

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
2201 6th Avenue, Mailstop RX-43
Seattle, Washington 98121



Division of Medicaid & Children's Health Operations

MaryAnne Lindeblad, Director
Health Care Authority
Post Office Box 45502
Olympia, Washington 98504-5502

RE: Washington's Home and Community-Based Services (HCBS) Children's Intensive In-home Behavioral Support Waiver (TN # 40669) Final Report

Dear Ms. Lindeblad:

Enclosed is the final report of the Centers for Medicare & Medicaid Services' (CMS) review of the Children's Intensive In-home Behavioral Support (CIIBS) waiver, control number #40669 that serves individuals, 8 years old through age 20, who are developmentally disabled (DD), live in their own home, are determined to be at high risk of out-of-home placement, and require an intermediate care facility for the mentally retarded (ICF/MR) level of care (LOC). Thank you for your assistance throughout this process, and for sending comments on the draft report. The State's responses to CMS' recommendations have been incorporated in the appropriate sections of the final report.

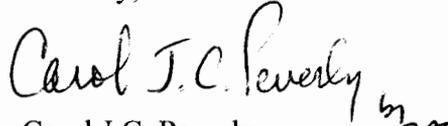
We found the State to be in partial compliance with the six assurance review components. For those areas in which the State is not compliant, please be sure they are corrected at the time of renewal. We have also identified recommendations for program improvements in two of the assurance areas. The State's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

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

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

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

Sincerely,

Handwritten signature of Carol J.C. Peverly in black ink. The signature is written in a cursive style and includes a date "6/7/08" at the end.

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

Cc:

Jane Beyer, Interim Assistant Secretary, Aging and Disability Services Administration
Linda Rolfe, Director, Division of Developmental Disabilities
Don Clintsman, Assistant Director, Division of Developmental Disabilities
Kris Pederson, HCBS Waiver Program Manager, Division of Developmental Disabilities
Christie Seligman, Program Manager, Children's Intensive In-home Behavioral Support



U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

Region 10

FINAL REPORT

**Home and Community-Based Services (HCBS) Waiver Review
Washington State Children's Intensive In-home Behavioral Support Waiver
Control #40669**

October 10, 2012

BACKGROUND AND DESCRIPTION

The Washington Children's Intensive In-home Behavioral Support (CIIBS) waiver was approved under Section 1915(c) of the Social Security Act (the Act) as a statutory alternative to Medicaid-funded institutional care. The Secretary of Health and Human Services renewed the waiver with an effective date of May 1, 2009. The current effective period is May 1, 2009, through April 30, 2012. The State was granted a waiver of Section 1902(a)(10)(B) of the Act in order to provide home and community-based services (HCBS) to individuals, 8 years old through age 20, who are developmentally disabled (DD), live in their own home and are determined to be at high risk of out-of-home placement, and require an intermediate care facility for the mentally retarded (ICF/MR) level of care (LOC). At the time of the review, the waiver served approximately 30 individuals, with an average annual cost per participant of \$24,112.

The Health Care Authority (HCA) is the single state agency responsible for administering the Medicaid program. The Washington Aging and Disability Services Administration, Division of Developmental Disabilities (DDD) located in the Department of Social and Health Services (DSHS) is the Agency responsible for operating HCBS DD services in Washington.

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

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

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

The State of Washington submitted an evidence package to CMS to document its compliance with the six assurances. The evidence package included data on performance measures. The performance measures reported by the State for the waiver review represent a 100 percent file or data review for each measure. As the waiver was in the process of identifying eligible individuals for the waiver, the numbers represented in the performance measures represent a 100 percent review for the files or data available on the date of the state oversight review or data pull. This results in different sample sizes for each review pull, and accounts for the difference in sample sizes for the reported performance measures.

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

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

Home and Community-Based Services Waiver Services

Introduction

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

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

State's Waiver Name:	Children's Intensive In-home Behavioral Support (CIIBS)
Administrative Agency:	Health Care Authority
Operating Agency:	Aging and Disabilities Services Administration (ADSA), Division of Developmental Disabilities (DDD)
State Waiver Contact:	Christie Seligman
Target Population:	Individuals age 8-20 with Developmental Disabilities
Level of Care:	Intermediate Care Facility for the Mentally Retarded (ICF/MR)
Number of Waiver Participants:	30, at the time of the review
Effective Dates of Waiver:	May 1, 2009, through April 30, 2012
Average Annual Cost:	\$24,112 per Person
Approved Waiver Services:	Personal Care; Assistive Technology; Nurse Delegation; Specialized Clothing; Specialized Nutrition; Therapeutic Equipment and Supplies; Vehicle Modifications; Respite; Behavior Management and Consultation; Staff/Family Consultation and Training; Environmental Accessibility Adaptations; Transportation; Specialized Medical Equipment and Supplies; Sexual Deviancy Evaluation; Specialized Psychiatric; Occupational Therapy; Physical Therapy; and Speech, Hearing and Language Services.
CMS Contact:	Wendy Hill Petras, (206) 615-3814

Observations, Findings, and Recommendations

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

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

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

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

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

The Centers for Medicare & Medicaid Services (CMS) reviewed the following information to assess compliance with the sub-assurance:

- Evidence Package, Appendix B
- LOC Assessment and Reassessments Management Functions
- Quality Control and Compliance (QCC) Team
- Comprehensive Assessment and Reporting Evaluation (CARE) Tool, and Case Management Information System (CMIS)
- Division of Developmental Disabilities (DDD) Assessment Activity Report for October 2010 (Draft)

Evidence Package. Appendix B, Performance Measure 1: The Percentage of all waiver participants who have received a redetermination of ICF/MR LOC prior to the end of the twelfth month since their initial determination. The State evidence package reported that there were no data for the first waiver year as all assessments were initial.

LOC Assessment and Reassessments Management Functions. To assure compliance with the sub-assurance the State's Central Office (CO) staff distributes a report of assessment due dates for the waiver to the regional management team monthly. The regional managers, Quality Assurance (QA) staff and CO program managers then monitor the assessment due dates through monthly, quarterly and annual file reviews to assure all dates have been met. The Case Resource Managers (CRM) utilize tickler systems to alert themselves of upcoming assessment dates. The CARE instrument tracks assessment due dates and management routinely pull reports off of the system to assure timeliness of evaluations and reevaluations.

Quality Control and Compliance (QCC) Team. The QCC team conducts an annual review of participant files to assure compliance with the sub-assurance. Reviews were conducted for 100%

of the CIIBS participant files. The QCC review findings were incorporated into the performance measures that were submitted to CMS as a component of the evidence package and appear in the body of this report.

