.
  - o When transportation to essential services is included in the personal care service plan, individual providers are also reimbursed for their mileage if they use their own private vehicle.
  - o Payments for health care benefits for individual and agency providers who provide personal care for at least 20 hours per month also have insurance premiums paid in the rate.

- Respite: Individual provider and agency hourly rates are based upon the rates provided to personal care providers. Rates for community-based settings such as senior centers and summer camps are based upon usual and customary charges.

- Behavior Support and Consultation: Regional DDA staff negotiate rates on a provider-specific basis.

- Staff/Family Consultation and Training: Regional DDA staff negotiate rates on a provider-specific basis.

- Environmental Accessibility Adaptations: Rates are based upon bids received by potential contractors.

- Transportation: The rate per mile is based upon historical reimbursement to state staff for transportation to and from meetings or on the rate negotiated for individual providers by the SEIU.

- Specialized Medical Equipment and Supplies: All rates are based upon the usual and customary charges for the specialized medical equipment/supplies.

- Sexual Deviancy Evaluation: The rate per evaluation is provider-specific and is negotiated by DDA regional staff.

- Specialized Psychiatric Services: DDA regional staff negotiate with providers on a client-specific basis unit rates that are at or below the DSHS standard rate.

- Nurse Delegation: The rate for nurse delegation services is based on the Medicaid unit rate with no vacation or overtime or vendor rate increase.

- Extended State Plan Services
  - o Occupational Therapy: Rates are negotiated by DDA regional staff on a provider-specific basis.

- o Speech, Hearing and Language: Rates are negotiated by DDA regional staff on a provider-specific basis.
- o Physical Therapy: Rates are negotiated by DDA regional staff on a provider-specific basis.

- Assistive Technology: All rates are based upon the usual and customary charges for assistive technology.

- Specialized Nutrition and Specialized Clothing: Rates are based upon the usual and customary charge for specialized nutrition and specialized clothing products.

- Therapeutic Equipment and Supplies: All rates are based upon the usual and customary charges for the therapeutic equipment and supplies.

- Vehicle Modifications: Rates are based upon bids received from potential contractors.

- Behavioral Health Stabilization Services
  - o Behavior Support and Consultation (privately-contracted): Rates are negotiated by DDA regional staff with the Regional Support Networks and/or individual providers.
  - o Behavior Support and Consultation (state-operated): Rates are established on a prospective basis by the ADSA/DDA cost reimbursement section.
  - o Specialized Psychiatric Services: Rates are negotiated by DDA regional staff with the Regional Support Networks and/or individual providers.
  - o Behavioral Health Crisis Diversion Bed Services (privately-contracted: Rates are negotiated by DDA regional staff with the Regional Support Networks and/or individual providers.
  - o Behavioral Health Crisis Diversion Bed Services (state-staffed): Rates are established on a prospective basis by the DDA cost reimbursement section.

Oversight of the rate determination process and rate negotiation:
The CIIBS Waiver will have two dedicated resource managers to execute contracts with providers that serve waiver recipients. Their training and supervision will focus in part upon contract rates, the processes whereby rates are established and appropriate rate parameters (e.g., minimum and maximum rates) for each service. Unit rates and maximum expenditure amounts are part of the contracting process and are contained in service contracts.

For those rates that have been pre-established (personal care, respite, transportation), Social Services Payment System (SSSP) edits ensure that the unit rate and total of number of units paid do not exceed the amounts authorized. Standardized unit rates are entered into SSPS based on the service code, so an authorization for service cannot contain a unit rate that is higher than the unit rate established for that service code.

For each of those services for which rates are negotiated or based on usual and customary charges, the Administration has established the maximum unit rate allowable.

Public Comments and Information Provided to Waiver Enrollees:
Public comments were obtained from the stakeholder workgroup that was established to provide public input regarding the development, implementation, and operation of this new waiver program. Workgroup members reviewed and provided input on the proposed maximum unit rates for each service and the rate negotiation process. Information about payment rates is made available to waiver participants annually during the development of the Individual Support Plan, since that information is included in the ISP.

Comparability of Waiver Services and Mitigation of Variances:
A standardized contract for each service will be used statewide, with all contracts for each service containing the same statement of work. Service expectations will be the same across the state and across waiver enrollees.

Since all contracts will be negotiated by two staff, they will work closely together to ensure variances in negotiated rates are based on appropriate factors, such as the local labor market and cost of living. Maximum rates will help

limit variance, and the CIIBS Waiver Program Manager will periodically review reports of unit rates to verify the variance is within acceptable levels (individually defined for each service) and that rates and expenditures are consistent with the economic and efficient provision of services.

