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 Behavioral Support

C. Waiver Number:WA.40669

D. Amendment Number:

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

01/01/15

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 indicates the use of a MMIS (ProviderOne)to pay providers for certain waiver services.

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
☐ **Appendix A – Waiver Administration and Operation**	
☐ **Appendix B – Participant Access and Eligibility**	
☐ **Appendix C – Participant Services**	
☐ **Appendix D – Participant Centered Service Planning and Delivery**	
☐ **Appendix E – Participant Direction of Services**	
☐ **Appendix F – Participant Rights**	
☐ **Appendix G – Participant Safeguards**	

Component of the Approved Waiver	Subsection(s)
☐ Appendix H	
☑ Appendix I – Financial Accountability	1, 2b, 2d & 4a
☐ Appendix J – Cost-Neutrality Demonstration	

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

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

Specify:
Add ProviderOne information.

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 Behavioral 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.014.01.04**

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

Background: A growing concern in the state of Washington has been the lack of funded alternatives to ICF/ID placement for children with developmental disabilities. Challenging behavior has been identified as a significant factor contributing to families' request for institutionalization for their children. As a result, a group of advocates, including parents of children with developmental disabilities and challenging behavior, introduced legislation in the 2008 legislative session which ran from 1/14/08-3/13/08, in support of a new program designed to serve this target population. Although, the proposed legislation did not pass during session, the legislature appropriated funding in the 2008 Supplemental Budget to begin the program. Legislation was passed during the 2009 regular session in support of the development of intensive supports for children and signed into law on April 23, 2009. The relevant RCW Sections consist of 1) 71A.24.005 Intent; 2)71A.24.010 Role of department -- Eligibility; and 3)71A.24.020 Intensive behavior support services -- Core team.

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 DDD 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 Aging and Disability Services Administration (ADSA)/Division of Developmental Disabilities (DDD), 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. DDD 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 (DDD) Waivers Quality Assurance Committee composed of self-advocates, advocates and providers.

During the 2008 legislative session, legislation to establish this waiver program in state law was introduced. A variety of stakeholders worked with the Legislature to have that legislation introduced. Although the legislation was not passed, the Division established an advisory group that includes those that originally worked with the Legislature as well as additional stakeholders. Division staff met on multiple occasions with that advisory group to obtain public input regarding the development and implementation of this waiver program. Division staff continue to meet with stakeholder groups to obtain publc input on the waiver's ongoing operation and to identify and promote best practices within the program model.

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: 98504-5310

Phone:

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 eligiblity 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 DDD will assist individuals determined to no longer be eligible for the DDD 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 DDD 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):

Appendix A: Waiver Administration and Operation

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

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

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:
Department of Social and Health Services/Aging and Disability Services Administration/Divison of Developmental Disabiliites

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 Medicaid Agency Waiver Management Committee includes representatives from the Health Care Authority (the Single State Medicaid Agency) and divisions within the operating agency: DDD, 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:

   ☐ **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:

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:

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
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.i.1: The percent of waiver amendment and waiver renewal requests for which approval was obtained from the Single State Medicaid Agency. Numerator: The number of waiver amendment and waiver renewal requests for which approval was obtained from the Single State Medicaid Agency. Denominator: The total number of waiver amendment 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.i.2: The percentage of scheduled meetings of the Medicaid Agency Waiver Management Committee that are actually held. Numerator: The number of scheduled meetings of the Medicaid Agency Waiver Management Committee that are held. Denominator: The total number of scheduled meetings of the 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:

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.i.1: The State Operating Agency obtains written approval from the Single State Medicaid Agency (Health Care Authority-HCA)to submit 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.i.2: The Medicaid Agency Waiver Management Committee includes representatives from the HCA and divisions within the operating agency: DDD, 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. The Waiver Program Manager verifies annually that these meetings were held.

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.i.1: If it is determined that HCA approval was not obtained for all 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.i.2: If the 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.

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**					
	☐	**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:

Note: "Autism" was not checked under B-1-a (Target Groups) because in Washington State "developmental disability" includes autism as an eligible condition when a child with autism also demonstrates evidence of substantial limitations of adaptive functioning as defined in Washington Administrative Code (WAC) 388-823-0515. WAC 388-823-0515 identifies the evidence needed to substantiate adaptive functioning limitations for the condition of autism.

In order to be considered for CIIBS enrollment, clients must be determined to be at high risk for out of home placement based on challenging behaviors. An algorithm within the LOC assessment tool will detect these risk factors. Additional screening factors for age, minimal behavior acuity score of high, and minimal caregiver risk acuity score of medium will be included in the eligibility tool.

The algorithm that will be used to determine the risk of out of home placement was developed through a contract with Research and Data Analysis within the State Medicaid Agency. Data was collected and analyzed to compare children and youth statewide who were previously placed out of their family home, including children identified by all regions as at high risk for out of home placement, and a control group. The coefficients from the regression model were used to create an algorithm for generating an out-of-home placement risk score based on assessment responses. The risk score involves the simple tabulation of points associated with different assessed client characteristics, with the total points compared against thresholds that define the different risk levels.

Regions were involved in the initial identification of children at high risk of out-of-home placement, which assisted in the analysis and identification of risk factors. CIIBS will be phased in starting in areas of dense population of both eligible clients and available service providers. By the end of the phase-in schedule, individuals residing in all areas of the state will be considered for enrollment.

Waiver enrollees will score in either the High or Severe category and be determined to have need of CIIBS waiver services for a minimum of 3 years not to exceed age 20. The CIIBS waiver is designed for children. As coordination and collaboration with the schools is an important feature of the program, and children with developmental disabilities continue to attend school past the age of 18, all enrollees will be offered the opportunity to continue to participate on the waiver through age 20.

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 DDD 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 preceeding 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	100
Year 4	100
Year 5	100

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

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

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

Table: B-3-b

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

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

The state 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 DDD 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(s) 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:

    - [x] **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 Division of Developmental Disabilities of the Department of Social and Health Services that are employed as a DDD Case/Resource Manager or a Social Worker 3 (or, in instances where staffing vacancies necessitate, a DDD Case-Resource Supervisor) and therefore meet the following qualifications:

DDD 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 Division within one year of their appointment.

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

OR

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

DDD 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 DDD determine my score for ICF/ID Level of Care if I am age birth through fifteen years old? DDD 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 DDD determine if I meet the eligibility requirements for ICF/ID Level of care if I am age birth through 15 years old? DDD 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. DDD Case Resource Managers or DDD Social Workers or DDD 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 (DDD Case Resource Manager or DDD Social Worker or DDD 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 Control and Compliance team members (QCC).
o The DDD assessment (on the CARE platform) tracks timeliness of reevaluations. Case Resource Managers or Social Service Specialists or DDD supervisors and DDD 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 DDD regional office. The electronic evaluation is on an electronic platform and can be viewed remotely from any DDD 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:
a.i.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 for CIIBS waiver services

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:

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.

Performance Measure:
a.i.b.1: The percentage of all waiver participants who have received a redetermination of ICF/ID level of care prior to the end of the twelfth month since their initial determination or last redetermination. Numerator= all participants

with a level of care redetermination prior to the end of the twelfth month since their initial or last redetermination. Denominator= all waiver participants

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 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: Quality Compliance and Control Team within DDD	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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:
a.i.c.1: The percentage of all LOC assessments that were completed according to state requirements, as specified in the waiver. N= Number of LOC assessments completed in accordance with state requirements, as specified in the waiver. D= All completed LOC assessments

Data Source (Select one):
Training verification records
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):
Other
If 'Other' is selected, specify:
Certification Verification 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 Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
CARE 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:
a.i.c.2: The percentage of LOC eligibility determinations that were consistent with reviewer determinations during the annual shadow review for inter-rater reliability. Numerator = LOC eligibility determinations consistent with reviewer determinations Denominator = LOC determinations subject to annual shadow 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 DDD	☐ **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 DDD	☑ **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.

Subassurance a.i.a.1:

Administrative data is collected real time in ADSA's 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.

Subassurance a.i.b.1:
1st Data Source - The DDD assessment is comprised of three modules, the first being the Support Assessment, which contains the ICF/MR level of care tool for children under age 16 and the Supports Intensity Scale (SIS) for individuals age 16 and older. The CARE system will not allow the assessor to create an ISP, which is the third module of the DDD assessment until the first and second module is complete. The system will only allow a waiver ISP to be finalized if the Support Assessment results in a determination of ICF/ID eligibility. As a result, tracking of timely DDD assessments provides the dual benefit of tracking timely LOC assessments.

Monthly reports are prepared by Central Office for a review of the progress toward achieving 100% timely DDD assessments, of which LOC is the first component. The data is analyzed by comparing the actual number of assessments completed on time to the regional monthly targets and to the list of assessment due each month. Reports are reviewed by Waiver Coordinators as well as regional and central office management.

2nd Data Source - The Quality Control and Compliance Team within DDD conducts an annual audit of waiver files. As a part of this audit, the team checks to see that the DDD assessment, which includes the level of care assessment as the first module, was completed prior to the last day of the 12th month following either the initial or the last assessment.

The QCC audit is one of several discovery processes that will be used to demonstrate evidence of compliance with the waiver assurances. This process utilizes a sampling approach that will generate representative samples by waiver over a 2-year period. The sample of record reviews from each waiver is statistically significant (95% confidence level with a 5% margin of error) when data is combined over a two year period. We will be using data from this process for both ongoing, individual level remediation and for systemic quality improvement.

Findings from all file reviews are analyzed by management. Based on the analysis necessary steps are taken.

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.

Subassurance a.i.c.1:
1st Data Source - Training to administer the SIS and the LOC for children is provided at the Academy Training for new Case/Resource Managers and Social Service Specialists. Training records are maintained through Human Resources Developmental Activity Reports. The Case Management Training Program Manager provides ongoing verification of attendance of new CRMs and SSSs at the Academy training. The first three DDD assessments completed by a new CRM or SSS are reviewed electronically by the supervisor prior to finalization.

2nd Data Source - Certification for the SIS includes academy training and 1:1 site support from trainers for one visit within 30 days of the training. Certification records are maintained by the Joint Requirements Planning Program Manager and verified against the record of new case managers and social service specialists hired.

3rd Data Source: Assessment information is stored real-time in the system. Monthly reports indicate timeliness of assessments and assessor name. The CARE system automatically enforces the utilization of the correct LOC assessment based on client age.

Subassurance a.i.c.2:
The Joint Requirements Planning (JRP) Team provides new CRMs with comprehensive training, in a classroom environment, regarding the use and administration of the LOC Assessment when they are hired. Within 30 days of completing their training, JRP must perform a 1:1 evaluation of new CRMs to ensure that the LOC assessment is administered correctly. In addition, the JRP conduct an annual 1:1 evaluation of all CRMs 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, the JRP accompany CRMs on a LOC assessment interview. The CRM conducts the assessment interview and both JRP and CRM independently complete separate LOC assessments based on the information provided in the interview. The CRM's LOC assessment is then compared to the JRPs to ensure that the CRM's determination for ICF/MR LOC eligibility is consistent with that of the JRP. The JRP also evaluate the CRM'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.
a.i.b.1: A list of overdue assessments is generated monthly and sent to Regions for analysis and follow-up. Regions report on progress toward achieving 100% timely assessments as a part of their quarterly reports to Central Office Management.

File Reviews:
Two opportunities occur throughout the course of a year for files to be reviewed. The same standard protocol is used for each review. All files reviewed are selected by random sampling.

1)The Annual QCC audit is one of several discovery processes that will be used to demonstrate evidence of compliance with the waiver assurances. This process utilizes a sampling approach that will generate representative samples by waiver over a 2-year period. We will be using data from this process for both ongoing, individual level remediation and for systemic quality improvement.

The QCC team reviews files in each of the 3 regions across the state for compliance with established waiver processes. Data are analyzed upon exit from each regional review. Each region submits a response plan to Central Office addressing trends identified during the audit. The QCC team audits to the performance measures as outlined in the QIS sections of the waiver application.

Any negative audit findings are expected to be corrected within 90 days of identification. QCC team members review progress on a 30/60/90 day basis and verify that individual corrections are made appropriately. Corrections are entered into a statewide database.

The state will have data on all waivers and by individual waiver on an annual basis. When data is compiled across a 2-year period, a sufficient number of cases will be available to analyze each waiver independent of the others using a 95% confidence level with a +/- 5% margin of error for each performance measure.

2)In addition to the QCC audits, supervisors review 1 file per CRM per month.(*NOTE: While a valid sample is produced for the QCC audit, the supervisor file review is strictly an additional measure to assist with ongoing quality assurance.) This additional review enhances the ability of regional staff to detect and correct individual problems as they arise.

Each region is assigned a Waiver Coordinator whose role is to support supervisors and CRMs with ongoing identification and remediation of individual problems.

a.i.c.1: If the ongoing review of training and certification records reveals that one or more individuals failed to complete the required processes, follow up occurs between Central Office and Regional Management to ensure that this is completed.

a.i.c.2: Individuals whose reevaluation reveals that the LOC tools were inappropriately applied will 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**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **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 DDD Case Resource Manager (CRM) or DDD Social Worker (SW) or DDD Supervisor (if necessary)discuss the alternatives available as a part of the annual assessment process. The individual and/or their legal representative sign the Individual Support Plan (ISP)Wrap-Up at the time of the annual review to indicate the 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 annual Individual Support Plan, to include all initials and signatures, is maintained in the client record in the local DDD 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 for 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		
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 hygeine.

Assistance with IADLs include meal preparation, ordinary housework, essential shopping, wood supply, 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 (DDD) to the agency provider or individual provider of services.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **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	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 DDD 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 (DDD administrative code that lists the limits to respite care),

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

* DDD 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 DDD regional staff on a provider-specific basis. All payments are made directly from the Single State Agency (DDD) 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 DDD 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 DDD 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 DDD 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 DDD regional staff on a provider-specific basis. All payments are made directly from the Single State Agency (DDD) 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 DDD regional staff on a provider-specific basis. All payments are made directly from the Single State Agency(DDD) 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 DDD 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 DDD 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 DDD 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 DDD.

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 (DDD) 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
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 DDD 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 DDD 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 DDD 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 DDD 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 DDD 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 DDD 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)

DDD 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)

DDD 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) DDD and the treating professional will determine the need and amount of services received.

(2) DDD reserves the right to require a second opinion from a department-selected provider.

(3) DDD 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 DDD staff negotiate rates on a provider-specific basis. All payments are made directly from the Single State Agency (DDD) 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 DDD 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 DDD 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.

DDD works closely with the Division of Behavioral Health and Recovery Services (DBHR)to Prevent duplication of RSN/State Plan MH Services. DSHS's expectation is that any DDD 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.
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 Division of Developmental Disabilities 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 DDD.
• Behavioral health stabilization services require prior approval by DDD 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 DDD 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 DDD regional staff with the Regional Support Network (RSN) and/or individual providers. Payments are made from the DDD 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 DDD 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 Division of Developmental Disabilities 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 DDD.
- Behavioral health stabilization services require prior approval by DDD 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 DDD regional staff with the Regional Support Network (RSN) and/or individual providers. Payments are made from the DDD 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.

DDD works closely with the Division of Behavioral Health and Recovery Services (DBHR) to prevent duplication of RSN/State Plan BH Services. DSHS's expectation is that any DDD 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.

Rates for state-staffed behavior support and consultation as a component of behavioral health stabilization services are established on a prospective basis by the ADSA/DDD 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**
- ☑ **Relative**
- ☑ **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 DDD 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 DDD, 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.