Comprehensive Assessment and Reporting Evaluation (CARE) Tool, and Case Management Information System (CMIS). During the course of the review, the State provided the CMS team with an overview of the CARE tool and CMIS system, and granted the team temporary access to the systems. The electronic CARE tool is utilized by the CRM to conduct LOC assessments. The CARE tool tracks assessment dates, records the type of assessment (initial, interim or redetermination), documents service episode record (SER) notes that can be categorized, and includes a number of additional assessment tools. The assessment tools include the Minimum Data Set (MDS), the Mini-Mental Status Exam (MMSE), and the Centers for Epidemiological Studies (CESD) - Iowa Depression Scale, the Cognitive Performance Scale, the Zarit-Burder Scale, and the Support Intensity Scale (SIS). The CARE tool houses the CMIS, which includes a tickler system designed to notify the CRM of assessment due dates, tags SERs with codes and provides management reports to assist in identifying trends related to LOC assessments and service plan development. The State reported that the CMIS reports are monitored at least annually by central office management. The CARE tool provides evidence of the State's ability to track reevaluations at the CRM level.

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

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

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

The Centers for Medicare & Medicaid Services (CMS) reviewed the following information to assess compliance with the sub-assurance:

- Evidence Package, Appendix B
- DD Academy and Regional Supervision
- Joint Requirement Planning (JRP) Team
- SIS Inter-rater Reliability (IRR) Review Procedures (Draft Version 1.7)

- IRR Database
- IRR Activity Report (March 2010 Draft)

Evidence Package. Appendix B, Performance Measure 2: The percentage of all LOC assessments that were consistent with reviewer determinations during the annual shadow visit for inter-rater reliability. The State's evidence package reported that 100 percent of the assessments completed were consistent with the JRP reviewer determination during the annual shadow visit. This information was based on the frequency in which the JRP and CRM score in the shadow visits concurred that a waiver applicant met LOC, resulting in a 100 percent score. CMS is concerned that the 100 percent score does not represent that all components within the CARE assessment were completed with 100 percent accuracy. The State is not currently breaking down the different components of the CARE assessment process to identify which areas inside and outside the SIS would require additional CRM training.

DD Academy and Regional Supervision. The State requires all new CRMs to attend a two week training on the CARE assessment tool through the DD Academy. Once the CRM completes the DD Academy training they are required to be shadowed on their first assessment by a member of the JRP team (see SIS IRR Review Procedures below). The Regional Manager reviews the first three assessments completed by the new CRM prior to the CARE assessment finalization. Additionally, regional supervisors review one file per CRM per month to assure compliance with the sub-assurance.

Joint Requirement Planning (JRP) Team. The State employs the DDD JRP team to ensure inter-rater reliability in the use of the CARE tool for individuals assessed using the SIS and the ICF/MR LOC assessment. The JRP team members are designated as Washington State's SIS and ICF/MR LOC assessment experts and are responsible for training State CRMs (ongoing and through the DD Academy), and shadowing visits for the required IRR reviews. Additionally, the JRPs may develop expertise in different areas of the LOC assessment to assist with the State's training efforts and provide technical assistance.

SIS Inter-rater Reliability (IRR) Review Procedures (Draft Version 1.7). All CRMs that conduct the CARE assessment are required to complete an initial two week training on the tool through the DD Academy. The CRM is then shadowed on his/her first LOC assessment by a JRP, who completes an individual assessment in addition to the one completed by the CRM for the SIS assessment. Once the assessment is completed by the CRM, it is sent forward to the JRP for review to establish the level of consistency between the two assessments. The results (JRP and CRM) of the assessments are entered into the JRP's IRR database to determine the IRR score.

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

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

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

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

CMS Required Recommendations:

Sub-assurance 1:

To assure compliance with LOC timeline requirements, the State must submit evidence of compliance with the LOC redetermination timelines. The State must submit the evidence to CMS no later than 60 days from its receipt of the final report.

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

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

Sub-assurance 2:

CMS strongly recommends that the State adjust the performance measurement for the sub-assurance to identify components of the CARE assessment tool that require additional CRM training. As noted above, an expansion of the IRR criteria beyond the threshold for LOC, to include an assessment to assure that the CRM was capturing all of the waiver participants LOC

needs, would enhance the current JRP process, and assist the State in identifying additional areas for training.

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

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

II. Service Plans are Responsive to Waiver Participant Needs.

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

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

Compliance: The State substantially meets this assurance.

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

The Centers for Medicare & Medicaid Services (CMS) reviewed the following information to assess compliance with the sub-assurance:

- Service Plan Development
- Evidence Package, Appendix D
- Individual Service Plan (ISP) Meeting Survey Database
- Necessary Supplemental Accommodation (NSA)

Service Plan Development. The State requires the CRMs to conduct follow-up visits with the waiver participant and the participant's support team monthly for the first three months the participant is enrolled in the waiver and at least quarterly thereafter. The follow-up visits: promote immediate use of the waiver resources; gather additional information on the participant's and his/her family's needs; include a discussion of participant incidents and family stress levels; and gather feedback on collaboration with all parties, satisfaction with services, and a check in on the status of referrals or recommendations made. The State process effectively identifies the needs of the waiver participant and the adequacy of the service plan in meeting his/her needs.

Evidence Package. Appendix D, Performance Measure 1(1): The percentage of ISPs conducted for waiver participants that address their assessed needs and personal goals by the provision of waiver services or other means. The State documented a 95 percent compliance rate for the performance measure. To remediate the issue, the State enhanced the CARE system in September 2009, to add a requirement that all health and welfare needs have been addressed in

the ISP before the CARE assessment can be marked as completed. The remediation is tracked by the JRP manager.

Evidence Package. Appendix D, Performance Measure 1(2): The percentage of ISPs conducted for waiver participants that address personal goals. The State reports a 100 percent compliance rate with the performance measure for the 16 plans reviewed.

Evidence Package. Appendix D, Performance Measure 2: The percentage of ISPs with a monthly waiver service provision or monitoring by a case manager during a break in service. The State evidence package submission cited a 100 percent compliance rate with this assurance for the 19 service plans reviewed.

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

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

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

The Centers for Medicare & Medicaid Services (CMS) reviewed the following information to assess compliance with the sub-assurance:

- State Oversight Mechanisms
- Evidence package, Appendix D

State Oversight Mechanisms. The QCC team audit reviews a statistically valid sample of files to assure that service plan development has been completed in accordance with the approved waiver. Additionally, the regional manager review of one file per CRM per month is used to evaluate compliance with the assurance. If trends are identified, training is implemented at the regional office level.

Evidence Package. Appendix D, Performance Measure (2): The percentage of all waiver ISPs that include emergency planning. The State's data documented a 100 percent compliance rate

with this performance measure. The State amended the CARE tool in September, 2009 to require the emergency planning piece to be completed prior to marking the CARE assessment complete.

Evidence Package. Appendix D, Performance Measure 2: The percentage of waiver participant records containing the ISP Wrap-up form, which includes verification that the waiver participant is satisfied with the development of the ISP. The State reported an 89 percent compliance rate with the performance measure for the 19 files reviewed. The State remediated each instance and emphasized the importance of the ISP Wrap-up form during its subsequent training sessions. Additionally, the State revised the questions on the form to effectively emphasize the intent of the form.

