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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
Community Protection Waiver

C. Waiver Number:WA.0411
Original Base Waiver Number: WA.0411.

D. Amendment Number:

E. Proposed Effective Date: *(mm/dd/yy)*
01/01/15
Approved Effective Date of Waiver being Amended: 09/01/12

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
This amendment indicates the use of a MMIS (ProviderOne) to pay providers for certain waiver services.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☑ **Waiver Application**	7;8
☐ **Appendix A – Waiver Administration and Operation**	
☐ **Appendix B – Participant Access and Eligibility**	
☐ **Appendix C – Participant Services**	
☐ **Appendix D – Participant Centered Service Planning and Delivery**	
☐ **Appendix E – Participant Direction of Services**	
☐ **Appendix F – Participant Rights**	

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

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

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

Specify:
Add ProviderOne information.

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

1. Request Information (1 of 3)

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

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Community Protection Waiver

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: WA.0411
Draft ID: WA.007.02.05

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

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

1. Request Information (2 of 3)

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

- ☐ **Hospital**

Select applicable level of care

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

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

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

☐ **Nursing Facility**

Select applicable level of care

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

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

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

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

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

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

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The purpose of the Community Protection Waiver is to provide an alternative to ICF/ID placement for individuals who:

- o Are at least 18 years of age, and
- o Meet the criteria for ICF/ID level of care, and
- o Live or are moving into the community, and
- o Require 24-hour, on-site, awake staff supervision to ensure the safety of others, and
- o Require therapies and other habilitation, and
- o Are found by DDD to meet the criteria for an "individual with community protection issues". Those criteria are as follows:

(1) The person has been convicted of or charged with a crime of sexual violence as defined in Chapters 9A.44 and 71.09 RCW, including, but not limited to, rape, rape of a child, and child molestation, and constitutes a current risk to others as determined by a qualified professional (note: excluding charges or crimes that resulted in acquittal);

(2) The person has been convicted of or charged with sexual acts directed toward strangers; individuals with whom a relationship has been established or promoted for the primary purpose of victimization; or persons of casual acquaintance with whom no substantial personal relationship exists, and constitutes a current risk to others as determined by a qualified professional (note: excluding charges or crimes that resulted in acquittal).

(3) The person has not been convicted and/or charged of a crime, but has a history of stalking, sexually violent, predatory, and/or opportunistic behavior, which demonstrates a likelihood to commit a sexually violent and/or predatory act based on current behaviors, and constitutes a current risk to others as determined by a qualified professional; or

(4) The person has committed one or more violent offenses, such as murder, attempted murder, arson, first degree assault, kidnapping, or use of a weapon to commit a crime (RCW 9.94A.030(45)).

The goal of the Community Protection Waiver is to provide a structured, therapeutic environment for persons with community protection issues in order for them to live safely and successfully in the community while minimizing the risk to public safety. This is accomplished by coordination of natural supports, community resources/services, Medicaid services and services available via the waiver. The Division of Developmental Disabilities wants people who receive Community Protection Waiver services to experience these benefits:

- Health and Safety
- Personal Power and Choice
- Personal Value and Positive Recognition By Self and Others
- A Range of Experiences Which Help People Participate in the Physical and Social life of Their Communities
- Good Relationships with Friends and Relatives
- Competence to Manage Daily Activities and Pursue Personal Goals

The objective of the Community Protection Waiver is to develop and implement supports and services to successfully maintain individuals in their homes and communities.

With regard to the organizational structure, the State of Washington's HCBS Community Protection Waiver is managed by the Aging and Disability Services Administration (ADSA)/Division of Developmental Disabilities (DDD), within the Department of Social and Health Services (DSHS. The Health Care Authority (HCA(is the State's Medicaid Agency (SMA), and the Division operates the Community Protection Waiver under a written agreement between DSHS and

HCA. The State monitors against waiver requirements for all services delivered. The principles of Continuous Quality Improvement are used to enhance the Community Protection waiver services delivery systems.

Washington contracts with its counties for the implementation of Day Program/Supported Employment/Individual Technical Assistance services. All other aspects of the Waiver are directly managed by the state. DDD operates this waiver within applicable federal regulations, manages the day-to-day administration and maintains operational responsibility for the waiver.

3. Components of the Waiver Request

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

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

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

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

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

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

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

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

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

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

4. Waiver(s) Requested

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

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

- ◉ **Not Applicable**
- ○ **No**
- ○ **Yes**

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

No

Yes

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

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

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

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

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

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

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

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

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or

as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

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

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

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

- o The Legislature and other state agencies;
- o County Coordinators for Human Services;
- o The State of Washington Developmental Disabilities Council (DDC);
- o The Arc of Washington State(advocacy organization), and
- o The Community Advocacy Coalition made up of advocates and providers.
- o The HCBS (DDD) Waivers Quality Assurance Committee composed of self-advocates, advocates and providers.

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

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

7. Contact Person(s)

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

Last Name: Perez

First Name: Evelyn

Title: Assistant Secretary

Agency: Developmental Disabilities Administration

Address:

Address 2: P.O. Box 45310

City:

State: Olympia

Zip: **Washington**

Phone: 98504-5310

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

E-mail: (360) 407-0954

PerezE@dshs.wa.gov

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

Last Name: Beckman

First Name: Bob

Title: Interim Waiver Services Unit Manager

Agency: Developmental Disabilities Administration/Program and Policy Development

Address: P.O. Box 45310

Address 2:

City: Olympia

State: **Washington**

Zip: 98504-5310

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

Fax: (360) 407-0955

E-mail: Beckmbc@dshs.wa.gov

8. Authorizing Signature

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name: Perez

First Name: Evelyn

Title: Assistant Secretary, Developmental Disabilities Administration

Agency: Department of Social and Health Services

Address: 4450 10th Ave SE

Address 2:

City: Lacey

State: **Washington**

Zip: 98504

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

Fax: (360) 407-0954

E-mail: PerezE@dshs.wa.gov

Attachments

Attachment #1: Transition Plan

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

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**

- **Adding or decreasing an individual cost limit pertaining to eligibility.**
- **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- **Reducing the unduplicated count of participants (Factor C).**
- **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

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

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

Adult Dental Waiver Amendment.
Comprehensive adult dental services will be restored to the Medicaid State Plan effective 1/1/14 per legislative directive. Therefore this service will be removed from the waiver benefit package as of 1/1/14.

Tribal notice was provided on August 14, 2013. This was a joint notice from Health Care Authority, Developmental Disabilities Administration and Aging & Long-Term Support Administration to the Tribal Leaders.

Joint public notice (from DDA and ALTSA) was provided on September 10, 2013. In addition, DDA provided information regarding the change in dental services to Stakeholders during the DDA HCBS QA quarterly meeting.

All enrolled waiver participants will receive a written notice by November 27, 2013 notifying them that comprehensive dental services will continue to be available to them but through their Medicaid medical coverage rather than through their waiver program. Participants' legal representatives and client-identified necessary supplemental accommodation representatives will also receive a copy of the client notice. This notice will serve as the amendment to the participants' plans of care.

The transition of dental services from the waiver to the state plan is anticipated to be seamless to waiver participants as the dental and transportation providers utilized for comprehensive adult dental services are the same under both the waiver and the Medicaid State Plan. The adult dental services available in the Medicaid State Plan beginning January 1, 2014 will be equal to or better than the adult dental services currently in the waiver program.

DDA will be revising the Community Protection Waiver program WAC to remove comprehensive adult dental services from its benefit package.

Health Care Authority, the State Medicaid Agency will complete the following tasks:
- submit a State Plan amendment to reinstate the dental benefits effective 1/1/14
- distribute notices to dental service providers and Medicaid transportation brokerage providers
- revise provider billing procedure manuals
- amend Washington Administrative Code to define the adult dental service benefit package
- publish a news release providing the public with information about the addition of adult dental services to the Medicaid State Plan

Copies of these notices are available from the Health Care Authority.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

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

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

Settings that do not meet HCBS characteristics for participants on the Community Protection Waiver: prevocational services. DDA is proposing to halt new enrollments to prevocational services effective 7/1/2015, and to transition all existing prevocational participants to other integrated service options within four years through person-centered service planning. Current options include individual supported employment, group supported employment (both include prevocational components) and community access services. In addition, DDA will assist individuals to explore and access other community options. Transition of prevocational participants is scheduled to be completed by March 1, 2019, and is documented in the transition plan, appendix C: State's remedial strategies and timelines.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

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

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

   (Complete item A-2-a).

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

   Specify the division/unit name:

Department of Social and Health Services/Aging and Disability Services Administration/Division of Developmental Disabilities within the Department of Social and Health Services

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

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

Schedule A5 of the Cooperative Agreement between the Health Care Authority and the Department of Social and Health Services delegates the following functions to the operating agency:

- Submission of all necessary application, renewal and amendment materials to CMS in order to secure and maintain approval of all proposed and existing waivers.
- Responsibility for the operation, management and reporting of allowable Medicaid administrative activities for approved federal waivers.
- Developing regulations, MMIS policy changes, and provider manuals.

The frequency of review and update of the Cooperative Agreement:

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

The methods that the Medicaid agency uses to ensure that the operating agency performs its assigned wiaver operation and administrative functions in accordance with waiver requirements:

The Medicaid agency is responsible for approving rules, regulations andpolicies that govern how waivers are operated and retains the authority to discharge its responsibilities for the administration of the Medicaid program pursuant to 42 CFR 431.10(3). The assigned operation and administrative functions are monitored as part of ADSA's annual Quality Assurance Review Cycle. Final QA outcome reports are provided to the Medicaid agency for review and follow-up.

The frequency of Medicaid agency assessment of operating agency performance:

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

is reviewed and approved for implementation by executive management.

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

Appendix A: Waiver Administration and Operation

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

   (●) **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
   Counties are responsible for the provision of prevocational, supported employment, and individual technical assistance services. They disseminate information concerning prevocational, supported employment and individual technical assistance services to potential enrollees, monitor waiver expenditures against approved levels, recruit providers and determine prevocational, supported employment, and individual technical assistance services payment amounts or rates.

   The Medicaid agency retains ultimate authority and responsibility for the operation of the waiver by exercising oversight over the performance of waiver functions by the Department of Social and Health Services and other state and local/regional non-state agencies and contracted entities.

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

Appendix A: Waiver Administration and Operation

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

   ( ) **Not applicable**

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

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

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

   WA State Counties, Regional Support Networks (RSNs)

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

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

   Local non-profit corporation.