DDD works closely with the Division of Behavior Health and Recovery Services (DBHR) to Prevent duplication of RSN/State Plan MH Services. DSHS's expectation is that any DDD 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 DDD.
• Behavioral health stabilization services require prior approval by DDD 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 DDD 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 DDD regional staff with the Regional Support Network (RSN) and/or individual providers. Payments are made from the DDD 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 ADSA/DDD 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):*
DDD 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 Disability Services Administration (ADSA) with 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 DDD 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 (DDD) 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
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 DDD 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 (DDD) 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 DDD regional administrator or designee

The rate per evaluation is provider-specific and is negotaited by DDD regional staff. All payments are made directly by the Single State Agency (DDD) 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 DDD regional administrator or designee for each authorization.

(2) DDD 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 (DDD) 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.

DDD 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.

DDD works closely with the DBHR to prevent duplication of RSN/State Plan MH Services, including EPSDT. DSHS's expectation is that any DDD 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 Division of Developmental Disabilities 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 DDD regional administrator or designee.

DDD 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 DDD 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.

DDD 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 (DDD) 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 DDD staff negotiate rates for staff/family consultation services services on a provider-specific basis. All payments are made directly by the Single State Agency (DDD) 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 (DDD) 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 DDD 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 DDD 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 (DDD) 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 DDD.
(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 (DDD) 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 Division of Developmental Disabilities of the Department of Social and Health Services that are employed as a DDD case/resource manager or a social worker 3 and therefore meet the following qualifications:

DDD 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 Division within one year of their appointment.

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

OR

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

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. (DDD 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 DDD 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 Division 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 Division.

(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), the Aging and Disability Services Administration (ADSA) receives reports and conducts investigations of abuse, neglect, exploitation and abandonment for clients enrolled with the Division of Developmental Disabilities. ADSA Residential Care Services (RCS) investigates abuse and neglect occurring in nursing homes, assisted living facilities, adult family homes, & supported living programs. ADSA 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 DDD 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. DDD 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 (DDD 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	☐

Waiver Service	Provided in Facility
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	☑
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	☐

Waiver Service	Provided in Facility
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:

Licensing will allow up to 6. DDD 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	☐
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	☑

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: 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
• Supervisory file reviews
• 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:
a.i.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: DSHS/Children's Administration/Division of Licensed Resources	☐ **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: Children's Administration	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.a.2 The percentage of waiver service providers requiring licensure, who initially met and continued to meet DDD contract standards, which includes appropriate licensure. Numerator: All waiver service providers that met contract standards, including licensure Denominator: All waiver service providers that require licensure

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 Control and Compliance Team within DDD	☑ **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**	☐ **Annually**	

Specify:		☐ **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:
a.i.b.1 The percentage of waiver service providers who initially met and continued to meet DDD contract standards. Numerator: All providers of waiver services

who initially met and continued to meet DDD contract standards Denominator: All providers of waiver services

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 and Control Team within DDD.	☑ **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:
a.i.b.2: 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. Numerator: Waiver participants responding to the NCI survey with provider performance satisfaction Denominator: 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:

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** 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:
a.i.c.1 The percentage of waiver service providers requiring licensure who meet state training requirements as verified by valid licenses and contracts.
Numerator: Waiver service providers requiring licensure who meet state training requirements Denominator: Waiver service providers requiring licensure

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 Control and Compliance Team within DDD	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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: Children's Administration/Division of Licensed Resources	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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: Department of Health	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Training verification records
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.i.c.2 The percentage of all waiver service providers who meet state training requirements as verified by valid contracts. Numerator: Waiver service providers meeting state training requirements Denominator: Waiver service 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 Control and Compliance Team within DDD	☑ **Annually**	☐ **Stratified** Describe Group:

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

Data Source (Select one):
Training verification records
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.i.a.1; and a.i.c.1(2): The Children's Administration FAMLink database containing the record of licensing inspections and required provider training is maintained and monitored by Children's Administration/Division of Licensed Resources (DLR). A schedule of unannounced visits is established for 100% of Foster Home and Staffed Residential providers to be reviewed to meet ongoing licensing requirements at a minimum of every 36 months. 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 will be used to determined whether or not licensure will continue or establish the frequency of unannounced visits. Communication regarding the licensing process occurs at the regional level. Annually reported from CA to DDD.

a.i.b.2: DDD compares data on response rates to NCI questions and responses from waiver year to waiver year. DDD constructs pie charts for questions and analyzes the outcome of the survey with the Waiver Oversight Committee and Stakeholders. DDD uses this information to assist with the development of the Waiver training curriculum as well as to develop needed policy changes.

a.i.b.1(1);a.i.a.2(1);a.i.c.1(1); and a.i.c.2(1): The Quality Control and Compliance Team within DDD conducts an annual audit of waiver files. As a part of this audit, the team checks to see that providers of service to waiver participants continue to meet contract standards, which includes appropriate licensure, as verified by a valid contract.

The QCC audit is one of several discovery processes that will be used to demonstrate evidence of compliance with the waiver assurances. This process utilizes a sampling approach that will generate representative samples by waiver over a 2-year period. We will be using data from this process for both ongoing, individual level remediation and for systemic quality improvement.

Findings from all file reviews are analyzed by management. Based on the analysis necessary steps are taken.

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.

a.i.b.1(2)and a.i.a.2(2): The Contracts Program Manager produces a quarterly report comparing claims data against the Enterprise All Contracts Database (EACD) to verify that providers of service to all clients meet contract standards, as verified by a valid contract.

a.i.c.1(3): Department of Health (DOH) boards, specific to individual licensed professions, monitor education and experience requirements prior to licensure as a health professional and continuing education requirements prior to license extension. Health professionals' initial license and renewal applications are reviewed for evidence that education requirements specific to the license have been met prior to licensing and renewal.
a.i.c.1(4); a.i.c.2(2): DDD maintains provider contract records in the Enterprise All Contracts Database (EACD) that verifies providers have met ongoing training requirements prior to contract renewal. EACD reports are run quarterly to verify completion of training 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.
Contracts Reports:
a.i.b.1(2)and a.i.a.3(2):
a.i.c.2(2):

The results of the quarterly 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.

Waiver File Reviews, including Annual QCC audit:
a.i.b.1(1);a.i.a.3(1);a.i.c.1(1); and a.i.c.2(1)
Two opportunities occur throughout the course of a year for files to be reviewed. The same standard protocol is used for each review. All files reviewed are selected by random sampling.

1)The Annual QCC audit is one of several discovery processes that will be used to demonstrate evidence of compliance with the waiver assurances. This process utilizes a sampling approach that generates representative samples by waiver over a 2-year period. We will be using data from this process for both ongoing, individual level remediation and for systemic quality improvement.

The QCC team reviews files in each of the 3 regions across the state for compliance with established waiver processes. Data will be analyzed upon exit from each regional review. Each region submits a response plan to Central Office addressing trends identified during the audit. The QCC team audits to the performance measures as outlined in the QIS sections of the waiver application.

Any negative audit findings are expected to be corrected within 90 days of identification. QCC team members review progress on a 30/60/90 day basis and verify that individual corrections are made appropriately. Corrections are entered into a statewide database.

The state will have data on all waivers and by individual waiver on an annual basis. When data is compiled across a 2-year period, a sufficient number of cases will be available to analyze each waiver independent of the others using a 95% confidence level with a 5% margin of error for each performance measure.

2)In addition to the QCC audits, supervisors review 1 file per CRM per month.(*NOTE: While a valid sample is produced for the QCC audit, the supervisor file review is strictly an additional measure to assist with ongoing quality assurance.) This additional review enhances the ability of regional staff to detect and correct individual problems as they arise.

Each region is assigned a Waiver Coordinator whose role is to support supervisors and CRMs with ongoing identification and remediation of individual problems.

The National Core Indicators Survey:

Washington State's Division of Developmental Disabilities (DDD) 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, DDD 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:

DDD Case-Resource Supervisor (when staffing vacancies necessitate coverage by a 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.

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 CRM or Social Service Specialist or Supervisor contacts the individual and his/her representative by phone and letter.

During the phone conversation the CRM or Social Service Specialist or Supervisor 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.

The letter the CRM or Social Service Specialist or Supervisor sends confirms the date and time of the meeting and includes the DDD HCBS Waiver Brochure. The DDD HCBS Waiver Brochure includes information about services, eligibility criteria and administrative hearing rights. The CRM or Social Service Specialist or Supervisor also extends invitations by phone and/or letter to individuals who are asked to participate in the ISP process.

Everyone involved in services and supports identified on the ISP is involved in the development of the plan. In those cases where a waiver participant does not want a particular family member or provider at a planning meeting the CRM or Social Service Specialist or Supervisor explores why. A participant’s refusal to have a provider involved in the planning meeting is always considered a red flag for investigation.

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):

Implemented June 2007, the DDD assessment is used assess all DDD clients. The Individual Support Plan (ISP) is the planning document produced for all clients receiving paid services, including waiver clients.

The DDD Assessment provides:

- An integrated, comprehensive tool to measure support needs for adults and children.
- An improved work process to support case management services because the system:
  - Identifies the level of support needed by a client;
  - Indicates whether a service level assessment is needed; and
  - Identifies a level of service to support the client's assessed need.
- Detailed information is gathered regarding client needs in many life domains. This allows CRM's to make more effective service referrals.
- An improved planning process because health and welfare needs identified in the assessment automatically populate 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 AAMR.

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

- The Individual Support Plan (ISP) is developed by the DDD Case/Resource Manager (CRM) or Social Service Specialist or Supervisor.
- Participants or contributors to this plan consist of:
  - The individual,
  - Their legal representative (if applicable),
  - Providers, and
  - Anyone else the individual would like to have participate or contribute (family, friends, 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 DDD Assessment which is administered by the DDD CRM or Social Service Specialist or Supervisor 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/MR Level of Care for individuals age 16 and above);
   b. ICF/MR Level of Care Assessment for individuals 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 tool;
   b. Employment Support Assessment tool;
   c. Sleep Assessment tool; and
   d. Mental Health Assessment tool;
   e. Equipment tool;
   f. Medication Management tool;
   g. Medication tool;
   h. Seizure & allergies tool.
3. The Individual Support Plan module contains:
   a. Service Summary tool;
   b. Support Needs tool;
   c. Finalize Plan tool;
   d. Environmental Plan tool;
   e. Equipment tool;
   f. DDD Referral tool;
   g. Plan review tool;
   h. Supported Living Rate Calculator;
   i. Foster Care Rate Assessment Calculator.

- DDD also uses external assessments as a part of the ISP process. Examples of external assessments include; nursing evaluations, PT/OT reports, psychological evaluations 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:

- The DDD HCBS Waiver Brochure is enclosed with the letter confirming the ISP meeting. The letter and brochure are sent approximately 60 days prior to the ISP meeting. The DDD HCBS Waiver Brochure identifies waiver services.
- During the course of the ISP meeting service options are described and discussed.
- The CRM or Social Service Specialist or Supervisor provides a Waiver “Facts” sheet at the ISP meeting which lists services available in the Waiver.
- Washington Administrative Code (WAC) fully defines services available under the waiver and is made available upon request and via the DDD 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 The Personal Elements section of the Service Level assessment captures documentation of participant goals. This section allows for the description, the status, begin and end date, and responsible person to act on each goal.

• Participant needs (including health care needs and risk factors):

o Health and welfare needs are identified throughout the course of the assessment on multiple screens (please see Section b above). The DDD assessment allows for thorough documentation of participant medical conditions,

diagnoses, personal care needs, physical and mental health status, behavioral support needs, communication needs, etc.
The assessment of personal care needs includes the assessment of self-performance, type of support provided in the last 7 days, level of unmet need, and assistance available for partially met needs (natural supports).
The assessment contains the following Nursing Services referral criteria:
1. The presence of any one or combination of diagnoses that are unstable or changing. This may be triggered by:
a. Diagnosis of insulin dependent diabetes and:
Greater than two ER visits in the past six months; or
Recurrent infections; or
Non-healing/deteriorating lesions; or
Open lesions (foot screen); or
Vision impaired and the client is administering the injection; or
The client does not adhere to the diet; or
BMI less than 19 or greater than 30; or
Presence of diagnosis of depression; or
Presence of diagnosis of cellulitis; or
Infection (cellulitis, drainage) (foot screen).
b. Diagnosis of quadriplegia; and
UTI; or
Current pressure ulcer; or
Recurrent infection; or
CPS score > than 3; or
Overall self sufficiency has declined in the past 90 days; or
Treatment includes a ventilator or tracheotomy; or
Incontinence; or
Fecal Impaction; or
Caregiver stress stability scale is >24.
c. More than one hospitalization in the last six months and more than one emergency room visit in the last six months;
d. An indication on the assessment that the client has:
“Pain daily”; or
A pain scale rating greater than 4 (5 to 10); and
Pain impact is “limiting activity”; and
Pain treatment is ineffective.
e. Treatment needs that may include:
Tracheotomy/suctioning;
Indwelling catheter care;
Injections;
Wound/skin care;
Passive ROM; or
Tube feedings; and the client has:
A UTI; or
Recurrent infections; or
Greater than two hospitalizations in the last six months; or
Greater than two ER visits in the last six months or a provider type that is not:
A Nurse Delegator;
A home health agency;
Hospice;
Facility staff; or
Waiver skilled nursing.
2. The presence of a medication regimen that has an effect on client assessment, service planning and delivery. This may be triggered by:
a. A Medication level that is “must be administered to person” and:
The client is choking or gagging on medications; or
The client is not taking medications as ordered; or
b. The client is declining assistance with medications and:
Is not taking medications as ordered; and
Has greater than one ER visit or greater than one hospitalization in the last six months; or
c. The client’s medication regimen is complex and:
The client has multiple prescribers; and
The client has had greater than one ER visit or greater than one hospitalization in the last six months; and

The client is not taking medications as ordered.
d. The client lives alone and:
The client needs assistance with medications and the need is unmet; and
The frequency is daily; and
The client's Classification Category is A Low or B Low.
3. Nutritional status or weight concerns affecting service planning and delivery. This may be triggered by indications of oral problems or oral hygiene and dental problems as evidenced by:
a. A weight loss or weight gain and:
A BMI of < 19 or > 30; and the client:
Has a chewing problem; or
Has a current swallowing problem; or
Is non-compliant with their diet; or
Has a poor appetite; or
An appetite change.
b. A current swallowing problem; and BMI of <19 or > 30 and the client is:
On a mechanically altered diet; or
Using a dietary supplement.
c. Nutritional approaches that include:
Enteral; or
Parenteral; and
The provider type is IP or home care agency worker; or
Informal support; or
Client; and there is no:
Nurse delegation;
Home health;
Self-directed care; or
Waiver skilled nursing.
d. A client age 2 – 20 with a BMI of underweight (BMI for age < 5th percentile) or Overweight (BMI for age > 95th percentile).