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

The Centers for Medicare & Medicaid Services (CMS) reviewed the following information to assess compliance with the sub-assurance:

- CRM Monitoring
- Regional Office file review: CARE tool
- Evidence Package, Appendix D

CRM Monitoring. The State requires the CRM to conduct follow-up visits with the waiver participant and the participant's support team monthly for the first three months the participant is enrolled in the waiver and at least quarterly after the first 90 days. The follow-up visits promote: immediate use of the waiver resources; gathering additional information on the participants' and family's needs; discussion of participant incidents and family stress levels; feedback on collaboration with all parties; satisfaction with services; and a check in on the status of referrals or recommendations made. The State process effectively identifies the needs of the waiver participant and the adequacy of the service plan in meeting his/her needs. The process provides evidence of an effective mechanism to identify the changing needs of each waiver participant in order to update the service plan when deemed appropriate.

Regional Office File Review: CARE tool. The CARE tool documents all assessments and reassessments, and SERs may capture notes indicating a need for service plan revision. An Incident Review (IR) may also generate a revision to the service plan. The information captured in the CARE database is reviewed during the management review of the client files to determine if the plan is updated as appropriate. As noted above the regional managers are required to review one file per CRM per month to assure compliance with the sub-assurance.

Evidence Package. Appendix D, Performance Measure 1(1&2): The percentage of annual ISPs for waiver participants completed before the end of the twelfth month following the initial assessment. The State reported no data for this measure as all ISPs for the time period were initial.

Evidence Package. Appendix D, Performance Measure 2(1): The percentage of ISPs that have been reviewed and amended as needed when one or more indicators suggest the need for a plan amendment. The State reported no data for this measure. The State responded that it has begun to monitor the sub-assurance through a review of files by the Incident Review Committee on a monthly basis.

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

The Centers for Medicare & Medicaid Services (CMS) reviewed the following information to assess compliance with the sub-assurance:

- CRM Monitoring
- Regional Office File Review: CARE Tool
- Evidence Package, Appendix D

Please see the *CRM Monitoring* and *Regional Office File Review: CARE tool* sections above.

Evidence Package. Appendix D, Performance Measure 2: The percentage of waiver ISPs with services that are delivered in accordance with the type, scope, amount, duration and frequency as specified in the ISP. The State reported a 94 percent compliance rate with the performance measure for the 18 files reviewed. The State provided evidence of its remediation of the finding in a timely fashion.

Evidence Package. Appendix D, Performance Measure 3: The percentage of waiver ISPs with services that are delivered within 90 days of the ISP effective date or as specified in the ISP. The State, through its file review, reported a 100 percent compliance rate and will continue with its current monitoring process.

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

The Centers for Medicare & Medicaid Services (CMS) reviewed the evidence package (Appendix D) and ISP Wrap-Up form to assess compliance with the sub-assurance.

Evidence Package. Appendix D, Performance Measure 1: The percentage of waiver participant records that contain an updated ISP Wrap-up, which includes verification that the waiver participant accepts waiver services in the community in lieu of an institution. The State's internal audit found that 95 percent of the files reviewed contain the ISP Wrap-Up form. The State remediation for the deficiency was to modify the CARE system (effective July, 2010) to require the CRM to verify choice has been provided and documented. The State's remediation efforts include a requirement in the CARE system for the CRM to verify that the waiver participant accepts services in the community, and the annual 2009-2010 training addressed the issue in further detail. For future review purposes CMS would like to see signed documentation of the waiver participant's choice, in addition to a completed field in the CARE tool.

Evidence Package. Appendix D, Performance Measure 2: The percentage of waiver participant records that contain the annual ISP Wrap-Up, which includes verification that the waiver participant had a choice of providers, and if not satisfied was able to select another qualified provider. The data submitted by the State documented an 89 percent compliance with the performance measure. The State's 2009-2010 training emphasized the importance of completing the ISP Wrap-up form.

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

CMS Required Recommendations:

Sub-assurance 1:

CMS has no recommendations for this sub-assurance.

Sub-assurance 2:

CMS has no recommendations for this sub-assurance.

Sub-assurance 3:

Evidence Package. Appendix D, Performance Measure 1(1&2). CMS is requiring the state to submit a copy of its latest monitoring report for the performance measure. The report must include a description of any issues identified and the state's remediation efforts. The state must submit the report no later than 60 days from its receipt of the final report.

State Response: We will submit the report as required within 60 days from our receipt of the final report.

Final Federal Response: The sub-assurance will be met upon receipt and CMS review of the monitoring report.

Sub-assurance 4:

CMS has no recommendations for this sub-assurance.

Sub-assurance 5:

Evidence Package. Appendix D, Performance Measure 1: The percentage of waiver participant records that contain an updated ISP Wrap-up, which includes verification that the waiver participant accepts waiver services in the community in lieu of an institution. For future review purposes CMS would like to see signed documentation of the waiver participant's choice, in addition to a completed field in the CARE tool.

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

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

III. Qualified Providers Serve Waiver Participants.

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

Authority: 42 CFR 441.302; and SMM 4442.4.

Compliance: The State substantially meets this assurance.

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

The Centers for Medicare & Medicaid Services (CMS) reviewed the following information to assess compliance with the sub-assurance:

- Evidence package, Appendix C
- Department of Health (DOH)
- Background Check Central Unit (BCCU) process
- Criminal Background Checks and the Abuse Registry
- Enterprise All Contracts Database (EACD)
- Division of Licensing Resources (DLR)
- Quality Control and Compliance (QCC) Audit
- Famlink

Evidence Package. Appendix C, Performance Measure 1: The percentage of residential service providers requiring licensure that have initially and continue to meet licensing requirements prior to the provision of waiver services, as verified by the Children's Administration. The State submitted data in its evidence package documenting a 100 percent compliance rate for contracted providers requiring licensure. The review results were based on information received from the Division of Licensing Resources and the Children's Administration databases.

Department of Health (DOH). The DOH reviews all health professionals' educational and continuing education requirements prior to issuing a license or license renewal. The DOH operates a provider search site that provides current and historical information on the credential status of the state's providers.

Background Check Central Unit (BCCU) Process. The BCCU is responsible for processing background check requests against the police and FBI system. The BCCU reviews all requests

against the police system and conducts an additional FBI screen if the applicant has not continuously resided in the State for the last three years. The background check system also includes all substantiated Residential Care Services (RCS), Child Protective Services (CPS), and Adult Protective Services (APS) findings

Criminal Background Checks and the Abuse Registry. The State requires all providers who have unsupervised contact with a child or vulnerable adult to complete criminal background checks. The background checks must be completed before a provider has unsupervised contact with a waiver participant and then must be redone every contract renewal (at least once every three years). As part of the background check for the CIIBS waiver, the BCCU cross checks all potential employees with the Children's Administration (CA) database. The CA database contains information on any individual with a finding of child abuse and/or neglect. Providers who have been entered into the abuse registry with a finding of guilt for abuse, neglect, exploitation or abandonment of a minor child or vulnerable adult are prohibited from providing unsupervised care to waiver participants. The Division of Licensing Resources (DLR) reviews compliance with the requirement for all residential service providers, including those that provide respite.

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

Division of Licensing Resources (DLR). The DLR is responsible for licensing and monitoring Children's Foster Homes, Group Homes and Staffed Residential Homes, which are utilized as respite resources in the CIIBS program. DDD works cooperatively with DLR to ensure homes are licensed and appropriate care is provided. The DLR site reviews occur at least every three years and include unscheduled visits to the provider sites. Issues identified through the course of the review are communicated to the regional office as well as entered into Famlink (see below).