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
Each biennium, DDD reviews and evaluates the state's Employment & Day program subcontractors. The evaluation incorporate all contractual requirements including but not limited to client direct services, program quality assurance, indirect systems, policies and procedure, and fiscal soundness. All counties are asked to complete and return the Employment & Day Contract Compliance review checklist, which is a self-assessment tool.

In addition to the tool, DDD asks counties to submit various other information– examples of requested information include:
- Their most recent Request for Qualifications for Employment & Day Program Services.
- Their site review schedule including dates and the names of providers to be reviewed.
- An overview of their "Quality Assurance & Evaluation" process including:
  - A sample site review engagement letter.
  - The evaluation tool used for the site review.
  - A sample follow-up site review letter (preferably a corrective action sample).
  - An explanation of how client review sampling is determined.

Once information is obtained, DDD compiles the information and determines which counties require further review. A county who elects not to submit the requested information is automatically chosen. Thus DDD conducts a 100% review of Counties and based on the information provided, DDD determines which Counties require on-site reviews and technical assistance.

When on-site reviews are conducted:

Client files will be reviewed for specific elements including:
- Relationship of clients' file notes describing services - to reporting documents - to DDD's Individual Support Plan;
- Quality of reporting documents, activity progress and outcome status;
- Accuracy of service hours reported, including separation of DVR hours;
- Required documentation such as grievance procedures, medical information, release of information, etc.

Direct service staff files will be reviewed for specific elements including:
- Background checks;
- Qualifications;
- Training information; and
- Documentation of Policy Review.

As a result of the site visits, counties receive written feedback which include necessary recommendations for corrective action.

The Medicaid agency is responsible for approving rules, regulations and policies that govern how waivers are operated. The assigned operational and administrative functions are monitored as part of ADSA's annual QA Review Cycle. At the end of each annual QA Review Cycle a report is generated which includes detailed data on a state-wide level. Final QA outcome reports are provided to the Medicaid agency for review and input. Monitoring results are also reviewed with the Medicaid Agency Waiver Management Committee at the quarterly meeting of the Committee immediately following compilation of the monitoring results.

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

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

Where possible, include numerator/denominator.

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

Performance Measure:
a.i.1: The percentage of counties that submit timely contract monitoring reports.
Numerator= The number of counties reporting to the state in a timely manner.
Denominator= The total number of contracted counties.

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

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: i.e., During the first fiscal year of the biennium.

Performance Measure:
a.i.2: The percent of counties that comply with their fiscal year waiver spending plans provided by the state. Numerator= The number of counties in compliance with fiscal year waiver spending plans. Denominator= The total number of contracted counties.

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:
a.i.3: The percent of counties that need on-site monitoring or technical assistance that receive on-site monitoring or technical assistance. Numerator= The number of counties who received on-site monitoring or technical assistance. Denominator= The number of counties identified to need on-site monitoring or technical assistance.

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

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

	Specify:

Data Aggregation and Analysis:

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

Performance Measure:
a.i.4: The percent of Regional Support Network (RSN) contracts that were monitored annually by regional resource managers to verify contract compliance. Numerator= The number of contracts with RSNs that were monitored. Denominator= The number of contracts with RSNs.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Contract monitoring off-site.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
a.i.5: The percent of Regional Support Networks (RSNs) that maintained certification. Numerator= The number of RSNs that maintained certification. Denominator= The total number of RSNs.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Off-site verification of provider certification.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
a.i.6: The percent of waiver amendment and waiver renewal requests for which approval was obtained from the Single State Medicaid Agency. Numerator: The number of waiver amendment and waiver renewla requests for which approval was obtained from the Single State Medicaid Agency. Denominator: The total number of waiver amendment and waiver renewal requests submitted to CMS.

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

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

☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
a.i.7: The percentage of scheduled meetings of the Medicaid Agency Waiver Management Committee that are actually held. Numerator: The number of scheduled meetings of the Medicaid Agency Waiver Management Committee that are held.

Denominator: The total number of scheduled meetings of the Medicaid Agency Waiver Management Committee.

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

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

Data Aggregation and Analysis:

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

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
a.i.1: The DDD County Services Program Manager has developed a self-report survey which counties complete and submit during the first year of the biennium. These are submitted to and reviewed by the DDD County Services Program Manager.

a.i.2: The DDD county Services Program Manager monitors county expenditures against fiscal year spending plans, ensures that billed budget categories are in agreement with approved budgets/contracts and provides general accounting oversight.

a.i.3: The DDD County Services Program Manager provides on-site monitoring or technical assistance to counties annually according to need.

The Division of Developmental Disabilities has a standard contract with each county that includes oversight expectations concerning waiver-related activities incuding provider enrollment/contracting and quality assurance/improvement activities.

In addition, on an ongoing basis Division staff communicate back and forth with county staff on topics including county performance data and changes in federal and state rules and waiver-related policies.

a.i.4: Regional resoruce managers annually monitor the RSNs to ensure commpliance with contract requirements.

a.i.5: Regional resource managers annually verify that RSNs have current certification.

a.i.6: The State Operating Agency obtains written approval from the Single State Medicaid Agency (Health Care Authority-HCA)to submit waiver amendment requests and waiver renewal requests to CMS. The Waiver Program Manager verifies annually that approval from the HCA was obtained for all waiver amendment requests and waiver renewal requests submitted to CMS.

a.i.7: The Medicaid Agency Waiver Management Committee includes representatives from the HCA and divisions within the operating agency: DDD, HCS, RCS, and DBHR. The committee meets at least quarterly to review all functions delegated to the operating agency, current quality assurance activity, pending waiver activity (e.g., amendments, renewals), potential waiver policy and rule changes and quality improvement activities. The Waiver Program Manager verifies annually that these meetings were held.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
a.i.1: If a county has not returned a completed self-report survey, the DDD County Services Program Manager follows up with the county to convey non-compliance and request the completed survey be submitted within approximately 25 days. If a survey indicates necessary contract monitoring is not being accomplished by the county, the DDD County Services Program Manager provides consultation and technical assistance to ensure necessary monitoring activities are completed and their completion is reflected in the following survey.

a.i.2: If county expenditures do not match the iscal year spending plan, or billed budget categories are not in agreement with approved budgets/contracts, the DDD County Services Program Manager provides consultation and technical assistance to the county to ensure compliance.

a.i.3: The DDD County Services Program Manager documents all on-site monitoring or technical assistance provided to counties.

a.i.4: If RSNs are out of compliance with contract requirements, a corrective action plan is required and compliance is monitored by the regional resource manager.

a.i.5: If a RSN is determined to have lost certification, the contract is terminated and renewed once the RSN has again obtained certification.

a.i.6: If it is determined that HCA approval was not obtained for all waiver amendment or waiver renewal requests submitted to CMS, the Waiver Program Manager will ensure that approval from the HCA will be obtained and processes will be reviewed and evaluated to determine if changes need to be made to ensure prospective approval is obtained in the future.

a.i.7: If the Medicaid Agency Waiver Management Committee did not meet quarterly, the Waiver Program Manager will ensure the process is modified as necessary so that in the future quarterly meetings are held.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Every other month; annually during the first year of the biennium.

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☑ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☑	Developmental Disability	18		☑
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

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

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

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

(a) Be attributable to mental retardation, cerebral palsy, epilepsy, autism, or another neurological or other condition found by DDD to be closely related to mental retardation or requiring treatment similar to that required for individuals with mental retardation;

(b) Originate prior to age eighteen;

(c) Be expected to continue indefinitely; and

(d) Result in substantial limitations to an individual's adaptive functioning.

Individuals on this waiver meet the criteria for ICF/ID level of care and
- Are at least 18 years of age, and
- Live or are moving into the community, and
- Require 24-hour, on-site, awake staff supervision to ensure the safety of others, and
- Require therapies and other habilitation, and
- Are found by DDD to meet the criteria for an "individual with community protection issues". These criteria are as follows:

1. The person has been convicted of or charged with a crime of sexual violence as defined in Chapters 9A.44 and 71.09 RCW, including, but not limited to, rape, rape of a child, and

child molestation, and constitutes a current risk to others as determined by a qualified professional (note: excluding charges or crimes that resulted in acquittal);

2. The person has been convicted of or charged with sexual acts directed toward strangers; individuals with whom a relationship has been established or promoted for the primary purpose of victimization; or persons of casual acquaintance with whom no substantial personal relationship exists, and constitutes a current risk to others as determined by a qualified professional (note: excluding charges or crimes that resulted in acquittal).

3. The person has not been convicted and/or charged of a crime, but has a history of stalking, sexually violent, predatory, and/or opportunistic behavior, which demonstrates a likelihood to commit a sexually violent and/or predatory act based on current behaviors, and constitutes a current risk to others as determined by a qualified professional; or

4. The person has committed one or more violent offenses, such as murder, attempted murder, arson, first degree assault, kidnapping, or use of a weapon to commit a crime (RCW 9.94A.030(45)).

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

- (●) **Not applicable. There is no maximum age limit**
- ( ) **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

  Specify the percentage:

- ( ) **Other**

Specify:

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

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

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

  - **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

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

      Specify the formula:

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

    Specify percent:
  - **Other:**

    Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

- ☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	463
Year 2	460
Year 3	458
Year 4	456
Year 5	454

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	463
Year 2	460

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 3	458
Year 4	456
Year 5	454

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

State regulations stipulate: When there is capacity on a waiver and available funding for new waiver participants, DDD may enroll people from the statewide data base in a waiver based on the following priority considerations:

(1) First priority will be given to current waiver participants assessed to require a different waiver because their needs have increased and these needs cannot be met within the scope of their current waiver.

(2) DDD may also consider any of the following populations in any order:

(a) Priority populations as identified and funded by the legislature.

(b) Persons DDD has determined to be in immediate risk of ICF/ID admission due to unmet health and safety needs.

(c) Persons identified as a risk to the safety of the community.
(d) Persons currently receiving services through state only funds.
(e) Persons on an HCBS waiver that provides services in excess of what is needed to meet their identified health and welfare needs.
(f) Persons who were previously on an HCBS waiver since April 2004 and lost waiver eligibility due to residing in an institution.)