The State Operating Agency is required to follow the Administrative Procedure Act, Chapter 34.05 RCW when soliciting public comments on rate determination methods. Changes to rates that are made by the legislature in the in he biennial and supplemental budget process are part of public hearings on budget and policy legislation. Rates are posted on public web sites.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The Department of Social and Health Services (DSHS) receives funding appropriated by the Legislature in the biennial budget. Funding (both state dollars and federal dollars) is provided to DSHS and within DSHS to the Developmental Disabilities Administration (DDA). The DDA receives the appropriation and allots funds to its operating regions via Regional Budgets for most services (e.g., residential, personal care, professional) categories.

Direct Service Payments

The DSHS/DDA contracts directly with providers of service for all CIIBS Waiver services. The DDA authorizes most services via the Social Services Payment System (SSPS), and providers bill the agency directly for services using the SSPS service voucher. Payments are made directly from DSHS/DDA to the providers of service.

Sometimes (e.g., in the case of a contractor or assistive technology vendor or contracted behavioral health stabilization services) billings are made using the A19 invoice voucher. In those cases contracts still must be in place and payments are also made directly from DSHS/DDA to the providers.

Each contract for a CIIBS Waiver service is unique to the service in question and contains standard DSHS terms and conditions as well as an individualized statement of work and payment information (e.g., unit rate and maximum expenditure under the contract). Contracts used by the DDA are approved through DSHS Central Contracting, and they are not the Health and Recovery Services (HSRA) standard Medicaid provider agreement.

How a provider invoice becomes a claim for Medicaid payment.

Social Service Payment System (SSPS): In the case of payments processed via the SSPS, an invoice based on the service authorization is sent to the provider. The invoice specifies the client; the type of service to be provided; the begin and end dates for delivery of the service, and the payment rate for the service. The provider completes the invoice by filling in the number of units of service provided. Currently most providers phone in this information. Once the invoice is completed, that invoice is the claim for Medicaid payment.

A19 Invoice Voucher: In the case of goods or services billed via the A19 invoice voucher, the vendor (or in some cases the state, if the vendor bills on their own form) completes the A19 (including the service or good being provided, the quantity, unit rate and total amount) and submits the invoice voucher to the Department (e.g., to a DDA regional office or to DDA headquarters) for processing. Staff verifies the information against the vendor contract or authorization and then process the document for payment (i.e., issue of a payment warrant). Expenditures are coded to the appropriate account code-federal or state- based on client waiver status as contained in CARE. The A19 invoice voucher becomes a claim for Medicaid payment after staff verification of the contract and waiver status of the individual client.

Payments to State Employees

Salaries for state-staffed behavior support and consultation and behavioral health crisis diversion bed services as components of behavioral health stabilization services are also included in the appropriation provided to the Administration by the Legislature. State employees that provide these services are paid twice a month like other state employee, with the payment amount determined by their job classification and experience.

Claim for FFP for Services Provided by State Employees

A prospective (daily) rate for state-staffed behavior support and consultation and behavioral health crisis diversion bed services as components of behavioral health stabilization services is established each year based on the projected

costs and number of days/hours of service for the ensuing year. The established rates are transmitted to the Office of Financial Recovery (OFR). OFR uses the reimbursement rates and the number of Medicaid eligible days/hours to calculate the federal share of cost for each facility. The OFR calculation report goes to the Office of Accounting Services and to DSHS. DSHS fiscal staff prepare a journal voucher to record the federal share under the federal funds appropriation in the FRS. Reported days/hours and FFP claims are reconciled with the Office of Financial Recovery each month. The DSHS includes the daily/hourly cost times the # of days/hours in the HCFA-64 Report to collect FFP for these services provided to waiver clients. At the close of each year, a settlement calculation is prepared to recover additional federal funds, or to pay back funds previously received.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

a.) Individual was eligible for Medicaid waiver payment on the date of service.
1) ProviderOne has a waiver identifier based on waiver status that indicates an individual is on a home and community-based services waiver.
2) Waiver Status in CARE Waiver Screen
The Developmental Disabilities Administration's CARE includes a Waiver Screen that contains the type of waiver an individual is on, the waiver begin date, and waiver end date (if any). A waiver effective date for the individual is entered into the Waiver Screen by CARE once the necessary waiver eligibility confirmation steps have been completed. These include verification of the need for ICF/IID Level of Care (LOC) and financial eligibility (as established by financial workers in the Long Term

Care Specialty
Unit within Home and Community Services), documentation of Voluntary Participation statement (Form #10-424), verification of disability per criteria established in the SSA, and completion of an Individual Support Plan (ISP). CARE enters a waiver effective date based on the effective date of the individual service plan (ISP), which is the last step in the waiver eligibility verification process. The waiver effective date serves as the beginning date for claiming of federal financial participation for waiver services.

3) SSPS: The Client Authorization Services Input System (CASIS) is used by case managers to create social service payment system (SSPS) authorizations for services using an automated electronic form. CASIS validates provider data via SSPS provider tables, and all service code data through SSPS account and service codes tables before submitting the authorization to the SSPS.