Quality Control and Compliance (QCC) Audit. The QCC team conducts an annual audit of waiver files. During this review the QCC team verifies that the waiver participant's providers continue to meet the contract standards.

Famlink. The Famlink database contains records of provider inspections and provider trainings and is monitored and administered through the Children's Administration/ Division of Licensing Resources (DLR). The outcomes of licensing visits, including areas of deficiencies are recorded in the Famlink database and used to determine whether to renew licensure and establish the frequency of unannounced site visits. Additionally, Famlink contains information on CPS intakes, screenings and investigations. The information is reported to the DDD on an annual basis or upon request.

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

The Centers for Medicare & Medicaid Services (CMS) reviewed the evidence package (Appendix C) and the EACD to assess compliance with the sub-assurance.

Evidence Package. Appendix C, Performance Measure 1(1): The percentage of waiver service providers who initially met and continue to meet DDD contract standards. The State submitted data in its evidence package documenting a 94 percent compliance rate for the 18 provider files reviewed. The State provided evidence of its remediation of its audit finding, but did not provide sufficient information to clarify whether the provider continued to serve waiver participants while the provider requirements were being met.

Evidence Package. Appendix C, Performance Measure 1(2): The percentage of waiver service providers who initially met and continued to meet DDD contract standards. The State reported a 100 percent compliance rate with the performance measure.

EACD. The EACD is utilized by the CRMs to monitor all State contracts to assure that provider contracts are valid prior to authorizing services. The State requires all unlicensed providers to be actively connected to a waiver individual. Unlicensed providers secure provider contracts through the state's contract staff. The unlicensed contracts are signed by the regional office supervisor and the information is entered into EACD. The contract staff is responsible for monitoring the quality of care delivered by these providers. The use of the EACD and the state staff's ongoing monitoring of the database to assure that provider contracts are valid provide evidence of an effective system for assuring adherence to waiver requirements.

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

The Centers for Medicare & Medicaid Services (CMS) reviewed the submitted evidence package (Appendix C), EACD and the state file review to assess compliance with the sub-assurance.

Evidence Package: Appendix C, Performance Measure 1(2): The percentage of waiver service providers requiring licensure who meet state training requirements as verified by valid licenses and contracts (EACD Database). The State reports a 100 percent compliance rate with the performance measure for its out of home respite providers.

Evidence Package: Appendix C, Performance Measure 1(4): The percentage of waiver service providers requiring licensure and/or certification who meet state training requirements as verified through valid licenses and contracts (verification through the Department of Health). The State reports a 100 percent compliance rate with the performance measure.

EACD and file review. The State tracks provider training through the EACD and through file reviews. The State's evidence package documented a 100 percent compliance rate documented through file review and 100 percent compliance rate as pulled from the EACD. The State

verifies that training was completed through the presence of a valid license in the database and/or documentation in the file review.

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

IV. Health and Welfare of Waiver Participants.

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

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

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

The Centers for Medicare & Medicaid Services (CMS) reviewed the following information to assess compliance with the assurance:

- Evidence Package, Appendices D & G
- Criminal Background Checks and the Abuse Registry
- BCCU Process
- EACD
- CRM Monitoring
- Complaint Tracking
 - DDD Complaint Database
 - CARE SER Notes
 - DDD Client Complaints (Policy 5.03)
- Critical Incident Tracking
 - DD Incident Reporting (IR) System
 - CPS
- Incident Review Team (IRT)
 - IRT Alleged Incidents Reported, Waiver Review. Power Point May 2010
 - Staff to Client Alleged Incidents Reported - Monthly Totals August 2008- March 2010
 - IR Committee Case File Review Example
- Positive Behavioral Support Plans (PBSP)
 - PBSP (Policy 5.14/Functional Assessment (FA))
 - PBSP
 - State Oversight Procedures
- Mortality Review
 - DDD Mortality Review Team (MRT)

- DDD Mortality Report (DSHS 10-331)

Evidence Package. Appendix D, Performance Measure 1(1): The percentage of all waiver ISPs which include emergency planning. The State reported a 100 percent compliance rate for this measure for the 31 participant files reviewed. The CARE tool was enhanced in 2009 to enforce rules requiring emergency planning for all waiver participants assessed with the tool.

Evidence Package. Appendix G, Performance Measure 1: The percentage of children and youth in the CIIBS program who are subject to a report of abuse, neglect or exploitation. The State reported 20 percent of the participants in the waiver program had at least one report of abuse, neglect or exploitation. The State reported that the high percentage of abuse, neglect and exploitation was due to family risk factors inherent to the waiver program's eligibility. The State reported that the case managers filed incident reports for 6 of the 30 children enrolled in the waiver. The State provided evidence of its ability to break out each event by type of incident, and that the case managers, who are mandatory reporters, are filing reports.

Evidence Package. Appendix G, Performance Measure 5: The percentage of waiver participants receiving psychoactive medications whose medications had been reviewed by a psychiatrist. The State reported a 50 percent compliance rate for the assurance for the 24 files reviewed. The decision to consult a psychiatrist is at the discretion of the child's parents or guardian. To improve the care to the waiver children, the case manager may provide recommendations to the family regarding the benefits of a psychiatric consultation. The State has also expanded its Physician Access Line (PAL) to allow primary care providers to contact experts at Children's Hospital for consultation regarding the use of psychoactive medications with children and youth.

Evidence Package. Appendix G, Performance Measure 7: The percentage of waiver participants experiencing hospitalizations and/or emergency room visits related to life-threatening conditions and serious injuries. The State reported two (2) of the 30 (7%) children enrolled in the waiver experienced hospitalization due to an emergency condition, one involving a shunt and the other for a side effect related to a medication change. The incidents were reported through the IR system and monitored by the CRMs, CIIBS program manager and the Incident Report Manager.

Evidence Package. Appendix G, Performance Measure 11: The percentage of critical incidents reported within the timelines specified in Policy 12.01 (Incident Management). The State reported an 82 percent compliance rate for the 11 critical incidents reported.

Evidence Package. Appendix G, Performance Measure 12: The percentage of substantiated findings of abuse or neglect by CPS for which the corresponding incident was documented in the DDD Incident Reporting Database. The State reported a 100 percent compliance rate with the performance measure.

Evidence Package. Appendix G, Performance Measure 13: The percentage of closed critical incident reports for which appropriate follow up occurred. The State reported an 87 percent compliance rate for this performance measure.

Evidence Package, Appendix G, Performance Measure 14: The percentage of reports of abuse or neglect substantiated by Child Protective Services (CPS), by type of incident. The submitted data provided evidence of the state's ability to track incidents by type and substantiation. The state reported that 13 of the 30 waiver participants had allegations during the measurement period. The State provided information on the four substantiated cases, including whether the participant remained in the home. The State also documented its remediation efforts which included tracking whether the addition of HCBS provider supports reduced the stress on the family resulting in decreased incidents.