4. The client is bedbound, or has care needs related to immobility that affects assessment, service planning and delivery. This may be triggered by:
a. The client is assessed as needing but not receiving:
ROM passive, ROM active, splint or brace assistance, transfer, or walking; and:
The client's overall self sufficiency has declined in the last 90 days; or
The provider code is client or family/informal supports, IP/agency, or self-directed care; or
b. The client is assessed as incontinent of bowel or bladder most or all of the time; and:
Uses and has leakage; or
Does not use and has leakage; and
The client is assessed as having:
Diarrhea; or
A UTI; or
A history of recurrent infections; or
Constipation; or
Fecal impaction.
c. The client ADL self performance code is (3) or (4) in column A in the following ADLs:
Bed mobility; or
Transfer; or
Walk in room, hallway, and rest of immediate living environment; or
Locomotion in room and immediate living environment; and:
The client is assessed as having a fall in the last 30 days or the last 31-180 days.
5. Skin breakdown or history of skin breakdown. This may be triggered by:
a. An indication in CARE that the client has one of the following skin problems not related to pressure, and the status is not healing or is deteriorating:
Abrasions, skin tears, or cuts; or
Burns; or
Open lesions; or
Rashes; or
Skin folder/perineal rash; or
Surgical wounds; or
Stasis ulcers; and on the Treatment Screen there is NO:

Application of dressing;
Application of medication;
Wound/skin care; or
Client needs treatment but does not receive it.
b. Foot problems including:
Fungus;
Infection;
Open lesions; or
In grown toenail and the problem is non-healing or deteriorating and on the Treatment Screen there is no:
Application of dressing;
Application of medication;
Wound/skin care; or
Client needs treatment but does not receive it.
6. Skin Observation Protocol - The Skin Observation Protocol specifies both case manager/social worker and nursing service responsibilities when a client meets the highest risk indicators identified in the protocol. This may be triggered by any of the following:
o Current pressure ulcer;
o Quadriplegia;
o Paraplegia;
o Total dependence in bed mobility;
o Comatose or persistent vegetative state;
o History of pressure ulcer within one year;
o Bedfast and/or chairfast, and cognition problems;
o Bedfast and/or chairfast, and incontinent of bladder or bowel;
o Hemiplegia, and cognition problems, and incontinent of bladder or bowel; or
o Bedfast and/or chairfast, and Insulin Dependent Diabetes Mellitus (IDDM).

Health and welfare needs are also identified by additional documentation submitted as part of the ISP process. Examples include medical reports, clinical assessments of behavioral health, recommendations by licensed therapists, etc.

• Preferences:
o Participant preferences are identified as requests for service. This is documented in the body of the assessment as well as in the ISP.
o Drop-down options and comment boxes are provided throughout the assessment to allow documentation of participant preferences as they pertain to each individual aspect of care. Drop-down options address the following categories: strengths, limitations, preferences, and caregiver instructions. Social/cultural, considerations, preferences, or traditions are identified under a specific subsection under ‘Personal Elements’.

• Desired Outcomes:
The ISP format documents DDD services, personal care scheduling, other supports provided, and other plans in place (e.g. Individualized Education Plans, and Positive Behavior Support Plans). Goals for services are described in the ISP section. Equipment and Environmental Plans, and referrals for nursing or other clinical services are included in the ISP. Begin and end dates are included to define delivery parameters.

(e) How Waiver and other services are coordinated.
Waiver and other services are coordinated by the CRM/Social Worker/Supervisor.
• Services, other supports, and plans that have been identified to meet health and welfare needs are documented in the ISP.
• The CRM provides participants with information on qualified providers available to provide services, document other plans in place for the participant, and facilitate the coordination of services across environments and agencies.
• 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 then monitors the ISP to ensure health and welfare needs are being addressed as planned.
• As changes occur throughout the year, the CRM amends the plan to include new services, providers, or plans.
• The CRM facilitates 30-90 day visits which are in the participant’s family home. These visits include all available support team members with the goal of ascertaining progress, identifying barriers to progress, and encouraging collaboration. The CRM gathers information from support team members unable to attend the meeting either before or after the meeting.

• Information gathered from these follow-up meetings and other contacts during the year are documented in Service Episode Records and/or a Share-Point database.

(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.
  - The identified needs populate the ISP.
    - Business rules require that each identified need is addressed.
  - When an identified need requires a Waiver funded service the CRM or Social Service Specialist or Supervisor is required to identify the specific provider and the service type that will address this need.
    - The CRM or Social Service Specialist or Supervisor is required to provide sufficient documentation to allow the provider and the participant to know what the provider responsibilities are.
  - When a provider or service has not been identified the plan reflects the steps in place to identify either the service or the provider.
    - When the service or provider is identified the ISP is amended to reflect the updated plan.
- The CRM or Social Service Specialist or Supervisor provides oversight and monitoring of the ISP. Frequency of monitoring is identified and documented at the time of the assessment.

(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).

- Per WAC 388-845-3075:
  - An individual may request a review of his/her plan of care at any time by calling his/her case manager. If there is a significant change in conditions or circumstances, DDD 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.
  - 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).
  - 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. Amendments to the ISP related to a change in the client's condition or support needs require a new assessment.
  Examples would be:

  - ISP Amendment with New Assessment
    - Change in status of client in key domain (behavior, ADL, etc.)
    - Addition of new service or amount of service related to a change in client condition
    - Change in residence related to a change in client support needs

- ISP Amendment Without New Assessment
  - Change in demographic information only
  - No change in status of client in key domain
  - Change of provider
  - Rate change only for residential services (e.g. roommate leaves so now only 3 clients vs. 4 clients in home)

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 DDD Assessment and ISP. The DDD assessment takes a comprehensive approach to assessing for risk and provides a mechanism for allowing the case manager and the individual and family to identify risks and develop a strategy to mitigate identified risk. As the CRM completes the DDD Assessment, an assessment algorithm assists the CRM in identifying potential areas for health and welfare risk for each individual. This is accomplished as information is collected via the assessment and triggers referral indicators that the CRM, individual, and family must address when completing the ISP. The CRM populates a "referral" screen in the ISP for each individual indicator and documents the plan/response to each item.

The case manager evaluates health, welfare and safety needs throughout the Support Assessment and Service Level Assessment modules in the DDD Assessment. These needs are then addressed with the individual and family in planning via formal referrals as described above, authorized paid DDD Services, and other documented support activities in the ISP.

CIIBS case managers conduct follow-up visits with each child and his/her support team every 30 days for the first 3 months of waiver enrollment in order promote a smooth transition to available services and supports necessary to assist with stabilization; to successful engage the family and prepare the team; and to develop a plan with which the child and family are comfortable and confident. After the initial 3 months of waiver enrollment, child and family team meetings are scheduled as necessary according to the team but on at least a quarterly basis. Follow-up visits and team meetings include the ongoing gathering of information on participant and family strengths and needs, prioritization and planning for needs, reviewing participant behavioral incidents and family stress levels; use of available services; feedback on collaboration of all parties; satisfaction with services and service providers; and follow-up on any referrals, action steps, or recommendations previously made.

Utilizing the DDD Assessment, the CRM 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 documents the plan/response to each item that populates the referral screen.

CRMs utilize case management system tools in their ongoing assessment of participant risk and tracking of risk management activities. These include plan monitoring schedules; amendment capability that allows case managers to amend ISPs according to participant need throughout the year; and tickler systems for following up on annual assessment reviews, referrals, monitoring plans, environmental needs, equipment needs, and 30/60/90 day follow-up visits with the child’s support team.

Emergency planning is an expected component of the ISP. Back up caregivers and emergency contacts are identified during the client'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. The client always has the choice of an ICF/ID if he/she feels needs are not being met in the community.

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 will be given free choice of all qualified/approved providers of each service approved in his/her plan. During the course of the ISP process the participant is advised they 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).

The CRM or Social Service Specialist or Supervisor facilitates access to provider lists and assist with the contracting process. In addition, CIIBS Resource Managers assist with ongoing recruitment and contracting of providers for behavior support and other CIIBS services. Provider contracting is open and continuous enrollment. Their role is to meet with families initially and support them to locate providers that will be a good match for them based on criteria that families value. When families need new providers or providers for new services, Resource Managers help to facilitate options that meet client needs.

- CIIBS Behavior Specialists/Technicians:
  - A list of potential providers is maintained by DDD Resource Managers and offered to families
  - Families may also choose another provider of behavior support from the community and refer for contracting. If providers are willing and meet DDD contractor criteria, they may provide services upon contract completion.

- Out of Home Respite Providers:
  - The names and addresses of licensed homes contracted with DDD and with availability at times families seek respite, are provided to families. Families can arrange visits to see the homes and meet with the staff ahead of time to determine their choice of provider.
  - Seattle Children's Hospital maintains a list of camps for children with special health care needs. Many of these are contracted with DDD as well. DDD provides a list of camps to families as well. Families may also refer camps to DDD for contracting.

Personal Care and In-home Respite:

- 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 area who are interested in being interviewed for potential hire.

DDD 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.

* Contractors for Environmental Adaptations are listed by Labor & Industries, along with information about their license and any actions taken against them. Families may choose from this broad list of contractors and refer to DDD for contracting. DDD also maintains a list of contractors.

* Provider One 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):

ADSA is an administration within DSHS, the operating agency. The individual case manager/social worker is an employee of ADSA/DDD. DDD determined client eligiblity and reuqires the use of the Divison's electronic assessment and servic eplanning tool. DDD case managers/social workers directly authorize all initial service plans and supervisors conduct quality assurance activities on service plans. ADSA/DDD has direct electronic access to all service plans.

DDD has a comprehensive audit process. In addition, DDD 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.

DDD audit process:
There are three opportunities throughout the course of a year for files to be reviewed. The same standard protocol is used for each review. All files reviewed are selected by random sampling. Supervisors review one file per quarter per CRM/Social Service Specialist. The 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.

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. Findings are analyzed by management. Based on the analysis necessary steps are taken.
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:
Washington State’s Division of Developmental Disabilities (DDD) 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, DDD 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 Survey:
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 at the Waiver Oversight Committee.

At the end of each QA Review Cycle, a final report is generated which includes detailed data on a state-wide level. 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. Quality assurance improvements are reviewed and approved for implementation by executive management.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

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

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

(a) The entity responsible for monitoring the implementation of the service plan and participant health and welfare:

The regional DDD Case Resource Manager (or Social Service Specialist or Supervisor) provides the primary oversight and monitoring of the ISP. The DDD Case Resource Manager (or Social Service Specialist or Supervisor) authorizes the Waiver Services identified as necessary to meet health and welfare needs in the ISP. The DDD Case

Resource Manager (or Social Service Specialist or Supervisor) monitors service provision at least four times per year. Follow-up visits with the child/family by the DDD Case Resource Manager (or Social Service Specialist or Supervisor) occur monthly for the first 3 months on the program and between 30-90 days thereafter per recommendation of the child and family team.

(b)The monitoring and follow-up method:

Service provision is monitored by one or more of the following:
(1)Face to face child and family follow-up visits;
(2)Telephone contact to the child/youth and parent/guardian;
(3)Contacting providers;
(4)Reviewing progress reports submitted by providers and reviewing additional assessments (e.g. IEP's, psychological evaluations, Occupational Therapy evaluations etc..).
(5)Contacting school professionals
(6)Child and family team meetings.

If the DDD Case Resource Manager (or Social Service Specialist or Supervisor) finds that the ISP is not meeting the individual's needs the ISP will be revised/amended. Other follow up activities include requests for amending the behavior support plans and requests for additional IEP meetings. All monitoring is documented in the Service Episode Record section of the electronic DDD Assessment. Responses to the questions asked at the follow-up visits are recorded in a separate database.

At the time of the annual review, the DDD Case Resource Manager (or Social Service Specialist or Supervisor) 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 DDD Assessment will allow the DDD Case Resource Manager (or Social Service Specialist or Supervisor) to create a new assessment.

Case managers verify with families of participants through a series of questions, as part of the Assessment Meeting Wrap-Up and at the 30-90 day follow-up visits, that the following items are addressed:

Partipant access to both waiver and non-waiver services in the service plan, including health services:

o Families verify after the ISP meeting that information was received regarding waiver services and qualified providers of the services needed to complete the plan.
o Families (and children to the extent of their ability) are asked questions at follow-up visits about their satisfaction with waiver and other service providers.
o CRMs ask follow-up questions of the child, family, school, and service providers about service delivery and satisfaction.
o Follow-up questions include questions about medication changes.

Participant exercise of free choice of providers:

o Families verify after the ISP meeting that a choice of qualified providers was offered to meet health and welfare needs.
o Follow up questions about satisfaction with providers are asked of child and family.

Effectiveness of back-up plans:

o Families verify after the ISP meeting that if any current provider is not to the family's satisfaction, a plan was made to meet the needs by selecting another provider or in other ways.
o Families verify after the ISP meeting that they know they can request a review of their child's plan at any time.
o Follow up questions about behavioral incidents and interventions, including back-up plans, are asked of the child, family, school, and providers.

Participant health and welfare:

o Families verify after the ISP meeting that health and welfare needs are either currently being met or an adequate plan is in place to meet them in a timely manner.
o Families verify after the ISP meeting that any issues or concerns brought up related to this plan of care have

been/are being addressed.
o Follow up questions regarding safety and comfort with the services and plans in place are asked of the child and family.
o Quarterly service provider progress reports are reviewed and utilized during the 30-90 day follow up visits.

Participant Rights:

o Families verify after the ISP meeting that their rights to appeal the decisions made by the Division of Developmental Disabilities have been explained.
o Families verify after the ISP meeting that the procedures for making an appeal have been explained.
o Planned Action Notices with an explanation of participant rights are provided for any approval, denial, or reduction of a service that occurs throughout the plan year.

Case managers submit answers to the questions from the 30-90 day visits to Central Office for recording in the CIIBS database. The CIIBS Program Manager will review a report at least annually of information collected through the IR database and the 30-90 day client follow up visits for waiver participants. The following criteria will be utilized as triggers for an electronic file review to determine whether or not an ISP or PBSP amendment should have occurred:

a)CPS referral for abuse/neglect/exploitation
b)Behavioral incident resulting in injury to self or others requiring more than first aid
c)Injury to client or others resulting from physical restraint
d)Client visits to the ER
e)Client psychiatric hospitalizations
f)Lack of behavioral improvement after initial 3 months on the program
g)Concern indicated by parent with the plan or provider
h)New behaviors or new intensity of behaviors
i)Reported concern with or lack of parent or provider involvement in the support plan
j)Negative response by parent or provider to "I believe the plan will work"

Results requiring remediation will be referred back to the CRM and Supervisor for prompt follow-up. All corrections are required to be completed within 90 days.

Data gathered will be presented for review at the Waiver Oversight Committee meeting at least annually.

The Quality Compliance and Control Team (QCC) reviews waiver files annually. This annual audit includes verification that the case manager used one of the methods described above to monitor the ISP. Results and required corrections are compiled into a statewide database. This team audits a statistically reliable sample and then charts the responses; requires follow up on those audit findings; and reports to management on system issues.

(c) Frequency of monitoring:

Follow-up visits by the DDD Case Resource Manager (or Social Service Specialist or Supervisor) occur monthly for the first 3 months on the program and between 30-90 days thereafter per recommendation of the child and family team. Other activities occur as needed.

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:
a.i.a.1(a): 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:
a.i.a.1(b): 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:
a.i.a.1(c): The percentage of families reporting through the NCI survey that their child's ISP addresses their health and welfare needs. Numerator: Families

reporting that the ISP meets their child's needs. Denominator: Families 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: Quality Assurance Team within DDD	☐ **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.i.a.2: 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. Numerator: Waiver ISPs with monthly waiver service provision or monitoring by the case manager during a break in service. 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 Control and Compliance Team (QCC) within DDD.	☑ **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.

Performance Measure:
a.i.b.1: The percentage of all waiver ISPs which include emergency planning. Numerator: All waiver ISPs with evidence of emergency planning. Denominator: All waiver ISPs.