The SSPS contains service codes unique to the IFS Waiver. The waiver status (in the CARE Waiver Screen) of the individual must be consistent with the code being authorized. Waiver expenditures are annually compared with waiver status to ensure that payments are consistent with the waiver status of the individual.

4) ProviderOne

Washington State's Health Care Authority (the single state Medicaid Agency) has a new MMIS named "ProviderOne". Payments for Medicaid State Plan services (except personal care and state-operated ICFs/IID and NFs) are made via ProviderOne.

In early 2015, payment to service providers categorized as "1099 providers" will be made via ProviderOne (i.e., will no longer be made via the SSPS payment system) directly to service providers. Included will be social service providers such as community residential providers, home care agencies, and medical providers that did not transition to the ProviderOne system in the first phase of the project. Virtually all Basic Plus Waiver providers except individual perssonal care providers and individual respite care providers will be reimbursed using ProviderOne.

The usual MMIS edits will be applied to billings under the IFS Waiver. I.e., the following will be verified: the individual is on the Basic Plus Waiver, the service is covered under the Basic Plus Waiver, the provider is a valid provider of the service, tne provider is a qualified provider with a current contract, and the specifics of the claim are consistent with the service authorization completed by the DDA case manager.

b.) Service was included in the participant's approved service plan to ensure that ISPs reflect the current needs of the individual, ISPs are updated as needed and at least annually (please see Appendix H-1-b-3 for a description of the steps taken to ensure ISPs are updated).

DDA Quality Compliance Coordinators (QCCs) annually review a statewide sample of waiver participants. Their review includes a comparison of service payments with the services contained in approved ISPs to ensure that services claimed against the Basic Plus Waiver are contained in the approved ISP.

c.) The services were provided.
Monitoring of the provision of services is outlined in Appendix H-1-b-4. Steps taken include:
- *QCC file reviews verify the authorization matches the ISP including the type, scope, amount, duration and frequency of the service. When findings occur, regions have 30 days to correct problems. QCCs monitor the corrective action plans.
- *CRMs or Social Service Specialists complete a review of last year's plan with the waiver recipient prior to beginning the planning process for the upcoming year. A portion of the review is to confirm that services were received in accordance with the ISP.
- *The State participates in the National Core Indicators Survey, which includes waiver

related questions. This annual face-to-face sampling of waiver participants enables DDA management to evaluate ISP outcomes from the recipient's perspective.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

- ○ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ◉ **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

  Payment to providers is made by the State Operating Agency.
- ○ **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
- ○ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- ☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☐ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- ☑ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

  Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

  Payment to providers for most services is made directly by the State Operating Agency.

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

○ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

◉ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Payments for state-staffed behavior support and consultation and state-staffed behavioral health crisis diversion bed services as components of behavioral health stabilization services are made to state employees.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [ ] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [x] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

  If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I -2-c:

  Department of Social and Health Services/Developmental Disabilities Administration(the State Operating Agency), which pays providers directly.

- [ ] **Other State Level Source(s) of Funds.**

  Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

Check each that applies:

- [ ] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ( ) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**

As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The only waiver service that is provided in a residential setting is out-of-home respite care. Room and board for respite in
licensed out of home settings is covered under this waiver.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C -3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

No. The State does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- **Nominal deductible**
- **Coinsurance**
- **Co-Payment**
- **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	44688.34	3617.00	48305.34	163879.00	1914.22	165793.22	117487.88
2	47560.07	3617.00	51177.07	181047.00	1914.22	182961.22	131784.15
3	47235.12	5502.56	52737.68	203911.00	1914.22	205825.22	153087.54
4	50161.01	5502.56	55663.57	197020.00	1914.22	198934.22	143270.65
5	50159.84	5502.56	55662.40	194854.00	1914.22	196768.22	141105.82

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	100	100
Year 2	100	100
Year 3	104	104
Year 4	107	107
Year 5	107	107

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The 315-day average length of stay for Waiver Renewal Year 1, the 348-day average length of stay for Waiver Renewal Year 2, the 347-day average length of stay for Waiver Renewal Year 3, and the 339-day average length of stay for Waiver Renewal Years 4 and 5 are based on the number of individuals that will be on the waiver the entire waiver year and the projected number of days on the waiver of those added to the waiver and those leaving the waiver during the waiver year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Projections for the following services for the Waiver Renewal are based on the Initial 372 Report prepared for Waiver Renewal Year 2 (5/1/2010 - 4/30/2011) with any exceptions noted:
• Personal Care Services •
Respite Care
• Behavior Support and Consultation
• Staff/Family Consultation and Training (which, due to variance between projected and actual values identified in 2014 in conjunction with CMS-372 Reports,
has been re-projected for Renewal Years 3,4 and 5 based on expenditure data for Waiver Renewal Year 1, 9/1/2012 - 8/31/2013)
• Environmental Accessibility Adaptations
• Specialized Medical Equipment and Supplies
• Nurse Delegation
• Sexual Deviancy Evaluation
• Speech, Hearing and Language
• Assistive Technology
• Specialized Clothing
• Therapeutic Equipment and Supplies
• Specialized Nutrition
• Specialized Psychiatric Services