If there is not sufficient capacity to allow potential entrants to be enrolled on the waiver, they can request placement in an ICF/ID.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

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

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

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

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

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

  Select one:

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

    Specify percentage:

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

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

Specify:

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- [x] **A special income level equal to:**

Select one:

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

Specify percentage:

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

Specify dollar amount:

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

Select one:

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Select one:

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

(*select one*):

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

Specify the percentage:

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

Specify dollar amount:

- **A percentage of the Federal poverty level**

Specify percentage:

- **Other standard included under the State Plan**

Specify:

- **The following dollar amount**

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

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

Specify:

The State will apply two different maintenance needs allowances:

1. For recipients who live in their own home, the State shall disregard the special income level (SIL), which is three hundred percent (300%) of the SSI Federal Benefit Rate (FBR) for an individual.

2. For recipients who live in a state-contracted or state-operated residence (i.e., group care home, group training home, adult family home, adult residential care facility), the maintenance allowance is at the Medically Needy Income Level (MNIL) (which is equal to the SSI payment standard [FBR]).

In addition to the MNIL, an allowance will be made for (when applicable):

a) Any payee and/or court-ordered guardianship fees (guardianship fees shall not exceed one hundred seventy-five dollars per month); plus

b) Any court-ordered guardianship-related attorney fees; plus

c) An amount for employed individuals equal to the first $65 of the recipient's earned income, if any [as provided for SSI recipients at 20 C.F.R. 416.1112(c)(4)] plus one-half of any remaining earned income [as provided for SSI recipients at 20 C.F.R. 416.1112(c)(6)].

The maximum amount for the maintenance needs allowance for individuals who live in a state-contracted or state-operated residence is three hundred percent (300%) of the SSI FBR for an individual.

○ **Other**

Specify:

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

◉ **Not Applicable**

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

Specify:

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

○ **SSI standard**

○ **Optional State supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

○ **The amount is determined using the following formula:**

Specify:

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

○ **Not Applicable (see instructions)**

○ **AFDC need standard**

◉ **Medically needy income standard**

○ **The following dollar amount:**

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

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

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

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

Select one:

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

Specify:

The deduction for medical and remedial care expenses that were incurred as the result of the imposition of a transfer of assets penalty is limited to zero.

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

Specify percentage:

- **The following dollar amount:**

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

The following formula is used to determine the needs allowance:

Specify formula:

The State will apply two different maintenance needs allowances:

1) For recipients who live in their own home, the State shall disregard the special income level (SIL), which is three hundred percent (300%) of the SSI Federal Benefit Rate (FBR) for an individual.

2) For recipients who live in a state-contracted or state-operated residence (i.e., group care home, group training home, adult family home, adult residential care facility), the maintenance allowance is at the Medically Needy Income Level (MNIL) (which is equal to the SSI payment standard [FBR]).

In addition to the MNIL, an allowance will be made for (when applicable):

a) Any payee and/or court-ordered guardianship fees (guardianship fees shall not exceed one hundred seventy-five dollars per month); plus

b) Any court-ordered guardianship-related attorney fees; plus

c) An amount for employed individuals equal to the first $65 of the recipient's earned income, if any [as provided for SSI recipients at 20 C.F.R. 416.1112(c)(4)] plus one- half of any remaining earned income [as provided for SSI recipients at 20 C.F.R. 416.1112(c)(6)].

The maximum amount for the maintenance needs allowance for individuals who live in a state-contracted or state-operated residence is three hundred percent (300%) of the SSI FBR for an individual.

Other

Specify:

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

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

a. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

   i. **Minimum number of services.**

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

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

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

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

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

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

Specify the entity:

- **Other**

Specify:

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

Regional DDD Case/Resource Managers are the only individuals who perform the initial evaluations of level of care prior to placement onto the waiver. In addition to meeting the following minimum qualifications, staff must pass a background check prior to being hired and receive mandatory waiver training prior to completing any evaluations.

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

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

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

retardation and related developmental disabilities.

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

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

How does DDD determine if I meet the eligibility requirements for ICF/ID Level of care if I am age 16 or older? If you are age sixteen or older, DDD determines you to be eligible for ICF/ID Level of care when you meet one or more of the following:

1. You have a percentile rank over nine percent for three or more of the six subscales in the SIS Support Needs Scale; or
2. You have a percentile rank over twenty-five percent for two or more of the six subscales in the SIS Support Needs Scale; or
3. You have a percentile rank over fifty percent in at least one of the six subscales in the SIS Support Needs Scale; or
4. You have a support score of one or two for any of the questions listed in the SIS Exceptional Medical Support Needs Scale; or
5. You have a support score of one or two for at least one of the following items in the SIS Exceptional Behavior Support Needs Scale:
   a. Prevention of assaults or injuries to others; or
   b. Prevention of property destruction (e.g. fire setting, breaking furniture); or
   c. Prevention of self-injury; or
   d. Prevention of PICA (ingestion of inedible substances); or
   e. Prevention of suicide attempts; or
   f. Prevention of sexual aggression; or
   g. Prevention of wandering; or
6. You have a support score of two for any of the questions listed in the SIS Exceptional Behavior Support Needs Scale; or
7. You meet or exceed any of the qualifying scores for one or more of the following SIS questions:

Question # of SIS Support	Text of Question "Type of Support" is:	Your score for	And your score for “Frequency of Needs Scale	is:
A1	Using the toilet	2 or more	4	
		3 or more	2	
A2	Taking care of clothes	2 or more	2 or more	
		3 or more	1	
A3	Preparing food	2 or more	4	
		3 or more	2	
A4	Eating food	2 or more	4	
		3 or more	2	
A5	Housekeeping and cleaning	2 or more	2 or more	
		3 or more	1	
A6	Dressing	2 or more	4	
		3 or more	2	
A7	Bathing and taking care of personal hygiene and grooming needs	2 or more	4	
		3 or more	2	
C3	Learning and using problems ssoving strateties	2 or more	3 or more	
		3 or more	2	
C9	Learning self-management strategies	2 or more	3 or more	
		3 or more	2	

B6 Shopping and purchasing goods and services 2 or more 3 or more 2 or more 1
E1 Taking medication 2 or more 3 or more 4 2
E2 Avoiding health and safety hazards 2 or more 3 or more 3 or more 2
E4 Ambulating and moving about 2 or more 3 or more 4 2
E6 Maintaining a nutritious diet 2 or more 3 or more 2 or more 1
E8 Maintaining emotional well-being 2 or more 3 or more 3 or more 2
F6 Using appropriate social skills 2 or more 3 or more 3 or more 2
G2 Managing money and personal finances 2 or more 3 or more 2 or more 1

How does DDD determine your percentile rank for each subscale in the SIS Support Needs Scale? DDD uses the following table to convert your total raw score for each subscale into a percentile ranking:

If your total raw score for the following SIS subscales is: Lifelong Living Safety subscale	Home Living SIS subscale	Comunity Learning subscale	Employment Support and	Health Social Activities	Then your percentile rank for the is:
>99					
>88	>94	>99			
87-88	93-94	>99			
85-86	91-92	>97	99		
81-84	88-90	>96	>95	92-97 >97	98
77-80	84-87	92-96	91-95	86-91 91-97	95
73-76	70-83	86-91	85-90	79-85 84-90	91
68-72	74-78	79-85	78-84	72-78 76-83	84
62-67	69-73	72-78	70-77	65-71 68-75	75
55-61	63-68	64-71	61-69	57-64 58-67	63
48-54	56-62	55-63	52-60	49-56 48-57	50
40-47	49-55	46-54	42-51	42-48 38-47	37
32-39	41-48	36-45	32-41	34-41 28-37	25
25-31	33-40	27-35	23-31	27-33 19-27	16
18-24	25-32	18-26	15-22	20-26 10-18	9
11-17	16-24	9-17	7-14	13-19 3-9	5
3-10	6-15	<9	<7	7-12 <3	2
<3	<6	1-6		1	
	<1	<1			
		<1			

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

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

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

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

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

A qualified and trained interviewer (DDD Case Resource Manager) completes the SIS at least annually by obtaining information about the person's support needs via a face to face interview with the person and one or more respondents who know the person well.

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

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

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

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

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

- Regional management is responsible for ensuring that Case Resource Managers (CRMs) complete annual evaluations.
- Assessment data is monitored monthly by regional waiver coordinators and HQ Program Managers and Quality Assurance staff to ensure compliance.
- Waiver Coordinators review Assessment Activity Reports that are generated monthly by HQ and distributed to CRM to promote completing assessment timely.
- CRMs have electronic reports (tickler system) which identify assessments not completed within 12 months.
- Annual and quarterly file reviews track compliance. Quarterly reviews are completed by supervisors. Annual reviews are completed by the Quality Compliance Coordinators (QCC).
- The DDD assessment (on the CARE platform) tracks timeliness of reevaluations. CRMs, DDD supervisors and DDD executive management all monitor these reports.

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

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
a.i.b.1: The % of all wvr enrollees who have a re-determination of ICF/ID LOC prior to the end of the 12th month since their initial/last redeter. Numerator= Enrollees with a LOC re-deter. completed prior to the end of the 12th month since the initial/last redeter. Demonimnator= All wvr enrollees with a LOC re-deter. due prior to the end of the 12th month since the initial/last re-deter.

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

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
a.i.c.1: The percentage of all LOC assessments that were completed according to state requirements, as specified in the waiver. Numerator= The number of LOC assessments completed in accordance with state requirements as specified in the waiver. Denominator= All completed LOC assessments.

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
a.i.c.2: The percentage of inter-rater reliability (IRR) LOC determinations made where the LOC criteria were accurately applied. Numerator= The number of IRR LOC eligibility determinations consistent with the LOC criteria. Denominator= IRR LOC determinations subject to review.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%

☑ **Other** Specify: Joint Requirements Planning (JRP) Team within DDD.	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

a.i.a.1:
Administrative data is collected real time in ADSA's CARE system, which is the database of record for client information. Waiver enrollment requests are processed in CARE, which will not allow completion of the request without a completed level of care assessment. A report based on data in CARE will be used to identify all applicants for waiver enrollment for whom an evaluation for LOC was completed prior to a completed request for waiver enrollment and to identify all waiver applicants.

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

tracking of timely DDD assessments provides the dual benefit of tracking timely LOC assessments.