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.i.b.2: The percentage of waiver participant records containing the ISP Wrap-up, which includes verification that the waiver participant is satisfied with the development of the ISP. Numerator: All waiver participant records including the ISP Wrap-Up Denominator: All waiver participant records

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 Control and Compliance Team within DDD	☑ **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.i.b.3: The percentage of families reporting through the NCI surveys that they are involved in the creation of their child's ISP. Numerator: All CIIBS waiver participant family members responding to the NCI survey and reporting

involvement in the creation of the ISP Denominator: All CIIBS 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: Quality Assurance Team within DDD	☐ **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:

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:
a.i.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 Control and Compliance (QCC) Team within DDD.	☑ **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.i.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**
☐ **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:
a.i.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** Specify: Quality Assurance Team within DDD	☐ **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:
a.i.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 Control and Compliance Team within DDD	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
a.i.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 Control and Compliance Team within DDD	☑ **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.i.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:	☑ **Annually**	☐ **Stratified** Describe Group:

Quality Control and Compliance Team within DDD		
	☐ **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:
a.i.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 including the annual ISP Wrap-Up Denominator: All waiver participant records

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 Control and Compliance Team within DDD	☑ **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.i.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 including the annual ISP Wrap-Up Denominator: All waiver participant records

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 Control and Compliance Team within DDD	☑ **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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **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.i.a.2; a.i.b.2; a.i.c.1(2); a.i.d.2; a.i.d.3; a.i.d.4; a.i.e.1; a.i.e.2(1):
The QCC team reviews files in each of the 3 regions across the state for compliance with established waiver processes and eligibility criteria. This process utilizes a sampling approach that generates representative samples by waiver over a 2-year period.

100% of the randomly selected files audited by the QCC Audit team include (among others) the following questions with the 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?"
"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 DDD annual or initial assessment?"
"Is there a signed Voluntary Participation statement from the annual or initial assessment in the client file?"

a.i.a.1(b): The DDD assessment allows for entry and addressing of personal goals. An annual report is generated at Central Ofice 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 provides 100% analysis of individual results.

a.i.a.1(c); a.i.b.3; a.i.d.1: DDD compares data on response rates to NCI questions and responses from waiver year to waiver year. DDD constructs pie charts for questions and analyzes the outcome of the survey with the Waiver Oversight Committee and Stakeholders. DDD uses this information to assist with the development of the Waiver training curriculum as well as to develop needed policy changes.

a.i.b.1: An annual report is created to verify that emergency plans are documented in waiver participants' ISPs.

a.i.c.1(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. A list of overdue assessments is generated monthly and sent to Regions for analysis.

a.i.c.2; a.i.e.2(2): ISP Meeting Survey:
A ISP Meeting survey is mailed to a random sample of 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 Waiver Oversight Committee. The following question (among others) are included in the survey:
"Were you given a choice of service providers?"
"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):
a.i.a.2; a.i.b.2; a.i.c.1(2); a.i.d.2; a.i.d.3; a.i.d.4; a.i.e.1; a.i.e.2(1):
Findings from the QCC Team reviews are analyzed by management, and based on the analysis, necessary steps are taken to increae compliance. For example:

The Annual QCC audit is one of several discovery processes that will be used to demonstrate evidence of compliance with the waiver assurances. This process utilizes a sampling approach that will generate representative samples by waiver over a 2-year period. We use data from this process for both ongoing, individual level remediation and for systemic quality improvement.

The QCC team reviews files in each of the 3 regions across the state for compliance with established waiver processes. Data are analyzed upon exit from each regional review. Each region submits a response plan to Central Office addressing trends identified during the audit. The QCC team audits to the performance measures as outlined in the QIS sections of the waiver application.

Any negative audit findings are expected to be corrected within 90 days of identification. QCC team members review progress on a 30/60/90 day basis and verify that individual corrections are made appropriately. Corrections are entered into a statewide database.

The state has data on all waivers and by individual waiver on an annual basis. Data are compiled across a 2-year period, with a sufficient number of cases available to analyze each waiver independent of the others using a 95% confidence level with a +/- 5% margin of error for each performance measure.

Each region is assigned a Waiver Coordinator whose role is to support supervisors and CRMs with ongoing identification and remediation of individual problems.

a.i.a.1(c); a.i.b.3; a.i.d.1: The National Core Indicators Survey.
Washington State's Division of Developmental Disabilities (DDD) 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, DDD 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.

a.i.c.3; a.i.e.2(2): ISP Meeting Survey.
DDD compares data on response rates to the ISP Meeting Survey and responses from waiver year to waiver year. DDD constructs pie charts for questions and analyzes the outcome of the survey with the Waiver Oversight Committee and Stakeholders. DDD 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 or respite 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 Disability Services Administration (ADSA) 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*:

- [x] **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) Information about participant direction opportunities:

- During service plan development the DDD Case Resource Manager or Social Work or Supervisor is responsible for informing the waiver participant of their ability to choose an 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:
  - o information about being an employer and resources for related skill development
  - o information about the financial management role of DSHS
  - o information about the role of the Health Care Referral Registry (HCRR) of Washington State

- During service plan development the DDD Case Resource Manager or Social Work or Supervisor is also responsible for informing the waiver participant of the potential liabilities (e.g., the provider(s) schedule may be difficult to coordinate, may need back-up providers, may need to hire a replacement provider quickly if a provider terminates employment) of selecting an individual provider.

(b) Entity or entities responsible for furnishing this information:
- The DDD Case Resource Manager or Social Worker or Supervisor 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	☑	☐
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 furnishes FMS services for all waiver participants. No action on the part of the participant is necessary.

Because the State Operaing Agency already possesses the infrastructure necessary to provide these services, they (FMS) are not procured from an outside contractor(s). Processing of payments for waiver services is conducted by the State Operaing Agency, which has the infrastructure (i.e., computerized payment systems and knowledgeable payment and IT staff, computerized accounting systems and knowledgeable accounting and IT staff) necessary to ensure that Federal, state and local employment taxes and labor and workers' compensation insurance rules related to household employment and payroll are implemented in an accurate and timely manner.

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**
- ☑ **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) Methods to 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:
  - o Supervisory review of client files includes contact with the client to verify services are provided as indicated in the payment authorization and ISP.
  - o Case Resource Managers verify services were provided as planned.
  - o The State Auditors Office and Operation Review and Consultation conduct routine audits of agency payments.

(b) Entity (or entities) responsible for this monitoring:

- The State Auditors Office and Operations Review and Consultation conduct routine audits of agency payments.

(c) How frequently performance is assessed:

- Performance is assessed by the Case Resource Manager at least annually at the time of plan review.
- The State Auditors Office 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:
- DDD Case Resource Manager or Social Worker or Supervisor
- HCRR

(b) how the supports are procured and compensated:
- DDD Case Resource Manager or Social Worker or Supervisor is a 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 DDD Case Resource Manager or Social Worker or Supervisor 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:
  - o Information about being an employer and resources for related skill development
  - o Information about the financial management role of DSHS
  - o Information about the role of the Health Care Referral Registry (HCRR) of Washington State
- The Home Care Referral Registry (HCRR)of Washington State provides:
  - o A referral Registry used to connect waiver participants to providers and staff to assist.
  - o Assistance with hiring and employee management.

(d) the methods and frequency of assessing the performance of the entities that furnish these supports:
- DDD Case Resource Managers or Social Workers or Supervisors receive yearly performance evaluations per state personnel policies. Supervisory audits are required for a standard number of records for each case manager.
- 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 or respite at any time. The DDD Case Resource Manager or Social Worker or Supervisor facilitates the transition and protects against a 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 with an individual provider for cause. In that case, the DDD Case Resource Manager or Social Worker or Supervisor will provide referral information to assist the participant in hiring a new provider, thus facilitating 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 clients have rights under Medicaid law, state law (RCW) and state rules (WAC) to appeal any decision of DDD affecting eligibility, service, or choice of provider.

During entrance to a waiver an individual is given appeal rights via the DDD HCBS Waiver Brochure (DSHS #22-605). The DDD CRM or Social Worker or Supervisor discusses fair hearing and appeal rights at the time of the initial and annual ISP meeting and appeal rights 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 appeal rights) for signature.

When the department makes a decision affecting eligibility, level of service or denial or termination of provider, Planned Action Notices (PANs) must be sent within 5 working days of the decision. The notice is sent to the client and their designee by the individual's case manager (i.e., DDD Case Resource Manager or Social Worker or Supervisor). 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 a fair 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 a fair hearing. If the tenth day happens before the end of the month, they have until the end of the month to ask for a fair hearing and still be able to get continued benefits. An explanation of the circumstances under which services will be continued during the participant's appeal period is contained in the PAN.

Phase 5 of the Division's computerized Case Management Information System (CMIS, implemented June 2009, includes automatic generation of PANs by the CMIS.

Assistance to the client with respect to pursuit of a Fair Hearing is provided by the Client Representative or Necessary Supplemental Accommodation (NSA) representative. Except for those instances where the client has chosen to represent her/himself, all DDD clients have a designated NSA representative who receives copies of all correspondence sent to the client and whose role is to assist them with that correspondence, which includes PANs. Per DDD Policy 5.02 (concerning Necessary Supplemental Accomodation), case managers contact the identified NSA representative annually to confirm that the person agrees to accept the DDD notices and other correspondence sent to the client and understands his or her responsibility to assist the eligible person to understand the documents and exercise the eligible person's rights.

A client or their designee may request an administrative hearing orally or in writing. Client appeals are heard and decided by Administrative Law Judges (ALJ) through an administrative hearing. Attorney representation is not required but is allowed. The client 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.

Copies of PANs are maintained in client files. Service Episode Records (SERs) document when a PAN was sent. SERs are contained electronically in the DDD Assessment on the CARE platform.

DDD uses a variety of PANs to communicate decisions. All PANs include relevant administrative hearing and appeal 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:

ADSA/DDD 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).

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

DDD provides participants with fair hearing and appeal rights and a complaints/grievance process. The Complaints/Grievance process is not a pre-requisite to a fair hearing, rather this policy provides participants with an opportunity to address issues that are not dealt with through the fair hearing and appeal process. Examples include DDD services/supports, DDD staff, contracted providers, client interactions/relationships.

(b) Process and timelines for addressing grievances/complaints:

Case Resource Managers (CRM) or Social Service Specialists (SSSs)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.

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 DDD Supervisor, the CRM or SSS will give his/her supervisor's name and telephone number to the complainant.

Complaints/grievances go through various levels of management(Supervisor, Regional Administrator, Central Office) until they are resolved. At each level, the expectation is that the complaint will be resolved within 10 working days. If the complaintant is not satisfied with the results, the complaint is referred to the next higher level.

(c) Mechanisms used to resolve grievances/complaints:

DDD uses both an informal and formal process to resolve complaints. If at any time a complainant is not satisfied with the attempted resolution, the complaint will be forwarded to the next higher level of management. Complaints and the resolution process are documented in a statewide database. Complaints that rise to the level of RA or Central Office are recorded in this database. Complaints resolved by case managers or social workers or supervisors are documented in the client record.

DDD policy 5.03 ("Client Complaints") outlines the complaint resolution process.

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).

State definitions of abuse and neglect of children are found in RCW 26.44.020 - Definitions

State definitions of abuse and neglect of vulnerable adults are found in RCW 74.34.020 Definitions and RCW 74.34.035 Reports — Mandated and permissive — Contents — Confidentiality

Alleged or suspected abuse, neglect, exploitation or abandonment is required by law to be reported to DSHS immediately. State law also requires any sexual or physical abuse to be reported to law enforcement. All DSHS employees and their contracted providers are mandated reporters per RCW 74.34 ("Abuse of vulnerable Adults"). Residential Care Services (RCS) is the designated DSHS authority for abuse and neglect investigations involving client's in residential programs. Adult Protective Services (APS) investigates incidents involving vulnerable adults residing in their own homes. Children's Protective Services (CPS) investigates incidents involving children. Abuse and neglect incidents are reported to the Department via state-wide and regional abuse reporting lines.

The Division of Developmental Disabilities requires all contracted residential providers to report a broader scope of serious and emergent incidents to the Division per DDD Policy 6.12 "Residential Reporting Requirements". Serious and emergent incidents are reported to DDD via fax, telephone and e-mail.

Division staff are required to input Serious and Emergent incidents defined in Policy 12.01, "Incident Management", into an Electronic Incident Reporting System.
Incident types reported and tracked by DDD 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

A. Phone call to Central Office within 1 Hour followed by Electronic IR within 1 Working Day

1. Known media Interest or litigation must be reported to Regional Administrator & CO within 1 hour. If issue also meets other incident reporting criteria, follow with Electronic IR within 1 working day.
2. Death of a RHC or SOLA client.
3. Suspicious deaths (suspicious or unusual)
4. Natural disaster or 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 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 abuse, neglect, exploitation, financial exploitation and abandonment by a DSHS employee, volunteer, licensee or contractor.
2. Criminal activity perpetrated by a DSHS employee.
3. Criminal activity by clients resulting in a case number being assigned by law enforcement.

4. Sexual abuse of a client not reported under column A.
5. Injuries resulting from client to client abuse requiring medical treatment beyond First Aid.
6. Injuries of known cause (other than abuse) resulting in hospital admission.
7. Missing person: (see definitions).
8. Death of client (not suspicious or unusual).
9. Eastern or Western State Hospital admissions.
10. Alleged or suspected abuse, neglect, exploitation, financial exploitation and abandonment by other non-client/non-staff screened in by APS or CPS for investigation.
11. Criminal activity against clients by others resulting in a case number being assigned by law enforcement.

C. Electronic IR Database within 5 Working Days

1. Serious injuries of known origin requiring medical treatment beyond First Aid, but not hospital admission. RHCs may use discretion (see Definitions).
2. Life-threatening medically emergent conditions: medical conditions that cannot be classified as injuries.
3. Mental health inpatient admission to a psychiatric facility other than Eastern/Western State Hospitals.
4. Non-accidental property destruction by a client over $200.
5. Emergency use of restrictive procedures and physical intervention techniques.
6. Neglect (see Definitions).
7. Substantiated findings reported by APS, CPS, or RCS.
8. Patterns of client to client abuse.
9. Medication error (see Definitions).
10. Sexual exploitation not otherwise reported under Column B (1 or 3).
11. Serious Community Protection Program treatment violations not otherwise defined.
12. Suicide threat/attempt/gesture (see Definitions).

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 Division of Developmental Disabilities works jointly with HCS, RCS, Children's Administration, and the DSHS Communications Division on education efforts for clients, families and providers associated with DSHS. Approximately 3,000 abuse awareness cards are handed out every year by DDD. DSHS also started an "End Harm" campaign several years ago. DDD 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, DDD's Director's Corner. Most residential programs have abuse and neglect reporting numbers posted in the participant's homes. Each year Residential Care Services receives 18,000-20,000 calls of alleged or suspected abuse for all vulnerable adults. Adult Protective Services conducts more than 2,500 intakes involving Division clients each year and the Division of Developmental Disabilities, logs, tracks and follows up on 4,000-5,000 incidents every year. Washington State has designated November as "Vulnerable Adult Awareness Month".

Every DDD CRM or Social Worker or Supervisor receives mandatory reporter/incident management training as a component of DDD Core Training.

All providers receive mandatory reporter training. Individual and AFH/ARC providers receive training via the Fundamentals of Caregiver training. DDD residential program employees receive training from their employer.

All DDD Employees must complete, sign, and return DSHS Form 03-380, Employee Annual Review Checklist, to their supervisor on an annual basis at the time of performance review. This annual review includes a refresher on the state's laws regarding abuse, neglect, and exploitation reporting requirements. In this manner, all employees verify that they understand their responsibility to report suspected abuse, neglect, and exploitation pursuant to RCW 26.44 (children) and RCW 74.34 (vulnerable adults), as a mandatory report of such information, whether on or off the job.

Provider contract language includes a statement of duty to report abuse, neglect, abandonment, and exploitation and provides the state reporting hotline. Contracts are renewed at least every 3 years. At the time of renewal, providers review and sign their contract for the next renewal period, agreeing to the statements within.