Evidence Package, Appendix G, Performance Measure 15: The percentage of complaints, by type, filed in the DDD complaints database. The complaints database recorded one complaint in its database. At this time the complaint database only tracks complaints once they reach the Regional Administrator (RA) level. The current policy for tracking complaints in the database does not permit the state to draw an accurate conclusion regarding the waiver program because it fails to capture enough data to track and trend. The State reported that Disability Rights of Washington has been in contact with the families enrolled in the waiver and has reported that the families have expressed concern regarding provider resources, and the length of time between program approval, enrollment and service plan development. The information provided through Disability Rights appears to highlight how the current complaint tracking fails to adequately track issues impacting the waiver participants. The receipt of one complaint over the waiver cycle appears to be exceptionally low when Disability Right is collecting information regarding complaints that are of significant concern about the administration of the waiver program. The State reports a 100 percent remediation rate for the one complaint received (Appendix G, Performance Measure 16), but given the information above the resolution does not appear to be impacting the systemic issues.

Criminal Background Checks and the Abuse Registry. See Qualified Providers Assurance Above.

BCCU Process. See Qualified Providers Assurance Above.

EACD. See Qualified Providers Assurance Above.

CRM Monitoring. The CRMs monitor the health and welfare of the waiver participants through the 30 and 90 day visits and record follow up actions in the CMIS. The CIIB CRMs use the visits to talk to the participant and the family about any incidents that have occurred, the effectiveness of the participant's backup plan, and discuss any need for any changes to the service plan to better address the participant's health and welfare needs.

Complaint Tracking. The State tracks complaints through the DDD Complaint database, and the review of the CARE SER notes.

- *DDD Complaint Database.* The State submitted a snapshot of the DDD complaint log database. A database entry is completed when a CRM is unable to resolve the complaint at either the CRM or regional office supervisory level. The database records: the date of receipt; the individual who received the complaint; complainant's program/waiver name;

the complainant's contact information; the client's identifying information; an explanation of the issue; previous actions taken; most recent actions taken; who is assigned; completion date; outcome; description of the outcome; and date complainant process is completed. The form captures a significant amount of information, however, CMS is concerned that the tracking does not occur within a central database until it reaches a Regional Administrator (RA) level. Lower level complaints are currently kept in waiver participants' files and may not be adequately tracked to identify trends of concern. The lack of a system tracking data at a lower/staff level results in a gap in the state's ability to quickly identify, and respond to trends that may impact the health and welfare of waiver participants.

- *CARE SER Notes.* The CRMs have the ability to enter complaints into the CARE tool SERs. The SER may be tagged to identify that the note regards a complaint, though the CMS file review found that SERs were inconsistently tagged to identify complaints. As the CRM complaint notes are housed in individual files, the state is not currently able to track and trend the majority of the complaints received to identify regional or statewide trends requiring state action.
- *DDD Client Complaints (Policy 5.03).* The policy directs the actions to be taken by DDD staff when a complaint is received from the client, family members, legal representatives or advocates. The policy requires complaints to be resolved at the lowest possible level, with the exception of complaints concerning services in the Residential Habilitation Centers (RHC) and State Operated Living Alternatives (SOLAs), which are required to be directed to the RA. Once a complaint reaches the RA level it is entered into the DD complaint tracking (CT) database. The RA or his/her staff will document the resolution of the investigation in the complaint database or transfer the complaint to the central office if resolution does not occur. Complaints made directly to the RA or central office, are transferred down to the CRM for resolution. The Office of Quality Programs and Services reviews the complaints entered into the database during its review cycle. The current policy does not provide the state with sufficient information to adequately track and trend complaints, as the database does not capture all complaints, and SER notes may not always be coded to identify complaints in the system.

Critical Incident Tracking. The DDD utilizes the IR database to record and track critical incidents through the remediation process. For the CIIBS waiver, DDD coordinates with CPS to respond to critical incidents related to the state's population with Developmental Disabilities.

- *DD Incident Reporting (IR) System.* The DDD uses the IR system to document and track the resolution of critical incidents. Critical incident information is entered into the IR tracking database by the CRM upon being informed of an incident. The IR system is designed to track and trend by incident type through resolution, but does not effectively track IRs by provider. Once the IR entry is completed, it is sent to management, the IR Team and CPS, as appropriate, for investigation. All IR entries are reviewed by the state's Incident Report Manager on a daily basis. The CRM is required to follow up on the IR by the 30th day; however, the current system does not contain a tickler to remind the CRM of that date. Additionally, during the CMS on-site review the state staff and

management reported that they have had issues with closing out the IRs due to inconsistent receipt of final resolution reports for investigations completed by CPS.

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

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

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

Incident Review Team (IRT). The State has established an IRT that is responsible for monitoring the State's response to critical incidents for the DD waivers. The team meets monthly to analyze data pulled from the DD IR database to identify cause and to ensure that remediation has occurred. The State submitted examples of the team's reports as evidence of its oversight of the current IR process. The IR team reviews monthly counts for 7 indicators: physical abuse; sexual abuse; mental abuse; financial exploitation; neglect; staff-to-client incidents; and client-to-client incidents.

- *IRT Alleged Incidents Reported, Waiver Review. PowerPoint, May 2010.* The State submitted a PowerPoint presentation that documents its ability to track the number of critical incidents reported, both by waiver and total incident reports for all DD waivers.
- *Staff to Client Alleged Incidents Reported - Monthly Totals August 2008- March 2010.* The State submitted evidence of its ability to track alleged staff-to-client incidents by waiver. The data is part of the IRT monthly analysis of IR data. The data pulled for the CMS review, included data for all five of the state's waivers serving individuals with developmental disabilities. The State provided evidence during the CMS review of its ability to track the information by waiver.

- *IR Committee Case File Review Example.* The State submitted a snapshot from its IR committee case file review as evidence of its oversight of the IR system and DDD staff response. The snapshot provided evidence of DDD management oversight of the IRs received to assure that the CRMs followed state procedures. The snapshot documented whether the supervisor had verified the system's response to the incident was sufficient, and if not, what was missing (insufficient SERs, PBSP not updated, no IR follow-up, necessary referrals not completed, or other); comments on system response; whether the waiver participant's plan was updated; comments on the plan update; whether the incident was reported to the proper investigative authority; whether mandatory reporter timeframes were followed; whether alleged abuse was reported to law enforcement; and follow-up notes. The snapshot provided an example of a thorough review process for IR reports to assure that staff members are consistently using the IR system. All files selected are reviewed to assure 100 percent remediation has occurred.

Positive Behavioral Support Plans (PBSP). PBSPs are developed by Behavioral Management and Support providers and follow the policies described below. The CIIBS waiver prohibits the use of restrictive interventions.