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

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

a.i.c.2:
The Joint Requirements Planning (JRP) Team provides new CRMs with comprehensive training, in a classroom environment, regarding the use and administration of the LOC Assessment when they are hired. Within 30 days of completing their training, JRP must perform a 1:1 evaluation of new CRMs to ensure that the LOC assessment is administered correctly. In addition, the JRP conduct an annual 1:1 evaluation of all CRMs to ensure that they maintain their skills in administering the LOC assessment in a consistent and reliable manner. During the initial and annual 1:1 evaluations, the JRP accompany CRMs on a LOC assessment interview. The CRM conducts the assessment interview and both the JRP and the CRM independently complete separate LOC assessments based on the information provided in the interview. The CRM's LOC assessment is then compared to the JRPs to ensure that the CRM's determination for ICF/MR LOC eligibility is consistent with that of the JRP. The JRP also evaluate the CRM's interviewing skills in the following areas: introduction to the tool, mechanics and style of the interview process, and understanding of scoring.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
a.i.b.1: A list of overdue assessments is generated monthly and sent to Regions for analysis and follow-up. Regions report on progress toward achieving 100% timely assessments as a part of their quarterly reports to Central Office Management.

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

a.i.c.2: Individuals whose reevaluation reveals that the LOC tools were inappropriately applied receive additional training.

ii. Remediation Data Aggregation

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

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

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

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

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

Appendix C: Participant Services

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

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

Service Type	Service
Statutory Service	Individual Supported Employment/Group Supported Employment
Statutory Service	Prevocational Services
Statutory Service	Residential Habilitation
Extended State Plan Service	Occupational Therapy
Extended State Plan Service	Physical Therapy
Extended State Plan Service	Speech, Hearing, and Language Services
Other Service	Behavior Support and Consultation
Other Service	Behavioral Health Stabilization Services - Behavior Support and Consultation
Other Service	Behavioral Health Stabilization Services - Behavioral Health Crisis Diversion Beds
Other Service	Behavioral Health Stabilization Services - Specialized Psychiatric Services
Other Service	Community Transition
Other Service	Environmental Accessibility Adaptations
Other Service	Individualized Techical Assistance
Other Service	Sexual Deviancy Evaluation
Other Service	Skilled Nursing
Other Service	Specialized Medical Equipment and Supplies
Other Service	Specialized Psychiatric Services
Other Service	Staff/Family Consultation and Training
Other Service	Transportation

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Individual Supported Employment/Group Supported Employment

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Supported employment services provide individualized assistance to gain and/or maintain employment and ongoing support. These services are tailored to individual needs, interests, abilities, and promote career development. These services are provided in individual or group settings.

(1) Individual supported employment services include activities needed to sustain minimum wage pay or higher. These services are conducted in integrated business environments and include the following:

(a) Creation of work opportunities through job development;
(b) On-the-job training;
(c) Training for the supervisor and/or peer workers to enable them to serve as natural supports to the participant on the job;
(d) Modification of the work site tasks;
(e) Employment retention and follow along support; and
(f) Development of career and promotional opportunities.

(2) Group supported employment services are a step on the pathway toward gainful employment in an integrated setting and include:

(a) The activities outlined in individual supported employment services;
(b) Daily supervision by a qualified employment provider; and
(c) Groupings of no more than eight workers with disabilities.

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

- Supported employment services are only available to individuals who do not have access to services available under the Rehabilitation Act of 1973, or the Individuals with Disabilities Education Improvement Act of 2004.
- Payment will be made only for the adaptations, supervision, training and support with the activities of daily living a person requires as a result of his/her disabilities.
- Payment is excluded for the supervisory activities rendered as a normal part of the business setting.
- An individual cannot be authorized to receive supported employment services if he/she receives prevocational services.

ADSA/DDD contracts with the counties for expanded habilitation (including supported employment) services. The counties in turn contract provide services directly or contract with local providers for expanded habilitation services. The ADSA/DDD reimburses the counties on a monthly basis for the cost of all services provided within the county. The counties in turn reimburse vendors for services provided based on the negotiated unit rates contained in their contracts with the vendors.

The amount of employment support will be based on the following items:
Client Employment Acuity is determined through the DDD assessment. Acuity reflects conditions typically related to the individual's disability that are not likely to change, and are generally not impacted by outside factors. Client acuity is determined as either “High”, “Medium” or “Low”.

Support level High –

- Requires support in the community at all times to maintain health and safety.
- Experiences significant barriers to employment or community participation.
- Requires frequent supervision, training, or full physical assistance with community activities most or all of the time.

Support Level Medium -

- Independent in the community some of the time and requires moderate support to obtain or maintain employment.
- Able to maintain health and safety in the community for short periods of time.
- May need some supervision, training, or partial physical assistance with community activities.
- May need regular monitoring or prompting to perform tasks.

Support Level Low –

- Generally independent in the community and requires minimal support to obtain or maintain employment.
- Able to communicate with others effectively and can maintain personal health and safety most of the time without supervision.
- May be able to independently transport self in the community and does not require physical assistance in community activities.
- Able to perform tasks with minimal or occasional monitoring or prompting.

Employment Algorithm Components
A combination of the following acuity scales and assessment items provided the most accurate determination of a person's employment acuity level:

- Activities of Daily Living
- Behavioral Support
- Interpersonal Support
- Environmental Support
- Level of Monitoring
- Employment Support
- Completing tasks with acceptable speed
- Completing tasks with acceptable quality
- Medical Support
- Seizure support

Client work history is determined by looking back over a 12-month period and is categorized into three main groupings:

- Continuous Employment – Received wages 9 consecutive month of the 12-month period
- Intermittent/Recent Employment – Received wages in at least one month of the 12-month period
- Not employed or unemployed last 12 months – No wages reported as earned during a 12-month period (subminimum wages fall to not employed)

The range of support hours the client receives will be dependent upon the individual's Employment Acuity, work history and phases of employment. DDD uses the following table to determine the number of hours of individiual employment service:

Employment support level:	Employment status is:	Then the service level is:	And s/he may receive up to this many supported employment service hours per month:
None	Working	A	0
	Not Working	B	0
Low	Working	C	4
	Not Working	D	7
Medium	Working	E	7
	Not Working	F	9
High	Working	G	11
	Not Working	H	12

Depending on factors detailed in the county employment plan, DDD may authorize additional hours of employment service:

Service level:	Support Level:	Employment Status:	Then DDD may authorize up to this many additional hours of supp. employment service:
A	None	Working	0
B	None	Not Working	0
C	Low	Working	5
D	Low	Not Working	7
E	Medium	Working	5
F	Medium	Not Working	7
G	High	Working	12
H	High	Not Working	5

Short term enhanced prevocational supports are available is a person is beginning a new job, has planned or expeceted change in job or job tasks, unexpected change in their condition or support is needed to maintain employment. These are short term hours department by the county and employment vendor and may be authorized for a maximum of 6 months.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Group Supported Employment
Agency	Group Supported Employment
Individual	Individual Supported Employment
Agency	Individual Supported Employment

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Individual Supported Employment/Group Supported Employment

Provider Category:
Individual
Provider Type:
Group Supported Employment
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards, which include Policy 6.13.

As stipulated in DDD policy 6.13 (concerning day program provider qualifications), all providers shall meet the following qualifications:

- Demonstrate experience or knowledge in providing services to individuals with developmental disabilities;
- Have a history of working with community-based employers and/or other community entities;
- Demonstrate a method for providing services/jobs based on individual choice and interest;
- Demonstrate an understanding of and commitment to integration of individuals with developmental disabilities with people who are not disabled;
- Have experience in working cooperatively with other organizations such as the Division of Vocational Rehabilitation (DVR),schools, and other community entities;
- Shall have the administrative capabilities necessary to safe guard public funds;
- Shall maintain books, records, documents and other materials relevant to the provision of goods and services;
- Shall provide for systematic accumulation, filing and retention of timely reports for department and/or federal audits;
- Shall be 18 years of age or older and have experience or received training in the

following areas:
- Positive Behavior Support
- Health and Welfare

- Shall have experience or training to provide training and support to clients in the program area(s) identified in the client's Individual Support Plan (ISP).

Verification of Provider Qualifications

Entity Responsible for Verification:
County

Frequency of Verification:
Every two years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Individual Supported Employment/Group Supported Employment

Provider Category:
Agency

Provider Type:
Group Supported Employment

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards, which include Policy 6.13.

As stipulated in DDD policy 6.13 (concerning day program provider qualifications), all providers shall meet the following qualifications:
- Demonstrate experience or knowledge in providing services to individuals with developmental disabilities;
- Have a history of working with community-based employers and/or other community entities;
- Demonstrate a method for providing services/jobs based on individual choice and interest;
- Demonstrate an understanding of and commitment to integration of individuals with developmental disabilities with people who are not disabled;
- Have experience in working cooperatively with other organizations such as the Division of Vocational Rehabilitation (DVR),schools, and other community entities;
- Shall have the administrative capabilities necessary to safe guard public funds;
- Shall maintain books, records, documents and other materials relevant to the provision of goods and services;
- Shall provide for systematic accumulation, filing and retention of timely reports for department and/or federal audits;
- Shall be 18 years of age or older and have experience or received training in the following areas:
  - Positive Behavior Support
  - Health and Welfare

- Shall have experience or training to provide training and support to clients in the program area(s) identified in the client's Individual Support Plan (ISP).

Verification of Provider Qualifications

Entity Responsible for Verification:

County
Frequency of Verification:
Every two years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Individual Supported Employment/Group Supported Employment

Provider Category:
Individual
Provider Type:
Individual Supported Employment
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards, which include Policy 6.13.

As stipulated in DDD policy 6.13 (concerning day program provider qualifications), all providers shall meet the following qualifications:

- Demonstrate experience or knowledge in providing services to individuals with developmental disabilities;
- Have a history of working with community-based employers and/or other community entities;
- Demonstrate a method for providing services/jobs based on individual choice and interest;
- Demonstrate an understanding of and commitment to integration of individuals with developmental disabilities with people who are not disabled;
- Have experience in working cooperatively with other organizations such as the Division of Vocational Rehabilitation (DVR),schools, and other community entities;
- Shall have the administrative capabilities necessary to safe guard public funds;
- Shall maintain books, records, documents and other materials relevant to the provision of goods and services;
- Shall provide for systematic accumulation, filing and retention of timely reports for department and/or federal audits;
- Shall be 18 years of age or older and have experience or received training in the following areas:
  - Positive Behavior Support
  - Health and Welfare

- Shall have experience or training to provide training and support to clients in the program area(s) identified in the client's Individual Support Plan (ISP).

Verification of Provider Qualifications
Entity Responsible for Verification:
County
Frequency of Verification:
Every two years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Individual Supported Employment/Group Supported Employment

Provider Category:
Agency
Provider Type:
Individual Supported Employment
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards, which include Policy 6.13.