Caregiver alerts, created by the Department as part of ongoing quality assurance and education efforts, are mailed periodically to providers and unpaid caregivers. These alerts include such topics as 'Responding to Signs of Sexual Abuse', 'Preventing Physical Abuse', in addition to other topics related to supporting the health and safety of children and vulnerable adults. Caregiver alerts are made available to the public on an ongoing basis at http://www1.dshs.wa.gov/ddd/publications.shtml#flyers

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.

Under state authority, Aging and Disability Services Administration/ 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. If a named alleged perpetrator is found to have committed abuse (physical, mental, sexual and exploitation of person), abandonment, neglect, self-neglect and financial exploitation, their name and the nature of the finding is submitted to any known employer and the Background Check Central Unit (BCCU).

In addition to investigating alleged named perpetrators, 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 sends the Statement of Deficiencies to providers within 10 days and will document their conclusion of their investigations in FAMLINK within 15 days of the last day of data collection. For each allegation, the RCS investigators completes 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 DDD 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. For allegations that involve named individuals that may have perpetrated abuse, neglect, or misappropriation of residents funds, response times are 10 days, 20 days, 30 days, or 60 days. 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. Referrals are also made to any state agency which has regulatory authority over the named alleged perpetrator. Any report received from a public caller is assigned an on-site investigative response time.

Under state authority, Aging and Disability Administration/Home and Community Services Division, Adult Protective Services (APS) receives reports and conducts investigations of abuse (physical, mental, sexual and exploitation of person), abandonment, neglect, self-neglect and financial exploitation.

APS administration 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.

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 chld 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 will be 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 CAMIS within:

a. 4 hours from the date and time CA receives the following referrals:

1. Emergent CPS or DLR/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 CA/N 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. This is called 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, the process is call 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. A public brochure is available online to describe the investigation process at http://www.dshs.wa.gov/pdf/Publications/22-452.pdf

CPS and RCS are using the FamLink system to document investigation activites including intake of complaints and outcome reports. APS will be using the FamLink system beginning in June of 2013. There is an electronic connection between the 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 identified in the client's CARE record.

ADSA will receive nightly data feeds from FamLink that will be used in this ADSA reporting system. FamLink information will be reviewed to determine if client information matches DDD waiver clients who are identified in CARE. DDD will use the ADSA 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) 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.

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.

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 Assistance Director and the 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 DDD through data pulled from FamLink. 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.

CPS and RCS are using the FamLink system to document investigation activites including intake of complaints and outcome reports. APS will be using the FamLink system beginning in June of 2013. There is an electronic connection between the 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 identified in the client's CARE record.

The Division of Developmental Disabilities requires serious and emergent incidents to be entered into a statewide electronic incident reporting system per DDD Policy. Incidents are entered into the system by DDD CRMs and Social Service Specialists with notification sent to appropriate staff.

Adult Protective Services is a state wide program within the state single Medicaid agency. The intakes, investigations and protective services performed by APS are continuously monitored at both the state and the regional levels. For example:

oRegional supervisors and program managers conduct on-going quality assurance audits of APS case records.

oThe 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.

oSeveral reports based on data pulled from the statewide APS data base are routinely generated and evaluated no less than annually by program managers and upper management at the state office.

oThe regions have and 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.

oAPS also routinely reports some aspects of program performance to the Governor for her review (Government Management Accountability and Performance).

oData is used to develop statewide training for case managers and the community on adult protective services and how to recognize and prevent instances or re-occurrences of abuse, neglect and exploitation.

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 the DDD Central Office is also sent out to the regions for follow up. Regional analysis is tracked in G-Map format and discussed at the Regional Ternary Quality Assurance Meeting. Best practices and significant issues are presented to Full Management Team three times per year.

Information and findings are communicated to the Medicaid agency at least quarterly via the 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:

ADSA/DDD is the agency responsible for detecting the unauthorized use of restraints or seclusion. Policy 5.19, Positive Behavior Support Policy for Children and Youth, is attached to all CIIBS Intensive Services provider contracts prior to contracting. Unauthorized use of restraints or seclusion by a paid service provider is a reportable incident in the Incident Reporting system.

The Positive Behavior Support for Children and Youth Policy describes the Division's expectations regarding the use of positive behavior support for children and youth with challenging behaviors. Procedural requirements are included regarding functional assessments and positive behavior support plans. The scope includes children receiving DDD funded services in licensed residential settings and in the family home.

Positive behavior support must be emphasized in all services funded by DDD for individuals of all ages with developmental disabilities. This policy focuses on changing the physical and interpersonal environment of children and youth and increasing their skill sets so that they are able to get their needs met without having to resort to challenging behavior.

Paid providers of Behavior Support and Consultation and Staff/Family Training and Consultation are not authorized to utilize restrictive procedures or physical interventions while working with a child on the CIIBS waiver nor to include their recommendation in the PBSP. In order to detect the unauthorized use of restrictive procedures and physical interventions by service providers and plan for the prevention of re-occurrence, any use of restrictive procedures and physical interventions by a service provider in the event of an emergency must be documented in an incident report per Policy 12.01 Incident Management. In addition, Antecedent Behavior

Consequence (ABC) Analysis will be conducted following their emergent use and documented in the client record.

Components of Positive Behavior Support and common types of support are described in the policy. Components include providing a supportive environment and learning opportunities; skill development and status; healthcare support; and mental health support.

Functional assessments (FA) and Positive Behavior Support Plans (PBSP) are defined and expectations for written reports are outlined. DSHS forms developed for FAs, PBSPs, and Quarterly Provider Reports are attached to the policy and required for children in the CIIBS Waiver Program. Timelines are outlined for submitting written FAs to DDD for approval, for reviewing behavioral data on a monthly basis, and for determining when PBSPs must be amended based on data analysis. A FA/PBSP rating tool will be attached for CRMs to utilize when reviewing the quality of submitted plans for children in the CIIBS Waiver.

CIIBS case managers provide monthly follow-up visits for each new enrollee for the first three months on the program and between 30-90 day follow-up visits thereafter based on the determination of the support team. Behavioral information, including questions regarding how responses to behavioral incidents were consistent with the Positive Behavior Support Plan (use of physical restraint or seclusion would be outside a PBS Plan), is collected at each follow-up visit and recorded in the CIIBS Program Database used for program evaluation. This collected information is analyzed at least annually by the Program Manager, Senior Researcher, and Waiver Oversight Committee.

Behavior Specialists review data they collect regarding participant behavior on no less than a monthly basis. This review includes Antecedent Behavior Consequence (ABC) analysis of behavioral incidents. Behavior Specialists include this information in required quarterly reports to the case manager.

The CIIBS Program Manager will review a report at least annually of information collected through the IR database and the 30-90 day client follow up visits for waiver participants. The following criteria will be utilized as triggers for an electronic file review to determine whether or not an ISP or PBSP amendment should have occurred. Some of this data will assist in detecting unauthorized use of restraints by service providers:

a)CPS referral for abuse/neglect/exploitation
b)Behavioral incident resulting in injury to self or others requiring more than first aid
c)Injury to client or others resulting from physical restraint
d)Client visits to the ER
e)Client psychiatric hospitalizations
f)Lack of behavioral improvement after initial 3 months following a new or amended PBS plan
g)Concern indicated by parent with the plan or provider
h)New behaviors or new intensity of behaviors
i)Reported concern with or lack of parent or provider involvement in the support plan
j)Negative response by parent or provider to "I believe the plan will work"

Data gathered will be presented for review at the Waiver Oversight Committee meeting at least annually.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

The State does not permit or prohibits the use of restrictive interventions

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

ADSA/DDD is the agency responsible for detecting the unauthorized use of restrictive interventions. Policy 5.19, Positive Behavior Support (PBS) Policy for Children and Youth, is attached to all CIIBS Intensive Services provider contracts prior to contracting. Unauthorized use of restrictive procedures by a paid service provider is a reportable incident in the Incident Reporting system.

The Positive Behavior Support for Children and Youth Policy describes the Division's expectations regarding the use of positive behavior support for children and youth with challenging behaviors. Procedural requirements are included regarding functional assessments and positive behavior support plans. The scope includes children receiving DDD funded services in licensed residential settings and in the family home.

Positive behavior support must be emphasized in all services funded by DDD for individuals of all ages with developmental disabilities. This policy focuses on changing the physical and interpersonal environment of children and youth and increasing their skill sets so that they are able to get their needs met without having to resort to challenging behavior.

Paid providers of Behavior Support and Consultation and Staff/Family Training and Consultation are not authorized to utilize restrictive procedures or physical interventions while working with a child on the CIIBS waiver. In order to detect the unauthorized use of restrictive procedures and physical interventions by service providers and plan for the prevention of re-occurrence, any use of restrictive procedures and physical interventions by a service provider in the event of an emergency must be documented in an incident report per Policy 12.01 Incident Management. In addition, Antecedent Behavior Consequence (ABC) Analysis will be conducted following their emergent use and documented in the client record.

Components of Positive Behavior Support and common types of support are described in the policy. Components include providing a supportive environment and learning opportunities; skill development and status; healthcare support; and mental health support.

Functional assessments (FA) and Positive Behavior Support Plans (PBSP) are defined and expectations for written reports are outlined. DSHS forms developed for FAs, PBSPs, and Quarterly Provider Reports are attached to the policy and required for children in the CIIBS Waiver Program. Timelines are outlined for submitting written FAs to DDD for approval, for reviewing behavioral data on a monthly basis, and for determining when PBSPs must be amended based on data analysis. A PBSP rating tool will be attached for CRMs to utilize when reviewing the quality of submitted plans for children in the CIIBS Waiver.

CIIBS case managers provide monthly follow-up visits for each new enrollee for the first three months on the program and between 30-90 day follow-up visits thereafter based on the determination of the support team. Behavioral information, including questions regarding interventions, is collected at each follow-up visit and recorded in the CIIBS Program Database used for program evaluation. This collected information is analyzed at least annually by the Program Manager, Senior Researcher, and Waiver Oversight Committee.

Behavior Specialists review data they collect regarding participant behavior on no less than a monthly basis. This review includes Antecedent Behavior Consequence (ABC) analysis of behavioral incidents. Behavior Specialists include this information in required quarterly reports to the case manager.

The CIIBS Program Manager will review a report at least annually of information collected through the IR database and the 30-90 day client follow up visits for waiver participants. The following criteria will be utilized as triggers for an electronic file review to determine whether or not an ISP or PBSP amendment should have occurred. Some of this data will assist in detecting unauthorized use of restrictive interventions by service providers:

a)CPS referral for abuse/neglect/exploitation
b)Behavioral incident resulting in injury to self or others requiring more than first aid
c)Injury to client or others resulting from physical restraint
d)Client visits to the ER
e)Client psychiatric hospitalizations
f)Lack of behavioral improvement after initial 3 months following a new or amended PBS Plan
g)Concern indicated by parent with the plan or provider
h)New behaviors or new intensity of behaviors
i)Reported concern with or lack of parent or provider involvement in the support plan
j)Negative response by parent or provider to "I believe the plan will work"

Data gathered will be presented for review at the Waiver Oversight Committee meeting at least annually.

The use of restrictive interventions is permitted during the course of the delivery of waiver services
Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The State does not permit or prohibits the use of seclusion

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

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/ADSA/DDD 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 Waiver Oversight Committee.

Medication management is a component of the DDD assessment. The DDD 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, 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 DDD 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 Health Care Authority (HCA) has established standardized guidelines for use of psychoactive medications in children and youth. Potentially harmful practices such as the concurrent use of contraindicated medications, and prescriptions exceeding recommended dosages are detected during the prior approval process. A second opinion is then triggered as a requirement for continued authorization. Additionally, HCA has prepared resources and support for primary care physicians, using the latest research and peer review process, in order to improve the quality of mental health care for children in the state. Additional quality improvement resources for primary care providers include the Partnership Access Line (PAL) for phone consultation support through Children's Hospital in Seattle, WA; and a peer reviewed guide for Primary Care Physicians (PCPs), based on current evidence in the literature about mental health treatments in children. These resources are provided free of charge to PCPs.

A common theme emerges in both clinical experience and in the results of formal research trials, that a combination of medical treatment and social/behavioral care often ensures the best of outcomes. This waiver's emphasis on collaboration across systems and establishment of Positive Behavioral Support strategies in the home and community works in tandem with the above described efforts of HRSA to provide participants with the highest quality behavioral health care.

In regard to medication administration by waiver providers of respite, the primary agencies within DSHS involved in oversight are:
- •Children's Administration - Division of Licensed Resources
- •Division of Developmental Disabilities

When participants are over 18 and receiving services in licensed and/or certified adult settings, the additional agency within DSHS involved in oversight is Residential Care Services.

All agencies involved in state oversight are part of the State Operating agency, DSHS. Information and

findings are communicated to the Medicaid agency at least quarterly via the Medicaid Agency Waiver Management Committee.

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 will be 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.

Residential Care Services has the responsibility of ensuring that policies, rules and laws are upheld through responses to the complaints received or certification or licensing reviews. Complaint review is an ongoing process, while certification reviews are conducted at least every two years. Licensing reviews vary based on the type of license. Some licenses are ongoing (e.g., adult family home), while others (e.g., assisted living facility) must be renewed annually. Adult Protective Services has the responsibility of ensuring rules and laws are upheld through response to complaints concerning the care of vulnerable adults. APS investigations occur on an ongoing basis. Children's Protective Services has the responsibility of ensuring rules and laws are upheld on behalf of children wherever they reside. CPS investigations occur on an ongoing basis.

Per DDD Policy 12.01 ("Incident Management"), medication errors are required to be reported through the IR system. The DDD IR Team meets monthly to review and follow-up on incidents, trends, and patterns identified.

WAC 388-148-0352 ("What are the requirements for the management of medication for children in my care?") contains DLR Medication Management Rules.

DDD Policy 6.15 ("Nurse Delegation Services") addresses nurse delegation services in all settings.

Issues with medication management will also be 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 Disability Services Administration (ADSA) receives reports and conducts investigations of abuse, neglect, and exploitation for clients enrolled with the Division of Developmental Disabilities. ADSA Residential Care Services (RCS) investigates abuse and neglect occurring in nursing homes, assisted living facilities, adult family homes, & supported living programs. ADSA Adult Protective Services (APS) investigates abuse and neglect involving adults residing in their own homes.

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.

CPS and RCS are using FamLink to document investigation activites including intake of complaints and outcome reports. APS will be using the FamLink system beginning in June of 2013. There is an electronic connection between the 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 identified in the client's CARE record.

ADSA will receive nightly data feeds from FamLink that will be used in this ADSA reporting system. FamLink information will be reviewed to determine if client information matches DDD waiver clients who are identified in CARE. DDD will use the ADSA 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) 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 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).

Medication administration by waiver service providers is limited to respite providers in licensed residential settings and in the home if nurse delegated.

WAC 388-148-0352 ("What are the requirements for the management of medication for children in my care?") contains DLR Medication Management Rules, which list general medication management requirements (e.g., medication must not be used for behavior control, unless prescribed for that purpose by another person legally authorized to prescribe medication), nonprescription medication requirements, presciption medication requirements, and requirements concerning the use of psychotropic medications (e.g., care providers must not consent to giving or stopping a psychotropic medication).

Division Policy 6.19 ("Residential Medication Management")(see G-3-b-i) specifies the requirements for residential medication management. It describes in detail the procedures that must be used by community residential services providers who contract with DDD to support persons with developmental disabilities who use medications.