Projections of the use of the following services are based on use by Core Waiver recipients and professional judgment:
• Behavioral Health Stabilization Services: Behavior Support and Consultation (privately-contracted)
• Behavioral Health Stabilization Services: Behavioral Health Crisis Diversion Bed Svcs (privately-contracted)
• Behavioral Health Stabilization Services: Specialized Psychiatric Services

Projections for the following services are based on provider capacity and professional judgment:
• Behavioral Health Stabilization Services: Behavior Support and Consultation (state-operated)
• Behavioral Health Stabilization Services: Behavioral Health Crisis Diversion Bed Svcs (state-operated)

Projections of the use of vehicle modifications are based on professional judgment.

Projections of the use of transportation for Waiver Renewal years 1 and 2 are based on the use of that service by individuals that would qualify (i.e., based on the algorithm) for this waiver that are currently on another DDA HCBS waiver. Due to variance between projected and actual values identified in 2014 in conjunction with CMS-372 Reports, the use of transporation has been re-projected for Renewal Years 3,4 and 5 based on expenditure data for Waiver Renewal Year 1, 9/1/2012 - 8/31/2013)

Projections of the use of physical therapy and occupational therapy are based on professional judgment (the # using each service), the use of these services by Core Waiver recipients (# of units of service/user), and the cost of these services for individuals on the DDA Individual and Family Services Program.

Projections of the number of units of service per person for behavior support and consultation and staff/family consultation and training for Waiver Renewal Years 2,3,4 and 5 have been reduced by 5% to reflect stabilization of the CIIBS Waiver population.

Projections of the number of units of service per person for respite services have been reduced by 5% for Waiver Renewal Years 4 and 5 to reflect stabilization of the CIIBS Waiver population.

The definition of respite care has been revised (effective 9/1/2014) to allow additional individuals to qualify for the service. The projected # of users has been increased by 1% to reflect the revised definition.

The unit rate for transportation has been increased for Waiver Renewal Years 3, 4 and 5 to reflect the new rate negotiated with the State Employees
International Union (SEIU).

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor D'' estimates for Waiver Renewal Years 1 and 2 are based on expenditures compiled for an Initial CMS-372 Report for Initial Waiver Renewal Year 3 (4/1/2009 - 3/31/2010). Factor D' estimates for Waiver Renewal Years 3, 4 and 5 are based on Medicaid State Plan expenditures for CIIBS Waiver participants for Waiver Renewal Year 1 (9/1/2013 - 8/31/2013). Factor D' values were re-projected as a result of variance between projected and actual values identified in 2014 in conjunction with CMS-372 Reports.

No trend factors were applied, due to reduced state revenue and a corresponding lack of vendor rate increases.

The base data for projections of Factor D'' are from a time period that is after implementation of Medicare Part D coverage. Consequently, the base data do not include expenditures for drugs covered under Part D, as those costs are not
reflected in Washington State's expenditure data for dual-eligible Medicaid clients.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Estimates of Factor G values for Waiver Renewal Years 1 and 2 are based upon the aggregate average daily cost for state-operated and privately-operated ICF/ID beds in Washington State for State Fiscal Year (SFY) 2012 (7/1/2011- 6/30/2012) times the number of days individuals on the waiver would be in an ICF/ID if the waiver did not exist. In the absence of the waiver, waiver participants would be on an ICF/ID for the same number of days that they are projected to be on the waiver. The average number of days on the waiver is contained in the projections of Factor D.

Estimates of Factor G values for Waiver Renewal Year 3 is based upon the aggregate average daily cost for state-operated and privately-operated ICF/ID beds in Washington State for State Fiscal Year (SFY) 2015 (7/1/2014- 6/30/2015) times the number of days individuals on the waiver would be in an ICF/ID if the waiver did not exist. This value was reduced by 1.1% when projecting Factor G for Waiver Renewal Years 4 and 5, based on reduced fixed costs as the institutional population declines.

No trend factors based on staff salary increases have been applied for the Waiver Renewal period, due to reduced state revenue and a corresponding lack of pay increases for state employees and privately-contracted service providers.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G'' projections are based on the actual per person cost ($1,914.22) of State Plan services by ICF/ID residents during Waiver Year 1 (5/1/2009 - 4/30/2010). No trend factors were applied for the Waiver Renewal period, due to reduced state revenue and a corresponding lack of vendor rate increases.