As stipulated in DDD policy 6.13 (concerning day program provider qualifications), all providers shall meet the following qualifications:

- Demonstrate experience or knowledge in providing services to individuals with developmental disabilities;
- Have a history of working with community-based employers and/or other community entities;
- Demonstrate a method for providing services/jobs based on individual choice and interest;
- Demonstrate an understanding of and commitment to integration of individuals with developmental disabilities with people who are not disabled;
- Have experience in working cooperatively with other organizations such as the Division of Vocational Rehabilitation (DVR),schools, and other community entities;
- Shall have the administrative capabilities necessary to safe guard public funds;
- Shall maintain books, records, documents and other materials relevant to the provision of goods and services;
- Shall provide for systematic accumulation, filing and retention of timely reports for department and/or federal audits;
- Shall be 18 years of age or older and have experience or received training in the following areas:
  - Positive Behavior Support
  - Health and Welfare

- Shall have experience or training to provide training and support to clients in the program area(s) identified in the client's Individual Support Plan (ISP).

Verification of Provider Qualifications
Entity Responsible for Verification:
County
Frequency of Verification:
Every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

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

Service Definition *(Scope):*

Prevocational services are shared among a group of nine or more individuals within a segregated setting designed to provide services for individuals with developmental disabilities. Prevocational services offer short term training and skill development in addition a limited amount of time in their community to pursue employment opportunities. The focus of prevocational services is to help the individual meet her/his employment goals and facilitate integration of the individual into her/his community. The client's individual work plan identifies their employment goals, which in turn determine the amount of time it will take to gain and maintain employment in the community.

Prevocational services cannot be authorized if the individual receives supported employment services.

New referrals for prevocational services require prior approval by the DDD Regional Administrator and County Coordinator or their designee.

Prevocational services are a time limited step on the pathway toward individual employment and the goal is to have participants demonstrate steady progress toward gainful employment over time. A participant's annual vocational assessment will include exploration of integrated settings within the next service year. Criteria that would trigger a review of the need for these
services include, but are not limited to:

- Compensation at more than fifty percent of the prevailing wage;
- Significant progress made toward the defined goals;
- An expressed interest in competitive employment; and/or
- Recommendation by the individual support plan team.

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

- Prevocational services are only available to individuals who do not have access to services available under the Rehabilitation Act of 1973, or the Individuals with Disabilities Education Improvement Act of 2004.
- An individual cannot be authorized to receive prevocational services if s/he receives supported employment services.
- The amount of prevocational support will be based on the following items:

Client Employment Acuity is determined through the DDD assessment. Acuity reflects conditions typically related to the individual's disability that are not likely to change, and are generally not impacted by outside factors. Client acuity is determined as either "High", “Medium” or “Low”.

Support Level High –

- Requires support in the community at all times to maintain health and safety.
- Experiences significant barriers to employment or community participation.
- Requires frequent supervision, training, or full physical assistance with community activities most or all of the time.

Support Level Medium -

- Independent in the community some of the time and requires moderate support to obtain or maintain employment.
- Able to maintain health and safety in the community for short periods of time.
- May need some supervision, training, or partial physical assistance with community activities.
- May need regular monitoring or prompting to perform tasks.

Support Level Low –

- Generally independent in the community and requires minimal support to obtain or maintain employment.
- Able to communicate with others effectively and can maintain personal health and safety most of the time without supervision.
- May be able to independently transport self in the community and does not require physical assistance in community activities.
- Able to perform tasks with minimal or occasional monitoring or prompting.

Employment Algorithm Components
A combination of the following acuity scales and assessment items provided the most accurate determination of a person's employment acuity level:

- Activities of Daily Living
- Behavioral Support
- Interpersonal Support
- Environmental Support
- Level of Monitoring
- Employment Support
- Completing tasks with acceptable speed
- Completing tasks with acceptable quality
- Medical Support
- Seizure support

Client work history is determined by looking back over a 12-month period and is categorized into three main groupings:

- Continuous Employment – Received wages 9 consecutive month of the 12-month period
- Intermittent/Recent Employment – Received wages in at least one month of the 12-month period
- Not employed or unemployed last 12 months – No wages reported as earned during a 12-month period
  (subminimum wages fall to not employed)

The range of support hours the client receives will be dependent upon the individual's Employment Acuity, work history and phases of employment. DDD uses the following table to determine the number of hours of prevocational service:

Employment support level:	Employment status is:	Then the service level is:	And s/he may receive up to this to prevocational service hours per month:
None	Working	A	0
	Not Working	B	0
Low	Working	C	4
	Not Working	D	7
Medium	Working	E	7

	Not Working	F	9
High	Working	G	11
	Not Working	H	12

Depending on factors detailed in the county employment plan, DDD may authorize additional hours of prevocational service:

Service level:	Employment Support Level:	Employment Status:	Then DDD may authorize up to this many additional hours of service:
A	None	Working	0
B	None	Not Working	0
C	Low	Working	5
D	Low	Not Working	7
E	Medium	Working	5
F	Medium	Not Working	7
G	High	Working	12
H	High	Not Working	5

Short term enhanced supports are available to a person who is beginning a new job, has a planned or expected change in job or job tasks, has an unexpected change in their condition, or support is needed to maintain employment. These are short term hours recommended by the county and employment vendor and are authorized by DDD for a maximum of 3 months.

ADSA/DDD contracts with the counties for day habilitation and expanded habilitation (including prevocational) services. The counties in turn contract provide services directly or contract with local providers for day habilitation and expanded habilitation services. The ADSA/DDD reimburses the counties on a monthly basis for the cost of all services provided within the county. The counties in turn reimburse vendors for services provided based on the negotiated unit rates contained in their contracts with the vendors.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Prevocational (Sheltered workshop)
Agency	Prevocational (Sheltered workshop)

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:
Individual
Provider Type:
Prevocational (Sheltered workshop)
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

As stipulated in DDD policy 6.13 (concerning day program provider qualifications), all providers shall meet the following qualifications:

- Demonstrate experience or knowledge in providing services to individuals with developmental disabilities;
- Have a history of working with community-based employers and/or other community entities;
- Demonstrate a method for providing services/jobs based on individual choice and interest;
- Demonstrate an understanding of and commitment to integration of individuals with developmental disabilities with people who are not disabled;
- Have experience in working cooperatively with other organizations such as the Division of Vocational Rehabilitation (DVR),schools, and other community entities;
- Shall have the administrative capabilities necessary to safe guard public funds;
- Shall maintain books, records, documents and other materials relevant to the provision of goods and services;
- Shall provide for systematic accumulation, filing and retention of timely reports for department and/or federal audits;
- Shall be 18 years of age or older and have experience or received training in the following areas:
  - Positive Behavior Support
  - Health and Welfare

- Shall have experience or training to provide training and support to clients in the program area(s) identified in the client's Individual Support Plan (ISP).

Verification of Provider Qualifications

Entity Responsible for Verification:
County

Frequency of Verification:
Every two years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:
Agency

Provider Type:
Prevocational (Sheltered workshop)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

As stipulated in DDD policy 6.13 (concerning day program provider qualifications), all providers shall meet the following qualifications:

- Demonstrate experience or knowledge in providing services to individuals with

developmental disabilities;
- Have a history of working with community-based employers and/or other community entities;
- Demonstrate a method for providing services/jobs based on individual choice and interest;
- Demonstrate an understanding of and commitment to integration of individuals with developmental disabilities with people who are not disabled;
- Have experience in working cooperatively with other organizations such as the Division of Vocational Rehabilitation (DVR),schools, and other community entities;
- Shall have the administrative capabilities necessary to safe guard public funds;
- Shall maintain books, records, documents and other materials relevant to the provision of goods and services;
- Shall provide for systematic accumulation, filing and retention of timely reports for department and/or federal audits;
- Shall be 18 years of age or older and have experience or received training in the following areas:
  - Positive Behavior Support
  - Health and Welfare

- Shall have experience or training to provide training and support to clients in the program area(s) identified in the client's Individual Support Plan (ISP).

Verification of Provider Qualifications

Entity Responsible for Verification:
County

Frequency of Verification:
Every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
(1) Residential habilitation services include assistance:
(a) With personal care and supervision; and
(b) To learn, improve or retain social and adaptive skills necessary for living in the community.
(2) Residential habilitation services may provide instruction and support addressing one or more of the following outcomes:
(a) Health and safety;
(b) Personal power and choice;
(c) Competence and self reliance;
(d) Positive recognition by self and others;
(e) Positive relationships; and
(f) Integration into the physical and social life of the community.

Residential habilitation services are provided in the individual's home in which the individual has their name on the rental agrement, pays the rent and for their food, and decorates the home to their taste. Participates in preparing their meals and chooses what too eat.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Rates (Please see Appendix I-2 for more detail):

- Contracted Supported Living daily rates are negotiated regionally utilizing policy and standards developed by the Central Office ADSA/DDD cost reimbursement section and the Central Office DDD residential program manager. Final rates are based on residential support levels (assigned by the DDD assessment), specific support needs listed in the assessment, support provided by others (e.g., family members), and the number of people living in the household who can share the support hours. (4/1/08)
- State-Staffed Supported Living daily rates are established on a prospective basis by the ADSA/DDD cost reimbursement section. At the close of each year, a settlement calculation is prepared to recover additional federal funds, or to pay back funds previously received.

With the exception of state-staffed supported living services, payments are made directly from the DDD to the provider. For state-staffed supported living services, a prospective (daily) rate is established each year for each location (region) based on the projected costs and number of resident days for the ensuing fiscal year. The established rates are transmitted to the Office of Financial Recovery. OFR uses the daily reimbursement rates and the number of Medicaid eligible days at each location to recalculate the federal share of cost for each location. The OFR calculation report goes to the Office of Accounting Services and to ADSA. The fiscal unit at ADSA prepares a journal voucher to record the federal share under the federal funds appropriation in the FRS. Reported resident days and FFP claims are reconciled with the Office of Financial Recovery each month. At the close of each year, a settlement calculation is prepared to recover additional federal funds, or to pay back funds previously received.

State regulations stipulate:
(1) An individual may only receive a residential habilitation service from one provider type at a time.
(2) None of the following can be paid for under the Community Protection Waiver:
(a) Room and board;
(b) The cost of building maintenance, upkeep, improvement, modifications

or adaptations required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code;
(c) Activities or supervision already being paid for by another source;
(d) Services provided in an individual's parents' home unless they are receiving alternative living services for a maximum of six months to transition you from their parents' home into their own home.