DDD Policy 6.15 ("Nurse Delegation Services") details eligibility requirements for services (including a stable and predictable client condition), which tasks can and cannot be delegated, training and certification requirements for delegated providers, the referral process, case manager responsibilities and Registered Nurse Delegator responsibilities, and authorization of services.

Training Requirements for Providers Who Perform Delegated Nursing Tasks

Before performing a delegated task, the provider must have completed:
1. Registration or certification as a Nursing Assistant and renew annually;
2. The Nurse Delegation for Nursing Assistants class (nine hours), either the classroom or self-study version;
3. For NAR only:
   a. For providers working in Supported Living: DDD Core Training (32 hours).
   b. For providers working in all other settings: Fundamentals of Caregiving (28 hours).
   c. An NAR may not perform a delegated task before DDD Core Training or Fundamentals of Caregiving is completed.
   d. DDD Core Training or Fundamentals of Caregiving is not required for an NAC to perform a delegated task.

Responsibilities of the Registered Nurse Delegator (RND)
The RND must:
1. Verify that the caregiver:

a. Has met training and registration requirements;
b. The registration is current and without restriction; and
c. The caregiver is competent to perform the delegated task.

2. Assess the nursing needs of the client, determine the appropriateness of delegation in the specific situation and, if appropriate, teach the caregiver to perform the nursing task.
3. Monitor the caregiver's performance and continued appropriateness of the delegated task.
4. Communicate the results of the nurse delegation assessment to the CRM.
5. Establish a communication plan with the CRM as follows:
   a. Specify in the plan how often and when the RND will communicate with the CRM; and
   b. Document the plan and all ongoing related communication in the client's nurse delegation file.
6. Document and perform all delegation activities as required by law, rule and policy.
7. Work with the CRM, providers, and interested parties when rescinding RND to develop an alternative plan that ensures continuity for the provision of the delegated task.

Nurse delegation is an intermittent service. The nurse is required to visit at least once every ninety days, and may not need to see a client more frequently. However, the delegating nurse may determine that some clients need to be seen more often. The ADSA/DDD Central Office Nurse Delegation Program Manager will monitor the nurse's performance, including frequency of visits and SSPS payments.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

Medication errors for DDD clients are to be reported to DDD per Incident Management Policy 12.01 ("Incident Management").

(b) Specify the types of medication errors that providers are required to *record:*

In residential settings, providers are required to document all medication administration and client refusals.

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 client.

WAC 388-101-3690 ("Medication Refusal") indicates
(1) When a client who is receiving medication support from the service provider chooses to not take his or her medications, the service provider must:

(a) Respect the client's right to choose not to take the medication(s) including psychoactive medication(s); and

(b) Document the time, date and medication the client did not take.

(2) The service provider must take the appropriate action, including notifying the prescriber or primary care practitioner, when the client chooses to not take his or

her medications and the client refusal could cause harm to the client 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 per Policy 12.01 ("Incident Management").

○ **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, Aging and Disability Services Administration:
- Division of Developmental Disabilities
- Division of Licensed Resources

As the CIIBS waiver serves only children living with their families, provider administration of medication is limited to respite in licensed residential settings or in the family home through the support of nurse delegation services.

The Division of Licensed Resources evaluates licensed residential providers for children at least once every three years. The licensing review includes an evaluation of provider compliance with licensing requirements regarding medication management outlined in WAC 388-148-0352, which includes access and administration of prescription, non-prescription, and psychotropic medications. 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). A schedule of unannounced visits is established for 100% of Foster Home and Staffed Residential providers to be reviewed to meet ongoing licensing requirements at a minimum of every 36 months. 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 will be used to determine whether or not licensure will continue or establish the frequency of unannounced visits.

Effective July 1, 2009, the Division of Developmental Disabilities Nurse Delegation Policy and training curriculum will include the additional requirement for all in-home providers of delegated skilled nursing tasks to maintain a Medication Administration Record (MAR). The completed MAR must be submitted to the Nurse Delegator on a monthly basis to assist with ongoing performance monitoring. MARs will specify the authorized tasks, instructions, and names of providers authorized to perform delegated tasks.

DDD uses a discovery and monitoring process to measure the performance of providers. Performance is measured in terms of outcomes. The various entities responsible for different service components develop measurable outcomes for the services they provide. DDD then gathers data to discover whether trends and patterns meet expected outcomes and begins an improvement process if they do not. The goal of Quality Improvement in DDD is to promote, encourage, empower and support continuous quality improvement.

The data that is acquired in order to monitor provider performance is gathered through:
1. Surveys initiated by DDD that look at the planning process and the performance of Providers:
a. National Core Indicators Survey
b. Individual Support Plan Survey
2. Audits, using a valid sample size; that specifically query provider issues.
3. Program Manager evaluation of program effectiveness, both on the Central Office and Regional Level
4. Stakeholder input gathered through on-going meetings as well as ad-hoc committees
5. Recommendations from the Washington State Developmental Council on a regular basis
6. Regional data produced quarterly for review of the director and central office staff.

The data that is gathered through these avenues is then analyzed by the following entities:
1. The CMS Oversight Committee reviews data from the waivers and makes needed corrections or recommendations for improvement.
2. The Central Office Management team review and make recommendations and take corrective actions on regional data and require reports back to the director on completion of assignments.
3. The results of the National Core Indicators Survey are:
a. Reviewed by Central Office and Regional Administrators for recommended changes;
b. Reviewed by the CMS Oversight Committee for needed changes and action
c. Reviewed by the Developmental Disabilities Council for recommendations to the state.
4. The results of the Individual Support Plan Survey are reviewed by the CMS Oversight Committee and recommendations are made regarding needed changes to the ISP.
5. The state Office of Compliance and Monitoring requires that the results of all audits which identify needed changes for the client are corrected immediately. Then analysis of regional and statewide results are presented to management for correction on the Regional and State level.
6. The State Quality Assurance Taskforce provides critical input that is then used in making needed changes to the waiver system.
7. Program managers are responsible to be continually reviewing and upgrading the performance of programs under their direction.

DDD Policies pertaining to Medication Administration:

Division Policy 6.19 ("Residential Medication Management") (see G-3-b-i) specifies the requirements for residential medication management.

Division Policy 6.15 ("Nurse Delegation Services") addresses Nurse Delegation services, including medication management in residential and in-home settings.

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:
a.i.1: The percentage of children and youth in the CIIBS program who were subject to a report of abuse, neglect, or exploitation. N = All children and youth in

the waiver program with at least one report of a/n/e (reported by type) D = All children and youth in the waiver program

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
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:
a.i.2: The percentage of families responding to the NCI survey who report that they know how to request a change in services or make a complaint about services. N= All families of waiver participants who respond to NCI survey and report that they know how to request a change in services or make a complaint about services D= All families of waiver participants who respond to 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:	☐ **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:
a.i.3: The percentage of critical incidents reported by type of incident.
Numerator= Number of critical incidents reported by type of incident.
Denominator= Total number of critical incidents reported

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:
a.i.4: The percentage of suspicious or unexplained deaths of waiver participants whose death was reviewed by the DDD Mortality Review Team (MRT).
Numerator = Waiver participants whose death was suspicious or unexplained
Denominator = All waiver participants whose deaths were reviewed by the DDD MRT

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:
a.i.5: The percentage of waiver participants with a reduction in aggressive behavior over time on the program. N= All waiver participants with a reduction in aggressive behavior over time on the program. D= All waiver participants

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:
a.i.6: The percentage of waiver participants experiencing hospitalizations and/or emergency room visits related to life-threatening conditions and serious injuries.
Numerator= All waiver participants who required one or more hospitalizations and/or ER visits related to life-threatening conditions and serious injuries
Denominator= All waiver participants

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):*
	☐ **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 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:
a.i.7: The percentage of waiver participants requiring psychiatric hospitalization.
Numerator= All waiver participants requiring psychiatric hospitalization
Denominator= All waiver participants

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

		☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
a.i.8: The percentage of critical incidents reported within the timelines specified in Policy 12.01 (Incident Management). Numerator = Number of critical incidents reported within the timelines specified in Policy 12.01. Denominator = Total number of critical incidents.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
a.i.9: The percentage of substantiated findings of abuse or neglect by CPS for which the corresponding incident was documented in the DDD Incident Reporting Database. N = The number of substantiated findings of abuse or neglect by CPS for which the corresponding incident was documented in the DDD IR Database. D = Total number of substantiated findings of abuse or neglect by CPS.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
a.i.10: The percentage of waiver recipients with a critical incident report whose ISP was amended when it should have been amended. Numerator= Number of waiver recipients with a critical incident report whose ISP was amended when it should have been amended. Denominator= Total number of waiver recipients with a critical incident whose ISP should have been amended.

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: Incident Review Committee	☐ **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** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.11: The percentage of closed critical incident reports for which appropriate follow up occurred. Numerator: The number of closed critical incidents for which appropriate follow up occurred. Denominator = The total number of closed critical incident reports.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
a.i.12: 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. Numerator=The number of substantiated allegations of abuse, neglect, abandonment, or financial exploitation by CPS, by incident type. Denominator= The total number of allegations substantiated by CPS

Data Source (Select one):
Other
If 'Other' is selected, specify:
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:
a.i.13. The number of complaints by type reported. Numerator=Number of complaints document in the CARE Service Episode Record and DDD complaints database by type reported. Denominator=The Total number of complaints reported involving waiver recipients.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDD Complaints Database and CARE system.

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.i.14: The Percentage of Positive Behavior Support Plans requiring an Exception to Policy (ETP) with an ETP in the CARE system. The Numerator=the number of waiver client files reviewed with a PBSP which had the required ETP. The Denominator=the number of waiver client files reviewed with a PBSP requiring an ETP.

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%+/-5
☑ **Other** Specify: Quality Control and Compliance (QCC) Team within DDD.	☑ **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.

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.

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.

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.i.1(1); a.i.3; a.i.6; a.i.7; a.i.8; a.i.9; and a.i.11: Incidents entered into the Incident Reporting (IR) System; are reviewed daily by the State Incident Report Manager; who notifies program managers of incidents occurring in their areas of expertise. The incidents are reviewed to ensure proper notifications were made, e.g. police, investigating agencies and dialogue is established with the case manager if there are issues. An information letter is sent to the Assistant Secretary regarding any issues above and beyond the normal day to day work.

Regional Quality Assurance (QA) Managers assist regional staff with appropriate action regarding critical incidents. They verify that individuals for whom there was a substantiated finding by CPS have a report of the critical incident in the IR system.

Also, the Incident Review Team meets monthly to review incidents that occur across the state and to look for trends and patterns of concern. The IR team then reviews electronic files for clients whose incident or pattern of incidents reflects the potential need for an ISP amendment.

a.i.1(2); and a.i.12: DDD will use the ADSA reporting system to review information that matches DDD waiver clients identified in CARE and client's identified in FAMLINK on a quaterly basis. Reports will identify waiver client's 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.

a.i.2: DDD compares data on responses to NCI questions from waiver year to waiver year. DDD constructs pie charts for questions and analyzes the outcome of the survey with the Waiver Oversight Committee and Stakeholders. DDD uses this information to assist with the development of the Annual Waiver Training curriculum as well as to develop needed policy changes.

a.i.4: The DDD Mortality Review Team meets monthly to review deaths of DDD clients in order to identify factors that may have contributed to the deaths and recommend measures to improve supports and services for persons served by DDD. Any CIIBS waiver participant death will be reviewed. Data is aggregated annually and reviewed by the Waiver Oversight Committee.

a.i.5;
Quarterly provider progress reports are recorded in the CIIBS Program Database used for program evaluation. Collected information is analyzed at least annually by the Program Manager, Senior Researcher, and Waiver Oversight Committee. (Note* Physical restraints and restrictive interventions are not allowed during the delivery of waiver services.)

The CIIBS Program Manager reviews a report at least semi-annually of information collected through the IR database and the 30-90 day client follow up visits for waiver participants. The following criteria are utilized

as triggers for an electronic file review to determine whether or not an ISP or PBSP amendment should have occurred:

a)CPS referral for abuse/neglect/exploitation
b)Behavioral incident resulting in injury to self or others requiring more than first aid
c)Injury to client or others resulting from physical restraint
d)Client visits to the ER
e)Client psychiatric hospitalizations

Data gathered are presented for review at the Waiver Oversight Committee meeting at least annually.

a.i.10: 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/CMIS 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.

a.i.13: The division uses two methods to track complaints: CARE Service Episode Records (SER) at a case manager, field service manager and supervisor level and the Complaints Tracking Database for complaints that raise up to Regional administrators and Central Office personnel. CRM are trained to document in CARE complaints that occurr on client specific cases in SER's using contact codes of "Complaint" or "Provider Issues". The Division maintains a Complaint Tracking Database which documents all complaints received by Regional or Central Office Administration. Reports that categorize this information by topic of the complaint and verify that the complaints were resolved or had appropriate action taken within Policy 5.03 (Client Complaints) timeframes are compiled twice a year and reviewed annually for trends and patterns.

a.i.14: 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 based on 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. The review protocol includes the following item:
-If the Positive Behavior Support Plan requires an Exception to Policy (ETP), was there an appropriate ETP in the CARE system?

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.i.1; a.i.3; a.i.6; a.i.7; a.i.8; a.i.9; a.i.11; and a.i.12: In the review of IR information, 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 occurences 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, provider alerts might be developed if a pattern across provicers is detected. In addition, case manager training might focus on prevention, detection, and remediation of critical incidents.

Also, in the review of the IR information, if an action is discovered not to have been taken, or there are questions about actions or results; the IR Program Manager follows up with supervisory or Regional management immediately. The Regional Authority, Program Manager or DDD Manager who is notified then takes immediate action to ensure that the person is protected and that the concerns are addressed.

a.i.4: 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".

a.i.10: 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.

a.i.13: Complaints that are not resolved or acted upon appropriately are reviewed semi-annually to determine what action is necessary. Protection and Advocacy reviews complaints semi-annually and recommends

action when necessary. Remediation may include revisions in training curriculum, policy clarification, personnel action, revisions in form format and instructions, revisions in Waiver WAC, and revisions in regional processes.

Any trends and patterns are addressed through training where indicated.

A.i.14: 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 Division of Developmental Disabilities (DDD) has managed at least one HCBS waiver since 1983. The last several years have seen great improvement in quality assurance processes. In 2003 a statewide effort was launched to coordinate the implementation of Quality Improvement in all agencies. DDD continually works to improve the way we do business. We have developed multiple processes for trending, prioritizing, and implementing system improvements that have been prompted as a result of data analysis.

Internal ADSA Systems
DDD uses several data systems that are vital to the implementation of the CIIBS Waiver. This is a unique waiver that is designed to support children to remain with their families while difficult behavioral issues are addressed. The intent is to meet not only the needs of the child with a behavioral disability, but the siblings and parents who are part of that family. The data systems DDD is using will help to capture information about the needs of the children and youth participants, their siblings and parents, and the success of the approach.

DDD Assessment:

o The DDD Assessment is designed to discover the individual support needs of each child who is assessed. It is a tool to help case managers plan for services and supports to meet the needs of children with developmental disabilities.
o All CIIBS Waiver participants will be assessed using this tool, which includes an assessment of caregiver stress, behavior issues, critical medical issues, and protective supervision needs.
• Reports are pulled by the Program Manager
• Reports are pulled at least annually
• Reports are analyzed by the Senior Researcher, Waiver Oversight Committee and as requested by management.