- *PBSP (Policy 5.14/Functional Assessment (FA)).* The State conducts FAs for individuals who have challenging behaviors that may impact their ability to have positive life experiences. The FA serves as the building block for the PBSP. The FA evaluates the individual's overall quality of life; factors that might increase the likelihood of challenging behavior; factors that might increase the likelihood for appropriate behavior; when and where challenging behavior occurs most frequently; the presence of a diagnosed mental illness or neurological dysfunction that may trigger a challenging behavior; and the function or purpose of the challenging behavior. The State provides the providers with guidelines for the development of a functional assessment in Attachment A of the policy.
- *PBSP.* Individuals served under the waiver are required to have a PBSP developed when they have challenging behaviors which may result in the threat of injury to themselves or others, or threaten significant damage to the property of others. The PBSP, which is developed from the functional assessment, includes prevention strategies (environmental, psychosocial/interpersonal, and intrapersonal), teaching/training supports, and strategies for responding to challenging behaviors. During the on-site review, the state staff and management interviewed identified that there is a current workload issue that impacts the staff's ability to complete exception to policy (ETP) reviews to assure that providers are in compliance with the PBSP.
- *State Oversight Procedures.* The State requires CRMs to conduct monthly meetings with the participant's family and support team during the first three months of waiver enrollment and then at least quarterly after the initial period. During these meetings, the CRM reviews the sufficiency of the waiver services and supports, including the PBSP, with the team, and enters notes from the meeting into the CMIS. The CMIS is reviewed by regional management during the one file per CRM per month review. Additionally, behavioral specialists who develop the PBSP are required to review the information

collected on participant behaviors on a monthly basis, including a review of behavioral incidents, and the information in the quarterly reports which are sent to the CRMs. The CIIBS program manager conducts a review of the PBSP to determine whether the plan required updates whenever the following triggers occur:

- CPS referral for abuse/ neglect/ or exploitation has been started;
- Behavioral incident resulting in an injury to self or others requiring more than first aid;
- Injury to participant or others as a result of a restrictive intervention;
- Participant visit to the emergency room;
- Participant psychiatric hospitalization;
- Lack of behavioral improvement after three months of waiver enrollment;
- Concern indicated by parent/guardian with the PBSP or provider;
- New behavior or new intensity of behaviors;
- Reported concern with the lack of parental/guardian or provider involvement in the PBSP; or
- Negative response by the parent/guardian or provider to “I believe the plan will work.”

If the CIIBS program manager determines that the PBSP requires modifications, the management works with the CRM to remediate the identified deficiencies. The remediation occurs within 90 days of identification.

DDD Mortality Review. The State’s evidence package reported that there had been no suspicious or unexplained deaths for the waiver participants during its review cycle. However, if one had occurred the following process is followed by the state staff.

- *DDD Mortality Review Team (MRT).* The State has formed an MRT that meets on a monthly basis. The MRT Policy 7.05 requires the team to review the deaths of all individuals receiving support from supported living providers or who reside in an AFH, companion home, group home, RHC, or ICF/MR. The review process includes an analysis of a report from the provider, a report from the regional QA staff, signatures from the CRM and regional manager and a final review by a multidisciplinary committee at central office. Systems issues identified during the review process are shared at the quarterly Full Management Team meeting. The State submitted an overview of the team’s activities and tracking as part of the evidence package, and reported that there had been no deaths of waiver participants during the review period.
- *DDD Mortality Report (DSHS 10-331).* The DDD Mortality Report is a three part report including a provider report, regional quality assurance report, and a central office review.
 - The provider report is completed by the provider and sent to the CRM within 14 days of the waiver participant’s death. The provider report includes: the deceased’s identifying information; date and time of death; apparent cause of death; co-existing causes; other significant conditions contributing to the death; whether 911 was called; whether the case was referred to the medical examiner; place of death; deceased’s

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

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

CMS Required Recommendations:

Evidence Package. Appendix G, Performance Measure 11. The State must submit evidence of its efforts to assure that critical incidents are reported within the timeframes required through Policy 12.01. The State must submit evidence of the assurance to CMS no later than 60 days from its receipt of the final report.

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

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

DDD has developed guidelines for central office and regional staff which include review expectations to ensure current reporting policy is followed. These guidelines were trained to and implemented in February and March of 2012.

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

Evidence Package, Appendix G, Performance Measure 13. The State must submit evidence of its remediation and training efforts to assure that appropriate follow up actions are taken in response to critical incidents. The State must submit evidence of the assurance to CMS no later than 60 days from its receipt of the final report.

State Response: DDD has developed policy that includes guidelines for central office and regional staff regarding expectations and requirements for appropriate follow up actions in response to critical incidents. These guidelines were trained to and implemented February and March of 2012.

Final Federal Response: CMS has no additional recommendations for this section of the assurance.

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

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

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

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

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

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

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

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

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

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

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

RCS requested additional investigative staff in the last legislative session.

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

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

The state must demonstrate that it retains ultimate administrative authority over the

waiver program and that its administration of the waiver program is consistent with its approved waiver application.

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

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

Sub-assurance 1: The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies and contracted agencies.

The Centers for Medicare & Medicaid Services (CMS) reviewed the evidence package to assess compliance with the sub-assurance

- Evidence Package, Appendix A
- Regional Office Quarterly Reports
- Children’s Intensive In-home Behavioral Support (CIIBS) Program Database
- JRP IRR Review
- Fair Hearings
 - Administrative Hearings Database
 - Planned Action Notice (PAN)
 - PAN Decision Request for Hearing
 - Barcode: Report of All Administrative Issues, October 2008-October 2009

- QCC Team
- DDD Incident Reporting Policy 12.01
- Waiver Oversight Committee (WOC)

Evidence Package, Appendix A, “Maintain administrative authority over sub-entities with whom we contract.” The State reported the section was not applicable as the State of Washington administers all aspects of the waiver operation. However, as the State operates the waiver through Regional Offices, it must assure that the waiver is administered consistently across the state.

Regional Office Quarterly Reports. The State utilizes a number of reports to monitor its regional offices to assure consistent administration of the CIIBS waiver. The regional offices complete quarterly reports which are sent to the central office that report the timeliness of evaluations, regional compliance with the waiver performance measures, and regional progress on corrections identified in the QCC audit.

Children’s Intensive In-home Behavioral Support (CIIBS) Program Database. As part of the CIIBS waiver design, the State incorporated a number of quality measures to evaluate the waiver program. The measures, which include information on behaviors, skill development, family stress and collaboration between support team members and systems, are collected during the initial meeting with the participant and serve as a baseline measure. During the CRMs ongoing

monitoring the CRM completes follow up forms that detail the effect of the waiver program on the individual. The information from the follow up form is then entered into the CIIBS database and reviewed by the CIIBS program manager to assess whether there are any programmatic concerns that need to be addressed.

JRP IRR Review. See Assurance 1: LOC Evaluation.

Fair Hearings.