(3) The following persons cannot be paid providers for residential habilitation services:
(a) The individual's spouse;
(b) the individual's natural, step, or adoptive parent unless the individual's parent is certified as a residential agency per chapter 388-101 WAC (ADSA administrative code concerning certified community residential services and support) or is employed by a certified or licensed agency qualified to provide residential habilitation services.
(4) The initial authorization of residential habilitation services requires prior approval by the DDD regional administrator or designee.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Contracted Supported Living
Agency	State Operated Living Alternatives (SOLA)

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency
Provider Type:
Contracted Supported Living
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Chapter 388-101 WAC (ADSA administrtive code concerning certified community residential services and support)
Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)
Frequency of Verification:
Every two years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency
Provider Type:
State Operated Living Alternatives (SOLA)
Provider Qualifications

License *(specify):*

Certificate *(specify):*
Chapter 388-101 WAC (ADSA administrative code concerning certified community residential services and support)
Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)
Frequency of Verification:
Every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

HCBS Taxonomy:

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

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

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

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

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

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

Before this therapy is offered as a waiver service, DSHS Form 13-734, Documentation of First Use of Medicaid Benefits, is used to document that clients have first accessed services to which they are entitled through the State Plan (including EPSDT).
State law stipulates:
"Occupational therapy" is the scientifically based use of purposeful activity with individuals who are limited by physical injury or illness, psychosocial dysfunction, developmental or learning disabilities, or the aging process in order to maximize independence, prevent disability, and maintain health. The practice encompasses evaluation, treatment, and consultation. Specific occupational therapy services include but are not limited to: Using specifically designed activities and exercises to enhance neurodevelopmental, cognitive, perceptual motor, sensory integrative, and psychomotor functioning; administering and interpreting tests such as manual muscle and sensory integration; teaching daily living skills; developing prevocational skills and play and avocational capabilities; designing, fabricating, or applying selected orthotic and prosthetic devices or selected adaptive equipment; and adapting environments for the handicapped. These services are provided individually, in groups, or through social systems.(An example of OT provided through a social system would be therapy provided in the home environment with the involvement of family members or providers. A goal would be to incorporate therapeutic activities into the individuals natural household routine.)

State law stipulates:
“Occupational Therapy” services must be provided by a person licensed to provide Occupational Therapy in the State of Washington. These requirements are comparable to the qualifications specified in 42 CFR 440.110 (concerning physical therapy, occupatoinal therapy, and services for individuals with speech, hearing and language disorders).

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

- Additional therapy may be authorized as a waiver service only after an individual has accessed what is available to her/him under Medicaid and any other private health insurance plan.
- The department does not pay for treatment determined by DSHS to be experimental;
- The department and the treating professional determine the need for and amount of service an individual can receive:
  - The department reserves the right to require a second opinion from a department selected provider.
  - The department will require evidence that the individual has accessed their full benefits through Medicaid and private insurance before authorizing this waiver service.

Unit rates for occupational therapy are negotiated by DDD regional staff on a provider-specific basis. All payments are made directly from the DDD to the provider of service.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Occupational Therapist
Individual	Occupational Therapist

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Occupational Therapist
Provider Qualifications
License *(specify):*
RCW 18.59.050 (State law concerning licensure requirements for occupational therapists)

Chapter 246-847 WAC (DOH administrative code concerning requirements for occupational therapists)
Certificate *(specify):*

Other Standard *(specify):*
RCW 18.59.060 (State law concerning examination requiremetns for occupational therapists)

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

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:
Occupational Therapist
Provider Qualifications
License *(specify):*
RCW 18.59.050 (State law concerning licensure requirements for occupational therapists)

Chapter 246-847 WAC (Department of Health-DOH-administrative code concerning requirements for ocupational therapists)
Certificate *(specify):*

Other Standard *(specify):*
RCW 18.59.060 (State law concerning examination requirements for occupational therapists)

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Physical therapy services are available through the waiver when a Medicaid provider is not available in the area in which a young adult lives or when the service is not covered due to medical necessity, but is determined

necessary for remedial benefit. An example of the need for PT as a waiver service would be to allow the therapy to be provided in the home. State plan services are provided in clinical settings and few providers are willing to come into the home to provide service. Individuals on the waiver often require or benefit more from therapy provided in the home with the inclusion of family members or providers due to high anxiety and challenging behavior that prevents them from accessing the clinical setting. In-home services offer the additional benefits of the natural environment which allows therapy to be incorporated into the individuals regular household routines.
State law stipulates:
"Physical Therapy" means the treatment of any bodily or mental condition of a person by the use of the physical, chemical, or other properties of heat, cold, air, light, water, electricity, sound massage, and therapeutic exercise, which includes posture and rehabilitation procedures; the performance of tests and measurements of neuromuscular function as an aid to the diagnosis or treatment of any human condition; performance of treatments on the basis of test findings after consultation with and periodic review by an authorized health care practitioner.

State law stipulates:
"Physical Therapy" services must be provided by a person licensed to provide this service in the State of Washington. These requirements are comparable to the qualifications specified in 42 CFR 440.110 (concerning physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders).

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

- Additional therapy may be authorized as a waiver service only after an individual has accessed what is available to him/her under Medicaid and any other private health insurance plan;
- The department does not pay for treatment determined by DSHS to be experimental;
- The department and the treating professional determine the need for and amount of service an individual can receive:
  - The department reserves the right to require a second opinion from a department selected provider.
  - The department will require evidence that the individual has accessed their full benefits through Medicaid and private insurance before authorizing this waiver service.

Unit rates for physical therapy are negotiated by DDD regional staff on a provider-specific basis. All payments are made directly from the DDD to the provider of service.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Physical Therapist
Agency	Physical Therapist

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Physical Therapist
Provider Qualifications
License *(specify):*
RCW 18.74.035 (State law concerning examination for a physical therapy license).

RCW 18.74.040 (State law concerning licensure of physical therapists).

Chapter 246-915 WAC (Deparment of Health-DOH-administrative code concerning requirements for Physical Therapists)
Certificate *(specify):*

Other Standard *(specify):*
RCW 18.74.030 (State law concerning minimum qualifcations to apply for licensure as a physical therapist).

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

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Physical Therapist
Provider Qualifications
License *(specify):*
RCW 18.74.035 (State law concerning examination for a physical therapy license).

RCW 18.74.040 (State law concerning licensure of physical therapists).

Chapter 246-915 WAC (DOH administrative code concerning requirements for Physical Therapists)
Certificate *(specify):*

Other Standard *(specify):*

RCW 18.74.030 (State law concerning minimum qualifications to apply for licensure as a physical therapist).

Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Extended State Plan Service

Service Title:
Speech, Hearing, and Language Services

HCBS Taxonomy:

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

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

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

State law stipulates:
"Speech-language pathology" means the application of principles, methods, and procedures related to the

development and disorders, whether of organic or nonorganic origin, that impede oral, pharyngeal, or laryngeal sensorimotor competencies and the normal process of human communication including, but not limited to, disorders and related disorders of speech, articulation, fluency, voice, verbal and written language, auditory comprehension, cognition/communication, and the application of augmentative communication treatment and devices for treatment of such disorders

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

State law stipulates:
“Speech-language pathology” and “Audiology” services must be provided by a person licensed to provide these services in the State of Washington. These requirements are comparable to the qualifications specified in 42 CFR 440.110 (concerning physical therapy, occupational therapy, and services for individuals with speech, hearing nad language disorders).

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

- Additional therapy may be authorized as a waiver service only after an individual has accessed what is available to her/him under Medicaid and any other private health insurance plan;
- The department does not pay for treatment determined by DSHS to be experimental;
- The department and the treating professional determine the need for and amount of service an individual can receive:
  - The department reserves the right to require a second opinion from a department selected provider.
  - The department will require evidence that the individual has accessed their full benefits through Medicaid and private insurance before authorizing this waiver service.

Unit rates for speech, hearing and language services are negotiated by DDD regional staff on a provider-specific basis. All payments are made directly from the DDD to the provider of service.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Audiologist
Provider Qualifications
License *(specify):*
RCW 18.35.080 (State law concerning certificates and licensure for speech-language pathologists and audiologists)
Certificate *(specify):*
WAC 246-828-095 (Department of Health-DOH-administratie code concenring audiology minimum standards of practice.)
Other Standard *(specify):*
RCW 18.35.040 (State law concerning licensure and examination for speech-language pathologists and audiologists).

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

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Speech-Language Pathologist
Provider Qualifications
License *(specify):*
RCW 18.35.080 (State law concerning certificates and licensure for speech-language pathologists and audiologists).
Certificate *(specify):*
WAC 246-828-105 (DOH administrative code concerning speech-language pathology—minimum standards of practice.)
Other Standard *(specify):*
RCW 18.35.040 (State law concerning licensure and examination for speech-language pathologists and audiologists).

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

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Audiologist
Provider Qualifications
License *(specify):*
RCW 18.35.080 (State law concerning certificates and licensure for speech-language pathologists and audiologists).
Certificate *(specify):*
WAC 246-828-095 (DOH administrative code concerning audiology minimum standards of practice.)
Other Standard *(specify):*
RCW 18.35.040 (State law concerning licesnure and examination for speech-language pathologists and audiologists).

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

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Speech-Language Pathologist
Provider Qualifications
License *(specify):*
RCW 18.35.080 (State law concerning certificates and licensure for speech-language pathologists and audiologists).
Certificate *(specify):*
WAC 246-828-105 (DOH administrative code concerning speech-language pathology—-Minimum standards of practice.)
Other Standard *(specify):*
RCW 18.35.040 (State law concerning licensure and examination for speech-language pathologists and audiologists).

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavior Support and Consultation

HCBS Taxonomy:

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

Service Definition *(Scope):*

Behavior support and consultation services provide individualized strategies and supports to promote positive behavior interactions between the individual and their family, friends, community and employer. Individualized behavioral strategies and supports are provided to family and/or providers to promote a consistent and effective ways of interacting and engaging the individual in their environment. Techniques, strategies and supports are implemented to promote effective communication skills and appropriate behaviors of the individual in order to get their needs met.

State regulations stipulate that:

(1)Behavior support and consultation may be provided to persons on any of the four HCBS waivers and include the development and implementation of programs designed to support waiver participants using:

(a) Strategies for effectively relating to caregivers and other people in the waiver participant's life; and

(b) Direct interventions with the person to decrease aggressive, destructive, and sexually inappropriate or other behaviors that compromise their ability to remain in the community (i.e., training, specialized cognitive counseling).