The base data for projections of Factor G'' are from a time period that is after implementation of Medicare Part D coverage. Consequently, the base data do not include expenditures for drugs covered under Part D, as those costs are not
reflected in Washington State's expenditure data for dual-eligible Medicaid clients.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Personal Care	
Respite	
Occupational Therapy	
Physical therapy	
Speech, Hearing, and Language Services	
Assistive Technology	
Behavior Support and Consultation	
Behavioral Health Crisis Stabilization Services-Specialized Psychiatric Services	
Behavioral Health Stabilization Services-Behavior Support and Consultation	
Behavioral Health Stabilization Services-Crisis Diversion Bed Services	
Environmental Accessibility Adaptations	
Nurse Delegation	
Sexual Deviancy Evaluation	
Specialized Clothing	
Specialized Medical Equipment and Supplies	
Specialized Nutrition	
Specialized Psychiatric Services	
Staff/Family Consultation and Training	
Therapeutic Equipment and Supplies	
Transportation	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Total:						**734927.60**
Personal Care	Hour	95	649.00	11.92	**734927.60**	
Respite Total:						**352709.60**
Respite	Hour	92	290.00	13.22	**352709.60**	
Occupational Therapy Total:						**3527.56**
Occupational Therapy	Hour	1	58.00	60.82	**3527.56**	
				GRAND TOTAL:		**4468834.18**
				Total Estimated Unduplicated Participants:		**100**
				Factor D (Divide total by number of participants):		**44688.34**
				Average Length of Stay on the Waiver:		315

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Physical therapy Total:						**1375.20**
Physical therapy	Hour	1	20.00	68.76	**1375.20**	
Speech, Hearing, and Language Services Total:						**38481.30**
Speech, Hearing, and Language Services	Hour	9	26.00	164.45	**38481.30**	
Assistive Technology Total:						**2003.50**
Assistive Technology	Each	5	1.00	400.70	**2003.50**	
Behavior Support and Consultation Total:						**1706978.84**
Behavior Support and Consultation	Hour	97	476.00	36.97	**1706978.84**	
Behavioral Health Crisis Stabilization Services-Specialized Psychiatric Services Total:						**2352.24**
Behavioral Health Crisis Stabilization Services-Specialized Psychiatric Services	Hour	3	4.00	196.02	**2352.24**	
Behavioral Health Stabilization Services-Behavior Support and Consultation Total:						**11659.08**
Behavior Support and Consutation (Privately-Contracted)	Hour	3	26.00	124.86	**9739.08**	
Behavior Support and Conslstation (State-Operated)	Hour	1	10.00	192.00	**1920.00**	
Behavioral Health Stabilization Services-Crisis Diversion Bed Services Total:						**219882.48**
Crisis Diversion Bed Services (Privately-Contracted)	Day	1	21.00	332.88	**6990.48**	
Crisis Diversion Bed Services (State-Operated)	Day	1	157.00	1356.00	**212892.00**	
Environmental Accessibility Adaptations Total:						**142172.82**
Environmental Accessibility Adaptations	Each	19	2.00	3741.39	**142172.82**	
Nurse Delegation Total:						**131.84**
Nurse Delegation	Hour	2	2.00	32.96	**131.84**	
Sexual Deviancy Evaluation Total:						**3000.00**
Sexual Deviancy Evaluation	Each	2	1.00	1500.00	**3000.00**	

GRAND TOTAL:	**4468834.18**
Total Estimated Unduplicated Participants:	**100**
Factor D (Divide total by number of participants):	**44688.34**
Average Length of Stay on the Waiver:	315

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Clothing Total:						**885.00**
Specialized Clothing	Each	2	2.00	221.25	**885.00**	
Specialized Medical Equipment and Supplies Total:						**13731.60**
Specialized Medical Equipment and Supplies	Each	3	10.00	457.72	**13731.60**	
Specialized Nutrition Total:						**5176.98**
Specialized Nutrition	Each	3	6.00	287.61	**5176.98**	
Specialized Psychiatric Services Total:						**3354.21**
Specialized Psychiatric Services	Hour	3	3.00	372.69	**3354.21**	
Staff/Family Consultation and Training Total:						**1188206.35**
Staff/Family Consultation and Training	Hour	97	409.00	29.95	**1188206.35**	
Therapeutic Equipment and Supplies Total:						**18632.68**
Therapeutic Equipment and Supplies	Each	17	2.00	548.02	**18632.68**	
Transportation Total:						**6056.25**
Transportation	Mile	5	2375.00	0.51	**6056.25**	
Vehicle Modifications Total:						**13589.05**
Vehicle Modifications	Each	5	1.00	2717.81	**13589.05**	
				GRAND TOTAL:		**4468834.18**
				Total Estimated Unduplicated Participants:		**100**
				Factor D (Divide total by number of participants):		**44688.34**
				Average Length of Stay on the Waiver:		315