- *Administrative Hearings Database.* The State utilizes the Administrative Hearing Database to track all hearings for the DD population. The reports are pulled and reviewed at least annually by the CIIBS Program Manager. The report allows the State to identify systematic issues impacting waiver participants.
- *Planned Action Notice (PAN).* The State submitted an example of a PAN that had been sent to a waiver participant. The PAN identified the waiver participant and her representative, the planned action, effective date of the action, the impacted service(s), the reasons for the action with supporting WAC authorities, an overview of the participant's appeal rights, and state contact information. The State reported that the PAN is sent on all actions even when benefits are continued. The PAN notice submitted served as an effective notification tool for waiver participants.
- *PAN Decision Request for Hearing.* The State submitted a copy of the PAN Decision Request for Hearing form as evidence of a waiver participant's ability to access the fair hearing system. The form identifies the impacted service, the action to be taken, when the waiver participant was informed of the action, if the waiver participant wished to continue services pending the appeal, information on who may be representing the waiver participant, an authorization for release of information to the representative, and whether or not the participant needs an interpreter. The form is signed and dated, then returned to the state, by fax or mail. The form served as evidence of a user-friendly request format through which waiver participants gain access to the fair hearing system.
- *Barcode: Report of All Administrative Issues - October 2008-October 2009.* The State submitted the administrative issues report that is pulled off of the Barcode system. The report captures administrative hearings information by region and includes the number of closed and pending cases, and the status and outcome of the administrative hearings across 29 issues/subjects. Each of the DD regional offices employs an individual who serves as the fair hearings coordinator. The coordinators meet monthly with the central office to review the Barcode reports for trends. The report demonstrates the state's ability to track administrative hearing information for the DDD waiver participants. DDD administrative fair hearing information was also available through the state's Fair Hearing Control System.

QCC Team. The QCC team is responsible for two oversight reviews per year: the waiver QA review and a second review whose focus is determined annually. The QCC team reports its findings to the central office and leadership through quarterly reports. The QCC is also

responsible for providing training at the DDD academy. The QCC team activities provide evidence of the State's ongoing oversight of the waiver's administration.

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

Waiver Oversight Committee (WOC). The WOC meets on a quarterly basis and includes the CIIBS program manager. During the WOC meeting the committee reviews and makes recommendations from the following reports related to waiver performance: QCC audits; ISP satisfaction surveys; fiscal reports; CRM face to face data from CMIS; and incident reports.

CMS Required Recommendations:

Evidence Package, Appendix A, "Maintain administrative authority over sub-entities with whom we contract." As noted above, the submitted evidence package stated that this assurance did not apply. The on-site review provided sufficient evidence to determine that the state had processes in place to assure consistent administration of the CIIBS program. However, the state will need to submit information in the evidence package for this assurance in future reviews. Subsequent to the review, the state reorganized moving the single state agency to the Health Care Authority, with DSHS's Aging and Disability Services Administration, Division of Developmental Disabilities retaining responsibility for delivery of HCBS DD services. The evidence package for future reviews should include assurances that articulate this arrangement and include performance measures documenting how information related to waiver program's administration is communicated to the HCA.

State Response: DDD will follow these recommendations and has submitted measures in the CIIBS renewal application to address the revised organizational structure within Washington.

Final Federal Response: This sub-assurance will be met upon the CMS approval of the CIIBS renewal application.

VI. State Provides Financial Accountability for the Waiver

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

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

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

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

The Centers for Medicare & Medicaid Services (CMS) reviewed the following information to assess compliance with the sub-assurance:

- Evidence Package, Appendix I
- Social Service Payment System (SSPS)

Evidence Package. Appendix I, Performance Measure 1: The percentage of waiver participants who initially meet and continue to meet financial eligibility for waiver enrollment. The State reported an 89 percent compliance rate with this measure for the 19 files reviewed. To remediate DDD reported working collaboratively with the Economic Services Administration to improve electronic communication. DDD also provided additional training to the CRMs on utilization of the data and communication systems used to verify financial eligibility.

Evidence Package. Appendix I, Performance Measure 3: The percentage of all waiver ISPs with service authorizations that are for services identified in the ISP. The State reported that 17 of the 18 files reviewed, 94 percent, were in compliance with this measure. The noncompliant file had exceeded the services authorized in the service plan. To remediate, the State planned to continue to train and audit to the standard.

Evidence Package. Appendix I, Performance Measure 5: The percentage of provider billings for waiver services that do not exceed the contracted rates of service. The State reported a 98 percent compliance rate for the 729 billings reviewed. The errors occurred because the case manager(s) had entered the total sum of the payment into the hourly rate. The State responded to the finding by correcting the error and providing SSPS training for the CRMs authorizing payment for services. The regional management is now reporting the SSPS audit results to the CIIBS program manager on a monthly basis as part of its remediation efforts.

Evidence Package. Appendix I, Performance Measure 6: The percentage of provider billings for waiver participants that are at or below the amount and rate authorized. The State reported a 100 percent compliance rate with this measure.

SSPS. The SSPS is the system responsible for the delivery/purchase and payment of waiver services. The SSPS system interfaces with the Agency Financial Reporting System (AFRS) to

maintain accounting records for the DD waiver participants. The AFRS is a mainframe financial system responsible for performing all aspects of the accounting process. DDD audits the SSPS system to verify that services in the ISP have been authorized appropriately, and that the services have only been authorized after the ISP is approved. The SSPS billing is reviewed by the Regional Waiver Coordinators and regional office supervisors on a monthly basis. The reviewers pull three files per CRM/month; all identified issues are remediated with the CRM.

CMS Required Recommendations.

Evidence Package. Appendix I, Performance Measure 1: The percentage of waiver participants who initially meet and continue to meet financial eligibility for waiver enrollment. CMS is requiring the State to submit a copy of its latest monitoring report for the performance measure. The report must include a description of any issues identified and the state's remediation efforts. The State must submit the report no later than 60 days from its receipt of the final report.

State Response: DDD will provide a copy of the report within the specified timeframe.

Final Federal Response: The assurance will be met upon the receipt and CMS review of the report. The report must be received within 60 days of the State's receipt of the final report.

Evidence Package. Appendix I, Performance Measure 3: The percentage of all waiver ISPs with service authorizations that are for services identified in the ISP. CMS is requiring the State to submit a copy of its latest monitoring report for the performance measure. The report must include a description of any issues identified and the State's remediation efforts. The State must submit the report no later than 60 days from its receipt of the final report.

State Response: DDD will provide a copy of the report within the specified timeframe.

Final Federal Response: The assurance will be met upon the receipt and CMS review of the report. The report must be received within 60 days of the State's receipt of the final report.

Appendix A: Summary of Findings

Assurance I: State Conducts Level of Care (LOC) Determinations Consistent with the Need for Institutionalization.		
Sub-assurance	Requirement	CMS Recommendations
1	The LOC of enrolled participants is re-evaluated at least annually or as specified in the approved waiver.	To assure compliance with LOC timeline requirements, the State must submit evidence of compliance with the LOC redetermination timelines. The State must submit the evidence to CMS no later than 60 days from its receipt of the final report.
<p>State Response: We are following your recommendation. Case resource managers have electronic reports (tickler system) which identify assessments that have not been completed within 12 months of the last annual assessment. Regional Waiver coordinators now have access to the Assessment activity timeliness report. Monthly, regional waiver coordinators review timeliness reports and distribute information to case resource managers to promote completing assessments timely as well as to seek follow up on getting overdue assessments completed. The Central office Waiver Program Manager will continue to review the assessment activity report to address system issues regarding timely completion of assessments.</p>		
<p>Final Federal Response: CMS has no additional recommendations for this sub-assurance.</p>		
2	The State's process and instruments documented in the approved waiver are applied appropriately and according to the approved description to determine participant LOC.	CMS strongly recommends that the State adjust the performance measurement for the sub-assurance to identify components of the CARE assessment tool that require additional CRM training. An expansion of the IRR criteria beyond the threshold for LOC, to include an assessment to assure that the CRM was capturing all of the waiver participant's LOC needs, would enhance the current JRP process, and assist the State in identifying additional areas for training.
<p>State Response: Washington State currently completes annual training for case managers based on findings from annual waiver audits. This includes training on ISP development, policies and procedures. DDD is interested in investigating this recommendation more fully in the future although we recognizes additional staffing would be required to implement.</p>		
<p>Final Federal Response: CMS has no additional recommendations for this sub-assurance.</p>		
Assurance II: Service Plans are Responsive to Waiver Participant Needs.		