CARE Platform:
o Assists case managers to provide effective monitoring of case status and service plans.
• Provides a system of “ticklers” or alerts to cue case resource manager action at specific intervals based upon client need.
• Replaced current paper processes with an automated process for Exception to Rule (ETR), Prior Approvals and Waiver Requests.
• Develop a consistent, reliable and automated process.
• Provides client demographic and waiver status at a moment’s notice.
o Provides management reports to look for trends and patterns in the CIIBS caseload.
• Reports are pulled by the Program Manager.
• Reports are pulled at least annually.
• Reports are analyzed by the Senior Researcher, Waiver Oversight Committee and as requested by management.

Quality Control and Compliance (QCC) Audit 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.
• Reports are developed by the Office of Compliance and Monitoring.
• Reports are created at least annually.
• Reports are analyzed by the Regional management, Program Manager, Waiver Oversight Committee and as requested by management.

DDD Incident Reporting system (IR):
o The IR system provides management information concerning significant incidents occurring in our client’s lives.
• Individual incidents come first to the CRM for input into the IR system.
• DDD has developed protocols and procedures to respond to incidents that have been reported.
• Analysis processes are in place to review and monitor the health and welfare of DDD clients.
• Reports are pulled by the Incident Program Manager.
• Reports are pulled quarterly.
• Reports are analyzed by the Incident Reporting Team and as requested by 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 representative of each waiver with a 95% confidence level and a confidence interval of +/-5%. Information collected is analyzed annually at the Waiver Oversight Committee.
o Any 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.
• Reports are pulled by the Research Specialist
• Reports are pulled at least annually
• Reports are analyzed by the Waiver Oversight Committee, the State Quality Assurance Task Force and as requested by management.

Complaint Data Base:
o DDD 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.
• In addition, complaints at the local level are identified via Service Episode Records (SERs) contained in the CARE automated system.
• Reports are pulled by the Research Specialist
• Reports are pulled at least annually
• Reports are analyzed by the Waiver Oversight Committee and as requested by management.

DSHS systems external to ADSA:

Social Service Payment System:
o DDD 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 DDD also audits information from this system to ensure that services are only authorized after first being identified in the Individual Support Plan.
• Reports will be pulled by the SSPS Program Manager
• Reports will be pulled at least annually
• Reports will be analyzed by the Program Manager, Waiver Oversight Committee and as requested by management.

Child Protective Services (CPS):
o CPS is the entity responsible for investigating and making official findings on any accusations of abuse or neglect of a minor child.
o DDD 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.
• Reports will be pulled by the Children's Administration
• Reports will be pulled at the request of the Program Manager
• Reports will be analyzed by the Program Manager and as requested by management.

Adult Protective Services (APS):
o APS is the entity 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 DDD 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.
• Reports will be pulled by APS
• Reports will be pulled at least annually
• Reports will be analyzed by the Regional Quality Assurance Managers and as requested by 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 CIIBS program.
o DDD works cooperatively with DLR to ensure homes are licensed and appropriate care is provided.
• Reports will be pulled by DLR
• Reports will be pulled at the request of the Program Manager
• Reports will be analyzed by the Program Manager and as requested by management.

Residential Care Services (RCS):
o RCS is the entity responsible for investigating and making official findings on any accusations 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 DDD 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.

• Reports will be pulled by the RCS
• Reports will be pulled at least annually
• Reports will be analyzed by the Program Manager, Waiver Oversight Committee and as requested by management.

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 DDD.
o DDD 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.
• Reports will be pulled by the Research Specialist
• Reports will be pulled at least annually
• Reports will be analyzed by the Program Manager, Waiver Oversight Committee and as requested by management

All Contracts Data base (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.
• Reports will be pulled by the Contracts Program Manager
• Reports will be pulled at least annually
• Reports will be analyzed by the Program Manager, Waiver Oversight Committee and as requested by management.

External Non Governmental Systems:

National Core Indicators (NCI) Survey:
o DDD has been participating in the National Core Indicators Survey since 2000.
o DDD has adapted the children's survey to do a face-to-face survey in the home that addresses satisfaction with DDD services, providers and other key life indicators.
o Additional questions have been added about waiver services.
• This data is reviewed with stakeholders and state staff.
• Recommendations for needed changes are drawn from this process and then acted upon.
• Reports will be pulled by the Research Specialist.
• Reports will be pulled at least annually.
• Reports will be analyzed by the Program Manager, Waiver Oversight Committee and as requested by management.

Developmental Disabilities Council (DDC):
• The DDC partners with the state to conduct focus groups that look at the NCI data and make recommendations to the state.
• Reports are developed by the DDC and submitted to the state for action.
• Reports will be pulled by the DDC.
• Reports will be pulled at least annually.
• Reports will be analyzed by the State Quality Assurance Task Force, Program Manager, Waiver Oversight Committee and as requested by management.

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. DDD 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 the occurrence of an egregious incident that requires immediate in-depth work.

Once the need for change has been determined through the analysis of data, DDD prioritizes quality improvement steps based on a risk management strategy that considers health and safety, best practices, legislative requirements, and CMS recommendations.

DDD 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. DDD 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: Some processes occur on a daily basis or an "as needed" basis

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.

DDD uses a discovery and monitoring process to analyze the effectiveness of our current systems. Performance is measured in terms of outcomes. DDD uses both internal and external groups to analyze this data. DDD reviews data from multiple data sources to discover whether trends and patterns meet expected outcomes. DDD begins an improvement process if they do not. DDD's Quality Improvement (QI) process has been part of the Division's activities for decades.

The goal of Quality Improvement in DDD is to promote, encourage, empower and support continuous quality improvement. Major areas of focus:

Family visits and surveys
- Case Managers conducts in-home face to face with the family at least every 90 days. Information collected at these visits assists DDD with analyzing the effectiveness of waiver services.
- ISP surveys give families 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.

Audits
- Audits ensure processes and procedures required in delivering waiver services are according to requirements.
- CIIBS audit findings are analyzed and shared with regional and statewide management teams for corrective action and system improvement.

Quarterly evaluations of performance measures
- Quarterly Regional management reports on CIIBS waiver performance.
- 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 audit findings, and many other key indicators of operational performance.

Training
- Training is a significant focus to ensure that Division employees are equipped with the skills and knowledge to carry out their waiver responsibilities.
- Annual Waiver training is provided for ongoing quality improvement.

There are many entities that play a critical role and are essential to DDD's Quality Management Strategy:

Internal (within DSHS)

Waiver Oversight Committee (WOC):
- This committee meets on a ternary basis and is comprised of representatives from across ADSA.
- The committee reviews and makes recommendations from the following data and reports:
  - QCC audits
  - National Core Indicators
  - ISP Meeting surveys
  - Fiscal reports
  - CRM face to face meeting data
  - Incident Reports

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 are:
  - 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 individual-specific health and safety concerns.
- Nurses consult with case managers on health and welfare concerns.

State Waiver Program Manager and Regional Waiver Coordinators:
- The primary responsibility for the implementation of this waiver resides with the Waiver Program Manager
  - Regional Waiver Coordinators work collaboratively with the Waiver Program Manager to ensure proper implementation at the regional level.
  - The Waiver Program Manager and Waiver Coordinators meet monthly to monitor waiver implementation and recommend necessary waiver changes.

Regional Quality Assurance (QA) Staff:

- Regional QA staff work in partnership with volunteers who are self-advocates or family members trained by the DDC to complete face-to-face surveys of waiver clients to ensure satisfaction with waiver services.
  - Regional QA staff provide quarterly reports which contains 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 Home.
- Child Protective Services (CPS) provides investigation of incidents of abuse, neglect, abandonment and exploitation involving children.

External

Medicaid Agency Waiver Management Committee
- The Medicaid Agency Waiver Management Committee includes representatives from the Health Care Authority (the Single State Medicaid Agency) and divisions within the operating agency: DDD, 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.

Developmental Disabilities Council (DDC):
- The DDC is comprised of self advocates, family members and department representatives.
  - Analyzes and provides recommendations for improvement using the National Core Indicators Survey as it's tool.
  - Regional Quality Assurance Staff work in partnership with volunteers who are self-advocates or family members trained by the DDC to do face-to-face surveys of waiver clients to ensure satisfaction with waiver services

The HCBS (DDD) Waivers Quality Assurance Committee:
- Sponsored by the DDC and comprised of self advocates, family members, providers and Department representatives.
  - Meets twice a year, with provision for more frequent sub-committee meetings on select topics as needed.
  - Provides a forum for active, open and continuous diaglogue between stakeholders and the DDD 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 CIIBS waiver. Through this review process these groups also provide feedback on opportunities for improvement.

Included in the distribution cycle are:

Internal

Division Director, HQ Management Team and Regional Management Team review:
- Quarterly Regional management reports on CIIBS waiver performance.
  - 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 audit findings, and many other key indicators of operational performance.

Division Director, HQ Management Team and all Regional Management Teams review:
- The Quarterly Regional Quality Assurance Managers' reports are compiled into one final report.
- Each regional QA report, also in a PowerPoint format contains 8 control charts from the "key" incident types, a detailed analysis of any client with 3 or more incidents, analysis of deaths, and information/data on many other QA activities in the region.
  - When the final report is compiled best practices and concerns are reviewed.

Waiver Oversight Committee reviews:
- Monthly fiscal reports provided by Management Services Division (MSD).
  - These reports provide detailed analysis of CIIBS Waiver expenditures and clients served.

- Quality Compliance and Control (QCC) audit reports. The QCC team reports quarterly on the outcome of regional audits. This is a review of the questions in the QCC audit and the percent conformance to the requirements.

QCC reviews:
- Statewide analysis of audit findings. The report includes data and recommendations from the annual audit cycle. This report is then shared with the Waiver Oversight Committee and the Statewide Management Team.
- Regional audit findings. The regional reports are specific to the regional audit. The report provides an analysis of the audit data from the most current review and compares historical data (when available).

ADSA Assistant Secretary Reviews:
- Monthly fiscal reports provided by Management Services Division(MSD).
  - These reports provide detailed analysis of CIIBS Waiver expenditures and clients served.

External

CIIBS Stakeholder Advisory Group review:
- This group was involved in the development of the CIIBS Waiver. This group participated in defining and reviewing the performance measures defined in the waiver.

Medicaid Agency Waiver Management Committee
- The Medicaid Agency Waiver Management Committee includes representatives from the Health Care Authority (the Single State Medicaid Agency) and divisions within the operating agency: DDD, 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.

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 management and the State Quality Assurance Task Force after every evaluation.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Division of Developmental Disabilities (DDD) 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.

Each year DDD improves services to waiver clients by using the numerous data collection points, appropriate analysis and prioritization techniques, evaluation and feedback from differing groups.

ADSA 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 renewal period. The following process will be followed in reviewing and updating the Quality Improvement Strategy:
o DDD will maintain a CIIBS waiver-specific management strategy.
o All processes and strategies will be continuously improved through the various methods of evaluation, monitoring, analysis and actions taken.
o DDD will work with participants, families, advocates, and providers to identify opportunities for performance improvement and report the progress being made back to stakeholders.
o State staff, providers and stakeholders provide ongoing monitoring of the system. Changes may be recommended by any of the above entities.
o The Waiver Oversight Committee reviews suggested changes and improvements and recommends actions that should be taken.
o The HCBS (DDD) Waivers Quality Assurance Committee will also review and provide input on the Quality Improvement Strategy.

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, 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 Auditor's 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 Office 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:
a.i.1: The percentage of waiver participants who initially meet and continue to meet financial eligibility for waiver enrollment. N= All waiver participants who initially meet and continue 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 = 95%
☑ **Other** Specify: Quality Control and Compliance Team within DDD	☑ **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.i.2: The percentage of waiver participants who initially and continue to meet disability criteria as established in the social security act. N= All waiver

participants who initially and continue 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 = 95%
☑ **Other** Specify: Quality Control and Compliance Team within DDD	☑ **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.i.3: The percentage of all waiver ISPs with service authorizations that are for services identified in the ISP. N= All waiver ISPs with service authorizations that are for services identified in the ISP D= 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 Control and Compliance Team within DDD	☑ **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.i.4: The percentage of all payments claimed under the CIIBS waiver that are made for CIIBS waiver recipients. N= All payments claimed under the CIIBS waiver that are made 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 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.i.5: The percentage of provider billings for waiver services that do not exceed the contracted rates of service. N= All provider billings for waiver services that do not exceed the contracted rates D= All provider billings for waiver services

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:
a.i.6: The percentage of provider billings for waiver participants that are at or below the amount and rate authorized. N= All provider billings for waiver participants that are at or below the authorized amount and rate D= All provider billings for waiver participants

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:

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.

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.i.1; a.i.2; a.i.3:

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 audit protocol includes (among others) the following questions with a target of 100% compliance.

"Was the client financially eligible per program requirements at the time of the initial or annual assessment?"

"Did the client meet disability eligibility criteria as established in the Social Security act at the time of the initial or annual assessment?"

"Does the client currently meet disability criteria as established in the Social Security Act at the time of the audit or 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 Social Service Payment System {SSPS} electronically prevents a provider from claiming payment for an amount and rate higher than what is authorized.)

The QCC audit is one of several discovery processes that is used to demonstrate evidence of compliance with the waiver assurances. This process utilizes a sampling approach that generates representative samples by waiver over a 2-year period. Data from this process will be used for both ongoing, individual level remediation and for systemic quality improvement.

Findings from all file reviews are analyzed by management. Based on the analysis necessary steps are taken.

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.

a.i.4:

A claims data report is run annually to verify that all claims made for FFP are for waiver participants.

a.i.5:

The Contracts Program Manager produces a quarterly report comparing claims data against the All Contracts Database (ACD) to verify that rates authorized to providers of service are in accordance with the contracted rates.

a.i.6:

The Social Service Payment System does not allow a provider to bill for an amount higher than the amount in the payment authorization. Additionally, a provider is not allowed to change the authorized rate of 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, including Annual QCC audit:
a.i.1; a.i.2; a.i.3:
Two opportunities occur throughout the course of a year for files to be reviewed. The same standard protocol is used for each review. All files reviewed are selected by random sampling.

1)The Annual QCC audit is one of several discovery processes that is used to demonstrate evidence of compliance with the waiver assurances. This process utilizes a sampling approach that generates representative samples by waiver over a 2-year period. Data from this process is used for both ongoing, individual level remediation and for systemic quality improvement.

The QCC team reviews files in each of the 3 regions across the state for compliance with established waiver processes. Data are analyzed upon exit from each regional review. Each region submits a response plan to Central Office addressing trends identified during the audit. The QCC team audits to the performance measures as outlined in the QIS sections of the waiver application.

Any negative audit findings are expected to be corrected within 90 days of identification. QCC team members review progress on a 30/60/90 day basis and verify that individual corrections are made appropriately. Corrections are entered into a statewide database.

The state will have data on all waivers and by individual waiver on an annual basis. When data is compiled across a 2-year period, a sufficient number of cases will be available to analyze each waiver independent of the others using a 95% confidence level with a 5% margin of error for each performance measure.

2)In addition to the QCC audits, supervisors review 1 file per CRM per month.(*NOTE: While a valid sample is produced for the QCC audit, the supervisor file review is strictly an additional measure to assist with ongoing quality assurance.) This additional review enhances the ability of regional staff to detect and correct individual problems as they arise.

Each region is assigned a Waiver Coordinator whose role is to support supervisors and CRMs with ongoing identification and remediation of individual problems.

a.i.4: Claims that are made for nonwaiver participants are removed from the claim for FFP.

Contracts Reports:

a.i.5:

The results of the quarterly report comparing claims data against the ACD are shared with the regions for immediate follow up. 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.

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**

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

c. Timelines

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

- ○ **No**
- ◉ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
The DDD will develop standardized reports to verify client financial eligibility (Performance Measure a.i.1), client disability (Performance Measure a.i.2), and the presence of all authorized services in the ISP (Performance Measure a.i.3) across all waiver enrollees.