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Total:						**811930.80**
Personal Care	Hour	95	717.00	11.92	**811930.80**	
Respite Total:						**389196.80**
Respite	Hour	92	320.00	13.22	**389196.80**	
Occupational Therapy Total:						**3892.48**
Occupational Therapy	Hour	1	64.00	60.82	**3892.48**	
Physical therapy Total:						**1512.72**
Physical therapy	Hour	1	22.00	68.76	**1512.72**	
Speech, Hearing, and Language Services Total:						**42921.45**
Speech, Hearing, and Language Services	Hour	9	29.00	164.45	**42921.45**	
Assistive Technology Total:						**2003.50**
Assistive Technology	Each	5	1.00	400.70	**2003.50**	
Behavior Support and Consultation Total:						**1789458.91**
Behavior Support and Consultation	Hour	97	499.00	36.97	**1789458.91**	
Behavioral Health Crisis Stabilization Services-Specialized Psychiatric Services Total:						**2352.24**
Behavioral Health Crisis Stabilization Services-Specialized Psychiatric Services	Hour	3	4.00	196.02	**2352.24**	
Behavioral Health Stabilization Services-Behavior Support and Consultation Total:						**12974.82**
Behavior Support and Consutation (Privately-Contracted)	Hour	3	29.00	124.86	**10862.82**	
Behavior Support and Consltation (State-Operated)	Hour	1	11.00	192.00	**2112.00**	
Behavioral Health Stabilization Services-Crisis Diversion Bed Services Total:						**243600.24**
Crisis Diversion Bed Services (Privately-Contracted)	Day	1	23.00	332.88	**7656.24**	
Crisis Diversion Bed Services (State-Operated)	Day	1	174.00	1356.00	**235944.00**	

GRAND TOTAL:	**4756007.37**
Total Estimated Unduplicated Participants:	**100**
Factor D (Divide total by number of participants):	**47560.07**
Average Length of Stay on the Waiver:	348

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations Total:						**142172.82**
Environmental Accessibility Adaptations	Each	19	2.00	3741.39	**142172.82**	
Nurse Delegation Total:						**131.84**
Nurse Delegation	Hour	2	2.00	32.96	**131.84**	
Sexual Deviancy Evaluation Total:						**3000.00**
Sexual Deviancy Evaluation	Each	2	1.00	1500.00	**3000.00**	
Specialized Clothing Total:						**885.00**
Specialized Clothing	Each	2	2.00	221.25	**885.00**	
Specialized Medical Equipment and Supplies Total:						**15104.76**
Specialized Medical Equipment and Supplies	Each	3	11.00	457.72	**15104.76**	
Specialized Nutrition Total:						**5176.98**
Specialized Nutrition	Each	3	6.00	287.61	**5176.98**	
Specialized Psychiatric Services Total:						**4472.28**
Specialized Psychiatric Services	Hour	3	4.00	372.69	**4472.28**	
Staff/Family Consultation and Training Total:						**1246309.35**
Staff/Family Consultation and Training	Hour	97	429.00	29.95	**1246309.35**	
Therapeutic Equipment and Supplies Total:						**18632.68**
Therapeutic Equipment and Supplies	Each	17	2.00	548.02	**18632.68**	
Transportation Total:						**6688.65**
Transportation	Mile	5	2623.00	0.51	**6688.65**	
Vehicle Modifications Total:						**13589.05**
Vehicle Modifications	Each	5	1.00	2717.81	**13589.05**	

GRAND TOTAL:	**4756007.37**
Total Estimated Unduplicated Participants:	**100**
Factor D (Divide total by number of participants):	**47560.07**
Average Length of Stay on the Waiver:	348

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Total:						**843757.20**
Personal Care	Hour	99	715.00	11.92	**843757.20**	
Respite Total:						**392197.74**
Respite	Each	93	319.00	13.22	**392197.74**	
Occupational Therapy Total:						**3892.48**
Occupational Therapy	Hour	1	64.00	60.82	**3892.48**	
Physical therapy Total:						**1512.72**
Physical therapy	Hour	1	22.00	68.76	**1512.72**	
Speech, Hearing, and Language Services Total:						**42921.45**
Speech, Hearing, and Language Services	Hour	9	29.00	164.45	**42921.45**	
Assistive Technology Total:						**2003.50**
Assistive Technology	Each	5	1.00	400.70	**2003.50**	
Behavior Support and Consultation Total:						**1855783.09**
Behavior Support and Consultation	Hour	101	497.00	36.97	**1855783.09**	
Behavioral Health Crisis Stabilization Services-Specialized Psychiatric Services Total:						**2352.24**
Behavioral Health Crisis Stabilization Services-Specialized Psychiatric Services	Hour	3	4.00	196.02	**2352.24**	
Behavioral Health Stabilization Services-Behavior Support and Consultation Total:						**12974.82**

GRAND TOTAL:	**4912452.74**
Total Estimated Unduplicated Participants:	**104**
Factor D (Divide total by number of participants):	**47235.12**
Average Length of Stay on the Waiver:	347