Sub-assurance	Requirement	CMS Recommendations
1	Service plans address all of the participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.	CMS has no recommendations for this sub-assurance.
2	The State monitors service plan development in accordance with its policies and procedures.	CMS has no recommendations for this sub-assurance.
3	Service plans are updated/revised at least annually or when warranted by changes in the participant's LOC.	<i>Evidence Package. Appendix D, Performance Measure 1(1&2).</i> CMS is requiring the State to submit a copy of its latest monitoring report for the performance measure. The report must include a description of any issues identified and the State's remediation efforts. The State must submit the report no later than 60 days from its receipt of the final report.
State Response: We will submit the report as required within 60 days from our receipt of the final report.		
Final Federal Response: The sub-assurance will be met upon receipt and CMS review of the monitoring report.		
4	Services are delivered in accordance with the service plan, including type, scope, amount and frequency specified in the plan of care (POC).	CMS has no recommendations for this sub-assurance.
5	Participants are afforded choice: (1) between waiver services and institutional care, and (2) among waiver services and providers.	For future review purposes CMS would like to see signed documentation of the waiver participant's choice, in addition to a completed field in the CARE tool.
State Response: DDD agrees with this recommendation. DDD's system was updated in 2010 to identify a box on the ISP for the CRM to document that the client has signed to voluntary participation choice statement for the specific Waiver program they are eligible for. In addition, the voluntary participation statement form has been updated and separated from the Assessment meeting wrap-up form.		
Final Federal Response: CMS has no additional recommendations for this sub-assurance.		

Assurance III: Qualified Providers Serve Waiver Participants		
Sub-assurance	Requirement	CMS Recommendations
1	The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other state standards prior to their furnishing services.	CMS has no recommendations for these sub-assurances
2	The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.	
3	The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.	
Assurance IV: Health and Welfare		
Sub-assurance	Requirement	CMS Recommendations
	The state must demonstrate that, on an ongoing basis, it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.	<i>Evidence Package, Appendix G, Performance Measure 11.</i> The State must submit evidence of its efforts to assure that critical incidents are reported within the timeframes required through Policy 12.01. The State must submit evidence of the assurance to CMS no later than 60 days from its receipt of the final report.
		<i>Evidence Package, Appendix G, Performance Measure 13.</i> The State must submit evidence of its remediation and training efforts to assure that appropriate follow up actions are taken in response to critical incidents. The State must submit evidence of the assurance to CMS no later than 60 days from its receipt of the final report.
		<i>DDD Complaint Database and CARE SER notes.</i> CMS strongly recommends that the State develop, or amend the current policy for tracking complaints in the DDD Complaint database to

		allow for data entry at the CRM level for all complaints.
		<i>Client Complaints Policy (Policy 5.03).</i> CMS strongly recommends that the State revise the current complaint tracking policy to require the use of a centralized tracking system at the CRM level.
		<i>Critical Incidents.</i> The State must submit a CAP to CMS that details a coordinated interagency (DDD, APS and CPS) identification and response to critical incidents to assure that the State is able to identify, track, trend, and remediate instances of abuse, neglect and/or exploitation. The CAP must include: how the State will work with partner agencies to identify waiver participants; the coordination of interagency efforts throughout the investigative process; and the process for reporting the results of critical incident allegation investigations. CMS recommends that the state update the current IR tracking system to allow for the system to track by provider. The plan must be submitted to CMS no later than 60 days from the receipt of the final report.

State Response:

Evidence Package. Appendix G, Performance Measure 11. The Corrective Action plan was approved by Centers for Medicare and Medicaid Services in April 2011. The Corrective Action Plan identifies a system process for CRM to be notified of critical incidents. The information will be documented in FAMLINK.

In addition:

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

DDD has developed guidelines for central office and regional staff which include review expectations to ensure current reporting policy is followed. These guidelines were trained to and implemented in February and March of 2012.

Evidence Package. Performance Measure 13. DDD has developed policy that includes guidelines for central office and regional staff regarding expectations and requirements for appropriate follow up actions in response to critical incidents. These guidelines were trained to and implemented February and March of 2012.

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

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

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

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

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

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

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

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

RCS requested additional investigative staff in the last legislative session.

Final Federal Response:

Evidence Package. Appendix G, Performance Measure 11. The requirement will be met upon successful implementation and completion of the State's CAP. The State must continue to meet with CMS to discuss the progress in meeting the CAP requirements in order to be in compliance with the measure.

Evidence Package. Performance Measure 13. CMS has no additional recommendations for this section of the assurance.

Division of Developmental Disabilities (DDD) Complaint Database and CARE Service Episode Record

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

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

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

Assurance V: Administrative Authority

Sub-assurance	Requirement	CMS Recommendations
1	The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies and contracted agencies.	<i>Evidence Package, Appendix A, Maintain administrative authority over sub-entities with whom we contract.</i> ” As noted above, the submitted evidence package stated that this assurance did not apply. The on-site review provided sufficient evidence to determine that the state had processes in place to assure consistent administration of the CIIBS program. However, the State will need to submit information in the evidence package for this assurance in future reviews. The evidence package for future reviews should also be revised to reflect the revised organizational structure within the State.

State Response: DDD will follow these recommendations and has submitted measures in the CIIBS renewal application to address the revised organizational structure within Washington.

Final Federal Response: This sub-assurance will be met upon the CMS approval of the CIIBs renewal application.

Assurance VI: State Provides Financial Accountability for the Waiver

Sub-assurance	Requirement	CMS Recommendations
1	State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.	<i>Evidence Package. Appendix I, Performance Measure 1.</i> CMS is requiring the State to submit a copy of its latest monitoring report for the performance measure. The report must include a description of any issues identified and the state’s remediation efforts. The State must submit the

		report no later than 60 days from its receipt of the final report.
		<i>Evidence Package. Appendix I, Performance Measure 3: The percentage of all waiver ISPs with service authorizations that are for services identified in the ISP. CMS is requiring the State to submit a copy of its latest monitoring report for the performance measure. The report must include a description of any issues identified and the State's remediation efforts. The State must submit the report no later than 60 days from its receipt of the final report.</i>
<p>State Response: <i>Evidence Package. Appendix I, Performance Measure 1 and 3. DDD will provide a copy of the report within the specified timeframe.</i></p>		
<p>Final CMS Response: <i>Evidence Package. Appendix I, Performance Measure 1 and 3. The assurance will be met upon the receipt and CMS review of the report. The report must be received within 60 days of the State's receipt of the final report.</i></p>		