The Department is also implementing a new MMIS (known as "ProviderOne") which will reimburse providers of social services to DDD clients (as well as reimbursing medical care providers, which will occur earlier). ProviderOne will verify financial eligibility status (as contained in the ACES), ensuring that waiver clients are financially eligible prior to authorization or payment for waiver services (Performance Measure a.i.1). ProviderOne will also verify waiver status prior to authorization or payment.

Phase 1 of ProviderOne (which covers most medical care reimbursement) was implemented May 9, 2010. Federal Certification for the ProviderOne MMIS was obtained on July 20, 2011.

Phase 2 of ProviderOne implemention will include payments for social services. The exact timing is still being determined, but the current target is to have ADSA providers reimbursed by ProviderOne no later than June 30, 2013.

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 Division of Developmental Disabilities (DDD) within the Aging and Disability Services Administration of the Department of Social and Health Services are employees of the State Medicaid 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/ADSA/ DDD.
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 ADSA Contract Manager. Benchmarks for all of these services already exist. Many of these services are covered under other DDD 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
  - Provider rates are standardized based on negotiations with the Service 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.
  - 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 DDD staff negotiate rates on a provider-specific basis.

- Staff/Family Consultation and Training: Regional DDD 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 DDD regional staff.

- Specialized Psychiatric Services: DDD 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 DDD regional staff on a provider-specific basis.
  - o Speech, Hearing and Language: Rates are negotiated by DDD regional staff on a provider-specific basis.
  - o Physical Therapy: Rates are negotiated by DDD 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 DDD 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/DDD cost reimbursement section.
  - o Specialized Psychiatric Services: Rates are negotiated by DDD regional staff with the Regional Support Networks and/or individual providers.
  - o Behavioral Health Crisis Diversion Bed Services (privately-contracted: Rates are negotiated by DDD 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 ADSA/DDD 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 Division 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 stanrdized 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.

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), which is the State Operating Agency, receives funding appropriated by the Legislature in the biennial budget. Funding (both state dollars and federal dollars) is provided to DSHS and allotted to the Developmental Disabilities Administration (DDA). DDA receives the appropriation and allots funds to its operating regions via Regional Budgets for most service (e.g., residential, personal care, professional) categories.

Direct Service Payments (Current)
DSHS/DDA contracts directly with providers of service for all services except state-staffed services, which are state-operated living alternatives (SOLA) services, state-staffed behavior support and consultation services and state-staffed behavioral health crisis diversion bed services as components of behavioral health stabilization services. For direct payment, DDA authorizes services via the social services authorization system, and providers bill the agency directly for services using service vouchers. Payments are made directly from DSHS/DDA via SSPS/ProviderOne to the providers of service.

Direct Service Payments (January,2015)
Washington State’s Health Care Authority (the single state Medicaid Agency) has a new MMIS titled “ProviderOne”. Payments for Medicaid State Plan services (except personal care and state-operated ICFs/ID and NFs) are made via ProviderOne.

Effective January, 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.
1099 Providers
• Adult Family Homes
• Assisted Living Facilities
• Counseling
• Durable Medical Equipment
• Group Homes/Group Training Homes
• Home Care Agencies
• Licensed Staff Residential
• Mental and Physical Incapacity Evaluations
• Nurse Delegation
• Physical, Occupational, Speech Therapy
• Private Duty Nursing
• Skilled Nursing

• Supported Living
Funding for Medicaid services covered under the CIIBS waiver will continue to be appropriated to the State Operating Agency, and the cost of payments for CIIBS waiver services will be charged directly to the State Operating Agency.

Payments to State Employees
The State-Operated Living Alternatives (SOLA) programs are supported living program staffed with state employees. Employee salaries are included in the appropriation provided to the Division by the Legislature. 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 Division 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 SOLA services is established each year for each location (region) based on the projected costs and number of resident days for the ensuing fiscal year. The established rates are transmitted to the Office of Financial Recovery (OFR). OFR uses the daily reimbursement rates and the number of Medicaid eligible days at each location to calculate the federal share of cost for each facility. The OFR calculation report goes to the Office of Accounting Services and to the Management Services Division (MSD). MSD fiscal staff prepare a journal voucher to record the federal share under the federal funds appropriation in the Financial Reporting System (FRS). Reported resident days and FFP claims are reconciled with OFR each month. The DSHS includes the daily cost multiplied by the number of days in the HCFA-64 Report to collect FFP for SOLA 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.
The same processes as described for SOLA services directly above are applied to determine the claim amount for state-staffed behavior support and consultation and state-staffed behavioral health crisis diversion bed services as components of behavioral health stabilization services.

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 client 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 CIIBS 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.
Effective January, 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 CIIBS waiver providers except individual respite care providers will be reimbursed using ProviderOne.
The usual MMIS edits will be applied to billings under the CIIBS waiver. I.e., the following will be verified: the individual is on the CIIBS waiver, the service is covered under the CIIBS waiver, the provider is a valid provider of the service, the 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 clients. Their review includes a comparison of service payments with the services contained in approved ISPs to ensure that services claimed against the CIIBS 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:

- **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:

  a.) and b.) Almost all waiver services will be paid and tracked through the State's automated Social Services Payment System (SSPS).

  The SSPS authorizes the delivery and/or purchase of social services for recipients, collects required state and federal statistical and management data, and initiates the payment process for purchased services.

  On the basis of SSPS CIIBS Waiver service codes, SSPS expenditure information interfaces with the department's accounting system (Financial Reporting System/Agency Financial Reporting System-FASTRACK/AFRS). Aging and Disability Services Administration (ADSA) Headquarters staff maintain an account coding crosswalk that links CIIBS Waiver SSPS service codes with the FASTRACK/AFRS system.

  Occasionally goods or services (i.e., privatey contracted behavioral health crisis stabilization services) will be 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 DDD regional office or to ADSA 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 the CARE system.

  c.) All payments are backed by an audit trail. Key steps in the audit trail include:

  - Verification of client and provider eligibility for Medicaid;
  - Service authorization;
  - Verification of service delivery;
  - Invoicing and payment; and
  - Calculation of FFP.

  Individual client case records document the recipient's eligibility for the waiver. Persons verified by the DDD case manager as meeting all eligibility requirements and placed on the waiver are identified in CARE. The CARE is a computer-based system tht contains (amongh other things) client information maintained by regional DDD staff. Information on client eligibility is maintained in client case records for a minimum of five (5) years.

All providers of waiver services must hold current contracts/provider agreements that define the services to be provided and the payment for those services. Contract agreements additionally require providers to document and retain records of all services and charges for at least three (3) years after service delivery.

Waiver services are authorized prior to service delivery by the DDD CRM or social worker or supervisor responsible for the recipient's individual written plan of care. Service authorizations specify the client; the type and amount of service to be provided; the begin and end dates for delivery of the service, the provider; the payment rate for the service; and identification of the case manager authorizing the service.

Services paid under the automated SSPS system are authorized electronically. Records of electronic authorizations are retained for a minimum of three (3) years on microfiche.

All providers are required to retain records which document actual service delivery on an individual recipient basis. The specific format and content of such records varies according to the particular service provided. Typical documentation includes records of days attended, hours of services delivered, specific service interventions used, and progress toward individual training plan objectives.

Contract agreements with providers of waiver services require providers to document and retain records of all services and charges for at least three (3) years after service delivery.

Acute care and other regular state plan services are paid and tracked through the State's Medicaid Management Information System (MMIS). No waiver services are paid or tracked through the MMIS.

Completion of the electronic SSPS service authorization results in automatic issuance of an invoice to the provider for each authorized service. The invoice identifies the individuals authorized to receive the particular service. The provider includes on the invoice the type of unit (e.g., hour, day), the number of units delivered during the month to each client, signs a certification statement, and returns it to the state for processing. Upon return to the state, it is entered into an electronic database and electronically cross-checked to verify consistency with authorized service types, delivery dates, service amounts, and unit rates; after which a warrant is issued.

Copies of provider contracts are maintained for a minimum of five years in ADSA/DDD regional offices.

Records of electronic authorizations for payment are retained for a minimum of three years on microfiche, and on a computer tape indefinitely. Back-up documentation for CMS-64 reports are maintained for a minimum of three years.

d) The federal financial participation (FFP) for CIIBS Waiver services is calculated through the state's approved and automated cost allocation plan. The FFP is collected through two payment systems: one automated (SSPS) and one manual (Invoice voucher A-19). Both payment systems' accounting information is processed through the State of Washington Agency Financial Reporting System (AFRS) and the Department of Social and Health Services FASTRACK System which includes the Federal Cost Allocation Plan. The basis for the dollars claimed under the CIIBS Waiver in the CMS 64 is waiver-specific account coding contained in the Department's FASTRACK/AFRS financial reporting system. All expenditures for services claimable under the CIIBS Waiver are coded using the CIBS Waiver account coding. Those expenditures are included in the CMS-64 under the CIIBS Waiver.

○ **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:

Payments to providers for services are made directly by the State Operating Agency, which is responsible for provider contracting, payment rates, client eligiblity, and provider payments.

☐ **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/Aging and Disability Services Administration/Division of Developmental Disabilities (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	47724.91	3617.00	51341.91	181567.00	1914.22	183481.22	132139.31
4	45269.09	3617.00	48886.09	172723.00	1914.22	174637.22	125751.13
5	43799.19	3617.00	47416.19	167000.00	1914.22	168914.22	121498.03

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	100	100
Year 4	100	100
Year 5	100	100

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 349-day average length of stay for Waiver Renewal Year 3, the 332-day average length of stay for Waiver Renewal Year 4 and the 321-day average length of stay for Waiver Renewal Year 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
• 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 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 DDD HCBS waiver.

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 DDD 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.

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' estimate for the Waiver Renewal is based on expenditures compiled for an Initial CMS-372 Report for Waiver Renewal Year 2 (5/1/2010 - 4/30/2011. 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 are based 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 clients on the waiver would be in an ICF/ID if the waiver did not exist. In the absence of the waiver, waiver clients 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.

No trend factors were 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	

Waiver Services	
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**	
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**	

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
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**	
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					**5176.98**	

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
	Each	3	6.00	287.61		
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**
				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
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 Conslstation (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	
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

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
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:						**814195.60**
Personal Care	Hour	95	719.00	11.92	**814195.60**	
Respite Total:						**390413.04**
Respite	Hour	92	321.00	13.22	**390413.04**	
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:						**1796631.09**
Behavior Support and Consultation	Hour	97	501.00	36.97	**1796631.09**	
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**
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:	**4772491.29**
Total Estimated Unduplicated Participants:	**100**
Factor D (Divide total by number of participants):	**47724.91**
Average Length of Stay on the Waiver:	349

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:						**1252119.65**
Staff/Family Consultation and Training	Hour	97	431.00	29.95	**1252119.65**	
Therapeutic Equipment and Supplies Total:						**18632.68**
Therapeutic Equipment and Supplies	Each	17	2.00	548.02	**18632.68**	
Transportation Total:						**6709.05**
Transportation	Mile	5	2631.00	0.51	**6709.05**	
Vehicle Modifications Total:						**13589.05**
Vehicle Modifications	Each	5	1.00	2717.81	**13589.05**	

GRAND TOTAL:	**4772491.29**
Total Estimated Unduplicated Participants:	**100**
Factor D (Divide total by number of participants):	**47724.91**
Average Length of Stay on the Waiver:	349

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:						**774561.60**
Personal Care	Hour	95	684.00	11.92	**774561.60**	
Respite Total:						**352709.60**
Respite	Hour	92	290.00	13.22	**352709.60**	
Occupational Therapy Total:						**3710.02**
Occupational Therapy	Hour	1	61.00	60.82	**3710.02**	
Physical therapy Total:						**1443.96**
Physical therapy	Hour	1	21.00	68.76	**1443.96**	
Speech, Hearing, and Language Services Total:						**39961.35**
Speech, Hearing, and Language Services	Hour	9	27.00	164.45	**39961.35**	
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:						**12600.24**

GRAND TOTAL:	**4526909.04**
Total Estimated Unduplicated Participants:	**100**
Factor D (Divide total by number of participants):	**45269.09**
Average Length of Stay on the Waiver:	332

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavior Support and Consutation (Privately-Contracted)	Hour	3	28.00	124.86	10488.24	
Behavior Support and Conslation (State-Operated)	Hour	1	11.00	192.00	2112.00	
Behavioral Health Stabilization Services-Crisis Diversion Bed Services Total:						232419.36
Crisis Diversion Bed Services (Privately-Contracted)	Day	1	22.00	332.88	7323.36	
Crisis Diversion Bed Services (State-Operated)	Day	1	166.00	1356.00	225096.00	
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	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:						1191111.50
Staff/Family Consultation and Training	Hour	97	410.00	29.95	1191111.50	
Therapeutic Equipment and Supplies Total:						18632.68
Therapeutic Equipment and Supplies	Each	17	2.00	548.02	18632.68	

GRAND TOTAL:	**4526909.04**
Total Estimated Unduplicated Participants:	**100**
Factor D (Divide total by number of participants):	**45269.09**
Average Length of Stay on the Waiver:	332

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation Total:						**6382.65**
Transportation	Mile	5	2503.00	0.51	**6382.65**	
Vehicle Modifications Total:						**13589.05**
Vehicle Modifications	Each	5	1.00	2717.81	**13589.05**	
				GRAND TOTAL:		**4526909.04**
				Total Estimated Unduplicated Participants:		**100**
				Factor D (Divide total by number of participants):		**45269.09**
				Average Length of Stay on the Waiver:		332

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:						**748516.40**
Personal Care	Hour	95	661.00	11.92	**748516.40**	
Respite Total:						**340547.20**
Respite	Hour	92	280.00	13.22	**340547.20**	
Occupational Therapy Total:						**3588.38**
Occupational Therapy	Hour	1	59.00	60.82	**3588.38**	
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					**2003.50**	
				GRAND TOTAL:		**4379918.69**
				Total Estimated Unduplicated Participants:		**100**
				Factor D (Divide total by number of participants):		**43799.19**
				Average Length of Stay on the Waiver:		321

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:						**1649601.40**
Behavior Support and Consultation	Hour	97	460.00	36.97	**1649601.40**	
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:						**12225.66**
Behavior Support and Consutation (Privately-Contracted)	Hour	3	27.00	124.86	**10113.66**	
Behavior Support and Conslstation (State-Operated)	Hour	1	11.00	192.00	**2112.00**	
Behavioral Health Stabilization Services-Crisis Diversion Bed Services Total:						**223950.48**
Crisis Diversion Bed Services (Privately-Contracted)	Day	1	21.00	332.88	**6990.48**	
Crisis Diversion Bed Services (State-Operated)	Day	1	160.00	1356.00	**216960.00**	
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	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**

GRAND TOTAL:	**4379918.69**
Total Estimated Unduplicated Participants:	**100**
Factor D (Divide total by number of participants):	**43799.19**
Average Length of Stay on the Waiver:	321

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
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:						1150439.40
Staff/Family Consultation and Training	Hour	97	396.00	29.95	1150439.40	
Therapeutic Equipment and Supplies Total:						18632.68
Therapeutic Equipment and Supplies	Each	17	2.00	548.02	18632.68	
Transportation Total:						6163.35
Transportation	Mile	5	2417.00	0.51	6163.35	
Vehicle Modifications Total:						13589.05
Vehicle Modifications	Each	5	1.00	2717.81	13589.05	

GRAND TOTAL:	4379918.69
Total Estimated Unduplicated Participants:	100
Factor D (Divide total by number of participants):	43799.19
Average Length of Stay on the Waiver:	321