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavior Support and Consutation (Privately-Contracted)	Hour	3	29.00	124.86	**10862.82**	
Behavior Support and Conslation (State-Operated)	Hour	1	11.00	192.00	**2112.00**	
Behavioral Health Stabilization Services-Crisis Diversion Bed Services Total:						**242244.24**
Crisis Diversion Bed Services (Privately-Contracted)	Day	1	23.00	332.88	**7656.24**	
Crisis Diversion Bed Services (State-Operated)	Day	1	173.00	1356.00	**234588.00**	
Environmental Accessibility Adaptations Total:						**142172.82**
Environmental Accessibility Adaptations	Each	19	2.00	3741.39	**142172.82**	
Nurse Delegation Total:						**131.84**
Nurse Delegation	Hour	2	2.00	32.96	**131.84**	
Sexual Deviancy Evaluation Total:						**3000.00**
Sexual Deviancy Evaluation	Each	2	1.00	1500.00	**3000.00**	
Specialized Clothing Total:						**885.00**
Specialized Clothing	Hour	2	2.00	221.25	**885.00**	
Specialized Medical Equipment and Supplies Total:						**18308.80**
Specialized Medical Equipment and Supplies	Each	4	10.00	457.72	**18308.80**	
Specialized Nutrition Total:						**6902.64**
Specialized Nutrition	Each	4	6.00	287.61	**6902.64**	
Specialized Psychiatric Services Total:						**5963.04**
Specialized Psychiatric Services	Hour	4	4.00	372.69	**5963.04**	
Staff/Family Consultation and Training Total:						**1294678.60**
Staff/Family Consultation and Training	Hour	101	428.00	29.95	**1294678.60**	
Therapeutic Equipment and Supplies Total:						**19728.72**
Therapeutic Equipment and Supplies	Each	18	2.00	548.02	**19728.72**	

GRAND TOTAL:	**4912452.74**
Total Estimated Unduplicated Participants:	**104**
Factor D (Divide total by number of participants):	**47235.12**
Average Length of Stay on the Waiver:	347

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation Total:						**7452.75**
Transportation	Mile	5	2615.00	0.57	**7452.75**	
Vehicle Modifications Total:						**13589.05**
Vehicle Modifications	Each	5	1.00	2717.81	**13589.05**	
				GRAND TOTAL:		**4912452.74**
				Total Estimated Unduplicated Participants:		**104**
				Factor D (Divide total by number of participants):		**47235.12**
				Average Length of Stay on the Waiver:		347

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Total:						**848656.32**
Personal Care	Hour	102	698.00	11.92	**848656.32**	
Respite Total:						**367833.28**
Respite	Hour	94	296.00	13.22	**367833.28**	
Occupational Therapy Total:						**3770.84**
Occupational Therapy	Hour	1	62.00	60.82	**3770.84**	
Physical therapy Total:						**1443.96**
Physical therapy	Hour	1	21.00	68.76	**1443.96**	
Speech, Hearing, and Language Services Total:						**41441.40**
Speech, Hearing, and Language Services	Hour	9	28.00	164.45	**41441.40**	
Assistive Technology Total:						**2003.50**
Assistive Technology					**2003.50**	
				GRAND TOTAL:		**5367228.47**
				Total Estimated Unduplicated Participants:		**107**
				Factor D (Divide total by number of participants):		**50161.01**
				Average Length of Stay on the Waiver:		339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Each	5	1.00	400.70		
Behavior Support and Consultation Total:						**1868611.68**
Behavior Support and Consultation	Hour	104	486.00	36.97	**1868611.68**	
Behavioral Health Crisis Stabilization Services-Specialized Psychiatric Services Total:						**2352.24**
Behavioral Health Crisis Stabilization Services-Specialized Psychiatric Services	Hour	3	4.00	196.02	**2352.24**	
Behavioral Health Stabilization Services-Behavior Support and Consultation Total:						**12600.24**
Behavior Support and Consutation (Privately-Contracted)	Hour	3	28.00	124.86	**10488.24**	
Behavior Support and Conslstation (State-Operated)	Hour	1	11.00	192.00	**2112.00**	
Behavioral Health Stabilization Services-Crisis Diversion Bed Services Total:						**236487.36**
Crisis Diversion Bed Services (Privately-Contracted)	Day	1	22.00	332.88	**7323.36**	
Crisis Diversion Bed Services (State-Operated)	Day	1	169.00	1356.00	**229164.00**	
Environmental Accessibility Adaptations Total:						**149655.60**
Environmental Accessibility Adaptations	Each	20	2.00	3741.39	**149655.60**	
Nurse Delegation Total:						**131.84**
Nurse Delegation	Hour	2	2.00	32.96	**131.84**	
Sexual Deviancy Evaluation Total:						**3000.00**
Sexual Deviancy Evaluation	Each	2	1.00	1500.00	**3000.00**	
Specialized Clothing Total:						**885.00**
Specialized Clothing	Each	2	2.00	221.25	**885.00**	
Specialized Medical Equipment and Supplies Total:						**18308.80**
Specialized Medical Equipment and Supplies	Each	4	10.00	457.72	**18308.80**	
Specialized Nutrition Total:						**6902.64**

GRAND TOTAL:	**5367228.47**
Total Estimated Unduplicated Participants:	**107**
Factor D (Divide total by number of participants):	**50161.01**
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Nutrition	Each	4	6.00	287.61	6902.64	
Specialized Psychiatric Services Total:						4472.28
Specialized Psychiatric Services	Hour	4	3.00	372.69	4472.28	
Staff/Family Consultation and Training Total:						1622127.36
Staff/Family Consultation and Training	Hour	96	233.00	72.52	1622127.36	
Therapeutic Equipment and Supplies Total:						19728.72
Therapeutic Equipment and Supplies	Each	18	2.00	548.02	19728.72	
Transportation Total:						143226.36
Transportation	Mile	54	4573.00	0.58	143226.36	
Vehicle Modifications Total:						13589.05
Vehicle Modifications	Each	5	1.00	2717.81	13589.05	
				GRAND TOTAL:		5367228.47
				Total Estimated Unduplicated Participants:		107
				Factor D (Divide total by number of participants):		50161.01
				Average Length of Stay on the Waiver:		339

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Total:						848656.32
Personal Care	Hour	102	698.00	11.92	848656.32	
Respite Total:						367833.28
Respite	Hour	94	296.00	13.22	367833.28	
				GRAND TOTAL:		5367103.19
				Total Estimated Unduplicated Participants:		107
				Factor D (Divide total by number of participants):		50159.84
				Average Length of Stay on the Waiver:		339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Occupational Therapy Total:						**3770.84**
Occupational Therapy	Hour	1	62.00	60.82	**3770.84**	
Physical therapy Total:						**1443.96**
Physical therapy	Hour	1	21.00	68.76	**1443.96**	
Speech, Hearing, and Language Services Total:						**41441.40**
Speech, Hearing, and Language Services	Hour	9	28.00	164.45	**41441.40**	
Assistive Technology Total:						**2003.50**
Assistive Technology	Each	5	1.00	400.70	**2003.50**	
Behavior Support and Consultation Total:						**1868611.68**
Behavior Support and Consultation	Hour	104	486.00	36.97	**1868611.68**	
Behavioral Health Crisis Stabilization Services-Specialized Psychiatric Services Total:						**2352.24**
Behavioral Health Crisis Stabilization Services-Specialized Psychiatric Services	Hour	3	4.00	196.02	**2352.24**	
Behavioral Health Stabilization Services-Behavior Support and Consultation Total:						**12600.24**
Behavior Support and Consutation (Privately-Contracted)	Hour	3	28.00	124.86	**10488.24**	
Behavior Support and Conslstation (State-Operated)	Hour	1	11.00	192.00	**2112.00**	
Behavioral Health Stabilization Services-Crisis Diversion Bed Services Total:						**236487.36**
Crisis Diversion Bed Services (Privately-Contracted)	Day	1	22.00	332.88	**7323.36**	
Crisis Diversion Bed Services (State-Operated)	Day	1	169.00	1356.00	**229164.00**	
Environmental Accessibility Adaptations Total:						**149655.60**
Environmental Accessibility Adaptations	Each	20	2.00	3741.39	**149655.60**	
Nurse Delegation Total:						**131.84**
Nurse Delegation	Hour	2	2.00	32.96	**131.84**	

GRAND TOTAL:	**5367103.19**
Total Estimated Unduplicated Participants:	**107**
Factor D (Divide total by number of participants):	**50159.84**
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Sexual Deviancy Evaluation Total:						**3000.00**
Sexual Deviancy Evaluation	Each	2	1.00	1500.00	**3000.00**	
Specialized Clothing Total:						**885.00**
Specialized Clothing	Each	2	2.00	221.25	**885.00**	
Specialized Medical Equipment and Supplies Total:						**18308.80**
Specialized Medical Equipment and Supplies	Each	4	10.00	457.72	**18308.80**	
Specialized Nutrition Total:						**6902.64**
Specialized Nutrition	Each	4	6.00	287.61	**6902.64**	
Specialized Psychiatric Services Total:						**4472.28**
Specialized Psychiatric Services	Hour	4	3.00	372.69	**4472.28**	
Staff/Family Consultation and Training Total:						**1622127.36**
Staff/Family Consultation and Training	Hour	96	233.00	72.52	**1622127.36**	
Therapeutic Equipment and Supplies Total:						**19728.72**
Therapeutic Equipment and Supplies	Each	18	2.00	548.02	**19728.72**	
Transportation Total:						**143101.08**
Transportation	Mile	54	4569.00	0.58	**143101.08**	
Vehicle Modifications Total:						**13589.05**
Vehicle Modifications	Each	5	1.00	2717.81	**13589.05**	

GRAND TOTAL:	**5367103.19**
Total Estimated Unduplicated Participants:	**107**
Factor D (Divide total by number of participants):	**50159.84**
Average Length of Stay on the Waiver:	339