(2)Behavior support and consultation may also be provided as a mental health stabilization service.

These services are only covered under the Waiver when they are outside the definition of service available through the Medicaid State Plan and EPSDT or the child does not meet access to care definitions(i.e., via the Regional Support Networks). It is anticipated some Waiver clients will not be eligible for these services under the Medicaid State Plan, since an individual must have a mental health (MH) diagnosis to receive mental health State Plan services. A MH diagnosis is not a requirement for enrollment on the Waiver program.

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

State regulations stipulate that:
(1) DDD and the treating professional will determine the need and amount of service an individual will receive, subject to the limitations in subsection (2) below.
(2) DDD reserves the right to require a second opinion from a department selected provider.
(3) Behavior support and consultation not provided as a mental health stabilization service requires prior approval by DDD.

Unit rates are negotiated by DDD regional staff and are provider-specific. All payments are made directly from the DDD to the provider of service.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Registered or certified counselor
Individual	Physician assistant working under the supervision of a psychiatrist
Individual	Psychiatric advanced registered nurse practitioner (ARNP)
Individual	Psychiatrist
Agency	Behavior Management Provider
Individual	Behavior Management Provider with 5 years of experience serving individuals with developmental disabilities
Individual	Polygrapher
Individual	Marriage and family therapist
Individual	Mental health counselor
Individual	Social worker
Individual	Registered nurse (RN) or licensed practical nurse (LPN)
Individual	Psychologist
Individual	Sex offender treatment provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support and Consultation

Provider Category:
Individual

Provider Type:
Registered or certified counselor

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Chapter 246-810 WAC (DOH administrative code concerning requirements for counselors)
Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)
Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support and Consultation

Provider Category:
Individual

Provider Type:
Physician assistant working under the supervision of a psychiatrist

Provider Qualifications
License *(specify):*
Chapter 18.71A RCW (DOH administrative code concerning requirements for Physician Assistants)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)
Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support and Consultation

Provider Category:
Individual

Provider Type:
Psychiatric advanced registered nurse practitioner (ARNP)

Provider Qualifications
License *(specify):*
RCW 18.79.050 (DOH administrative code concerning “Advanced registered nursing practice” and exceptions)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support and Consultation

Provider Category:
Individual
Provider Type:
Psychiatrist
Provider Qualifications
License *(specify):*
Chapter 18.71 RCW (DOH administrative code concerning requirements for Physicians)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)
Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support and Consultation

Provider Category:
Agency
Provider Type:
Behavior Management Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
An agency could employee any of the individual provider types listed above and the employees must meet the qualifications listed.

Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)
Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support and Consultation

Provider Category:
Individual

Provider Type:
Behavior Management Provider with 5 years of experience serving individuals with developmental disabilities

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Five years experience serving individuals with Developmental Disabilities.

Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support and Consultation

Provider Category:
Individual

Provider Type:
Polygrapher

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support and Consultation

Provider Category:
Individual

Provider Type:
Marriage and family therapist

Provider Qualifications

License *(specify):*
Chapter 246-809 WAC (Department of Health-DOH-administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support and Consultation

Provider Category:
Individual

Provider Type:
Mental health counselor

Provider Qualifications

License *(specify):*
Chapter 246-809 WAC (DOH administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavior Support and Consultation

Provider Category:
Individual
Provider Type:
Social worker
Provider Qualifications
License *(specify):*
Chapter 246-809 WAC (DOH administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)
Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support and Consultation

Provider Category:
Individual
Provider Type:
Registered nurse (RN) or licensed practical nurse (LPN)
Provider Qualifications
License *(specify):*
Chapter 246-840 WAC (DOH administrative code concerning requirements for Practical and Registered Nursing)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)
Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support and Consultation

Provider Category:
Individual
Provider Type:
Psychologist

Provider Qualifications

License *(specify):*
Chapter 246-924 WAC (DOH administrative code concerning requirements for Psychologists)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support and Consultation

Provider Category:
Individual

Provider Type:
Sex offender treatment provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Chapter 246-930 WAC (DOH administrative code concerning requirements for Sex Offender Treatment Provider)

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Behavioral Health Stabilization Services - Behavior Support and Consultation

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Behavioral health stabilization services assist persons who are experiencing a behavioral health crisis. These services are available to individuals determined by behavioral health professionals or DDD to be at risk of institutionalization in a psychiatric hospital without one or more of the following services:
(1) Behavior support and consultation.
(2) Specialized psychiatric services;
(3) Behavioral health crisis diversion bed services

Per WAC 388-845-0500 Behavior Support and Consultation:
(1)Includes the development and implementation of programs designed to support waiver participants using:
a) Strategies for effectively relating to caregivers and other people in the waiver participant's life; and
b) Direct interventions with the person to decrease aggressive, destructive, and sexually inappropriate or other behaviors that compromise their ability to remain in the community (i.e., training, specialized cognitive counseling, development and implementation of a positive behavior support plan).

These services are provided to individuals who are experiencing a behavioral health crisis that overwhelms their family and current providers, placing them at risk of psychiatric hospitalization. Once the crisis situation is resolved and the individual is stabilized, behavior support and consultation as a component of behavioral health crisis stabilization services is terminated. Any need for ongoing behavior support and consultation is met under the stand-alone behavior support and consultation service category.

These services are only covered under the Community Protection Waiver when they are outside the definition of service available through the Medicaid State Plan and EPSDT or the youth does not meet access to care definitions (i.e., via the Regional Support Networks). It is anticipated some Community Protection Waiver clients will not be eligible for these services under the Medicaid State Plan, since an individual must have a mental health (MH) diagnosis to receive mental health State Plan services. A MH diagnosis is not a requirement for enrollment on the Community Protection Waiver.

DDD works closely with the Division of Behavioral Health and Recovery Services (DBHR) to prevent duplication of RSN/State Plan MH Services. DSHS's expectation is that any DDD eligible client who meets the DBHR access to care and medical necessity standards will receive mental health services through Regional Support Networks (RSNs) or Prepaid Inpatient Health Plans (PIHP). Individuals that do not meet access to care or medical necessity standards for the service type may be served under the crisis prevention and intervention contracts.
Most Medicaid mental health services in Washington are provided through a 1915-B waiver, which clarifies Access to Care criteria for those individuals needing more intensive mental health supports. Community mental health services through the waiver are provided through Regional Support Networks, which carry out the contracting for local mental health care. Access to Care criteria excludes the DSM diagnoses classes that include mental retardation; learning, motor skills and communication disorders; and pervasive developmental disorders. Individuals with primary diagnoses and functional impairments that are only a result of these diagnoses are not eligible for mental health waiver services. As a result, individuals with these issues must

display an additional covered diagnosis in order to be served through the mental health system, must be able to benefit from the intervention, and their unmet needs cannot be met more appropriately by another formal or informal system, such as the Division of Developmental Disabilities or community natural supports.

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

• Behavioral health stabilization services are intermittent and short-term.
• The duration and amount of services needed to stabilize the individual in crisis is determined by a mental health professional and/or DDD.
• Behavioral health stabilization services require prior approval by DDD or its designee.

"Short-term" reflects the fact that these services are not provided on an on-going basis. However, there is no pre-determined limit on the duration of these services. They are provided to individuals who are experiencing a behavioral health crisis and are at risk of psychiatric hospitalization. Once the crisis situation is resolved and the individual is stabilized, behavioral health crisis stabilization services will be terminated. Any ongoing need for behavior support and consultation will be met under the stand-alone behavior support and consultation services category.

Rates for privately contracted behavior support and consultation as a component of behavioral health stabilization services are negotiated by DDD regional staff with the Regional Support Network (RSN) and/or individual providers. Payments are made from the DDD to the RSN or individual provider of service.

Rates for state-operated behavior support and consultation as a component of behavioral health stabilization services are established on a prospective basis by the ADSA/DDD cost reimbursement section.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Sex Offender Treatment Provider (SOTP)
Individual	Physician Assistant working under the supervision of a psychiatrist
Individual	Registered or Certified Counselor
Agency	Behavior Support Agency Provider (State-Operated)
Individual	Marriage and Family Therapist
Individual	Psychiatric Advanced Registered Nurse Practitioner (ARNP)
Agency	Behavior Support Agency Provider (Privately Contracted)
Individual	Social Worker
Individual	Mental Health Counselor
Individual	Polygrapher
Individual	Registered Nurse (RN) or Licensed Practical Nurse (LPN)
Individual	Behavior Support Provider wiht five years of experience serving individuals with developmental disabilities.
Individual	Psychiatrist
Individual	Psychologist

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavioral Health Stabilization Services - Behavior Support and Consultation

Provider Category:
Individual
Provider Type:
Sex Offender Treatment Provider (SOTP)
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Chapter 246-930 WAC (DOH administrative code concenring requiremetns for Sex Offender Treatment Providers).
Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
EVery 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services - Behavior Support and Consultation

Provider Category:
Individual
Provider Type:
Physician Assistant working under the supervision of a psychiatrist
Provider Qualifications
License *(specify):*
Chapter 18.71A (State law concerning reuqirements for Physician Assistants).
Certificate *(specify):*
Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services - Behavior Support and Consultation

Provider Category:
Individual
Provider Type:
Registered or Certified Counselor
Provider Qualifications

License *(specify):*

Certificate *(specify):*
Chapter 246-810 WAC (DOH administrative code concerning requirements for counselors).
Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services - Behavior Support and Consultation

Provider Category:
Agency
Provider Type:
Behavior Support Agency Provider (State-Operated)
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
A state-operated agency (i.e., with state employees as staff) could employ any of the provider types listed and the employees must meet the qualifications listed.

Verification of Provider Qualifications

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services - Behavior Support and Consultation

Provider Category:
Individual
Provider Type:
Marriage and Family Therapist
Provider Qualifications

License *(specify):*
Chapter 246-809 WAC (DOH administratibe code concerning licensure for mental health counselors, marriage and family therapists, and social workers).
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services - Behavior Support and Consultation

Provider Category:
Individual

Provider Type:
Psychiatric Advanced Registered Nurse Practitioner (ARNP)

Provider Qualifications

License *(specify):*
RCW 18.79.050 (State law concerning "Advanced registered nursing practice" and exceptions).

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services - Behavior Support and Consultation

Provider Category:
Agency

Provider Type:
Behavior Support Agency Provider (Privately Contracted)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
A contracted agency could employee any of the provider types listed and the emplyees must meet the qualifications listed.

Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services - Behavior Support and Consultation

Provider Category:
Individual

Provider Type:
Social Worker

Provider Qualifications

License *(specify):*
Chapter 246-809 WAC (DOH administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers).

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services - Behavior Support and Consultation

Provider Category:
Individual

Provider Type:
Mental Health Counselor

Provider Qualifications

License *(specify):*
Chapter 246-809 WAC (DOH administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers).

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:

EVery 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services - Behavior Support and Consultation

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services - Behavior Support and Consultation

Provider Category:
Individual
Provider Type:
Registered Nurse (RN) or Licensed Practical Nurse (LPN)
Provider Qualifications
License *(specify):*
Chapter 246-840 WAC (DOH administrative code concerning requirements for Practical and Registered Nursing).
Certificate *(specify):*
Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services - Behavior Support and Consultation

Provider Category:
Individual

Provider Type:
Behavior Support Provider wiht five years of experience serving individuals with developmental disabilities.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Five years experience serving individuals with developmental disabilities.

Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services - Behavior Support and Consultation

Provider Category:
Individual

Provider Type:
Psychiatrist

Provider Qualifications

License *(specify):*
Chapter 18.71 RCW (State law concerning requirements for physicians).

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services - Behavior Support and Consultation

Provider Category:
Individual

Provider Type:
Psychologist

Provider Qualifications

License *(specify):*
Chapter 246-924 WAC (DOH administrative code concerning requirements for psychologists).

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Behavioral Health Stabilization Services - Behavioral Health Crisis Diversion Beds

HCBS Taxonomy:

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

Service Definition *(Scope):*

Per

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

WAC 388-845-1015, Behavioral health stabilization services assist persons who are experiencing a behavioral health crisis. These services are available to individuals determined by behavioral health professionals or DDD to be at risk of institutionalization in a psychiatric hospital without (one or more of) the following services:

- Behavioral health crisis diversion bed services
- Behavior support and consultation
- Specialized psychiatric services

Behavioral health crisis diversion bed services:
Are temporary residential and behavioral services that may be provided in a client's home or licensed or certified setting or in a setting staffed and operated by state employees. These services are available to eligible clients who are at risk of serious decline of mental functioning and who have been determined to be at risk of psychiatric hospitalization. These services also provide respite to the primary caregiver to promote the client's return to her/his home.

Most Medicaid mental health services in Washington are provided through a 1915-B waiver, which clarifies Access to Care criteria for those individuals needing more intensive mental health supports. Community mental health services through the waiver are provided through Regional Support Networks, which carry out the contracting for local mental health care. Access to Care criteria excludes the DSM diagnoses classes that include mental retardation; learning, motor skills and communication disorders; and pervasive developmental disorders. Individuals with primary diagnoses and functional impairments that are only a result of these diagnoses are not eligible for mental health waiver services. As a result, individuals with these issues must display an additional covered diagnosis in order to be served through the mental health system, must be able to benefit from the intervention, and their unmet needs cannot be met more appropriately by another formal or informal system, such as the Division of Developmental Disabilities or community natural supports.

These services are only covered under the Waiver when they are outside the definition of service available through the Medicaid State Plan and EPSDT or the child does not meet access to care definitions (i.e., via the Regional Support Networks). It is anticipated some Waiver clients will not be eligible for these services under the Medicaid State Plan, since an individual must have a mental health (MH) diagnosis to receive mental health State Plan services. A MH diagnosis is not a requirement for enrollment on the Waiver.

DDD works closely with the Division of Behavioral Health and Recovery Services (DBHR) to prevent duplication of RSN/State Plan BH Services. DSHS's expectation is that any DDD eligible client who meets the DBHR access to care and medical necessity standards will receive behavioral health services through Regional Support Networks (RSNs) or Prepaid Inpatient Health Plans (PIHP). Individuals that do not meet access to care or medical necessity standards for the service type may be served under the crisis prevention and intervention contracts.

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

- Behavioral health stabilization services are intermittent and short-term.
- The duration and amount of services needed to stabilize the individual in crisis is determined by a mental health professional and/or DDD.
- Behavioral health stabilization services require prior approval by DDD or its designee.

"Short-term" reflects the fact that these services are not provided on an on-going basis. However, there is no pre-determined limit on the duration of these services. They are provided to individuals who are experiencing a behavioral health crisis and are at risk of psychiatric hospitalization. Once the crisis situation is resolved and the individual is stabilized, behavioral health crisis stabilization services will be terminated. Any ongoing need for behavior support and consultation will be met under the stand-alone behavior support and consultation services category.

Rates for privately-contracted behavioral health crisis diversion bed services as a component of behavioral health stabilization services are negotiated by DDD regional staff with the Regional Support Network (RSN) and/or individual providers. Payments are made from the DDD to the RSN or individual provider of service.

Rates for state-staffed behavioral health crisis diversion bed services as a component of behavioral health stabilization services are established on a prospective basis by the ADSA/DDD cost reimbursement section. At

the close of each year, a settlement calculation is prepared to recover additional federal funds, or to pay back funds previously received.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Behavioral Health Stabilization-Behavior Health Crisis Diversion Beds (State-Operated)
Agency	Behavioral Health Stabilization- Behavioral Health Crisis Diversion Bed Services (Supported Living Agency)
Agency	Behavioral Health Stabilization- Behavioral Health Crisis Diversion Bed Services (Other department -certified agencies)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services - Behavioral Health Crisis Diversion Beds

Provider Category:
Agency
Provider Type:
Behavioral Health Stabilization-Behavior Health Crisis Diversion Beds (State-Operated)
Provider Qualifications
License *(specify):*

Certificate *(specify):*
State-operated providers of behavioral health crisis diversion bed services will be certified by Residential Care Services (RCS) of the Aging and Disabiliity Services Administration (ADSA) within the Department of Social and Health Services (DSHS).
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
State Operating Agency
Frequency of Verification:
Every 2 years.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavioral Health Stabilization Services - Behavioral Health Crisis Diversion Beds

Provider Category:

Agency

Provider Type:

Behavioral Health Stabilization- Behavioral Health Crisis Diversion Bed Services (Supported Living Agency)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Chapter 388-101 WAC (ADSA administrative code concerning requirements for certified community residential services and support)

Other Standard *(specify):*

Contract Standards

DDD Policy 15.04 (concerning standards for community protection residential services (applicable only if they serve CP clients).

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every two years

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavioral Health Stabilization Services - Behavioral Health Crisis Diversion Beds

Provider Category:

Agency

Provider Type:

Behavioral Health Stabilization- Behavioral Health Crisis Diversion Bed Services (Other department-certified agencies)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Chapter 388-101 WAC (ADSA administrative code concerning requirements for certified community residential services and support)

Other Standard *(specify):*

Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavioral Health Stabilization Services - Specialized Psychiatric Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

Behavioral health stabilization services assist persons who are experiencing a behavioral health crisis. These services are available to individuals determined by behavioral health professionals or DDD to be at risk of institutionalization in a psychiatric hospital without one or more of the following services:
(1) Behavior support and consultation.
(2) Specialized psychiatric services;
(3) Behavioral health crisis diversion bed services

Per WAC 388-845-1900, specialized psychiatric services:
(1) Are specific to the individual needs of persons with developmental disabilities who are experiencing mental health symptoms.

(2) Service may be any of the following:
a) Psychiatric evaluation,
b) Medication evaluation and monitoring,
c) Psychiatric consultation.

These services are only covered under the Waiver when they are outside the definition of service available through the Medicaid State Plan and EPSDT or the child does not meet access to care definitions (i.e., via the Regional Support Networks). It is anticipated some Waiver clients will not be eligible for these services under the Medicaid State Plan, since an individual must have a mental health (MH) diagnosis to receive mental health State Plan services. A MH diagnosis is not a requirement for enrollment on the Waiver.
DDD works closely with the Division of Behavioral Health and Recovery (DBHR) Mental Health Division to prevent duplication of RSN/State Plan MH Services. DSHS's expectation is that any DDD eligible client who meets the DBHR access to care and medical necessity standards will receive mental health services through Regional Support Networks (RSNs) or Prepaid Inpatient Health Plans (PIHP). Individuals that do not meet access to care or medical necessity standards for the service type may be served under the crisis prevention and

intervention contracts.
Most Medicaid mental health services in Washington are provided through a 1915-B waiver, which clarifies Access to Care criteria for those individuals needing more intensive mental health supports. Community mental health services through the waiver are provided through Regional Support Networks, which carry out the contracting for local mental health care. Access to Care criteria excludes the DSM diagnoses classes that include mental retardation; learning, motor skills and communication disorders; and pervasive developmental disorders. Individuals with primary diagnoses and functional impairments that are only a result of these diagnoses are not eligible for mental health waiver services. As a result, individuals with these issues must display an additional covered diagnosis in order to be served through the mental health system, must be able to benefit from the intervention, and their unmet needs cannot be met more appropriately by another formal or informal system, such as the Division of Developmental Disabilities or community natural supports.

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

- Behavioral health stabilization services are intermittent and temporary.
- The duration and amount of services needed to stabilize the individual in crisis is determined by a mental health professional and/or DDD.
- Behavioral health stabilization services require prior approval by DDD or its designee.

There is no pre-determined limit to the duration of these services. However, they are not provided on an on-going basis. They are provided to individuals who are experiencing a behavioral health crisis and are at risk of psychiatric hospitalization. Once the crisis situation is resolved and the individual is stabilized, behavioral health crisis stabilization services will be terminated. Any ongoing need for specialized psychiatric services will be met under the stand-alone specialized psychiatric services category.
Rates for specialized psychiatric services as a component of behavioral health stabilization services are negotiated by DDD regional staff with the Regional Support Network (RSN) and/or individual providers. Payments are made from the DDD to the RSN or individual provider of service.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	All individual provider types listed under Specialized Psychiatric Services.
Agency	All agency provider types listed under Specialized Psychiatric Services.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services - Specialized Psychiatric Services

Provider Category:
Individual

Provider Type:
All individual provider types listed under Specialized Psychiatric Services.

Provider Qualifications

License *(specify):*
Refer to provider qualifications under Specialized Psychiatric Services

Certificate *(specify):*
Refer to provider qualifications under Specialized Psychiatric Services

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating Agency

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Health Stabilization Services - Specialized Psychiatric Services

Provider Category:
Agency

Provider Type:
All agency provider types listed under Specialized Psychiatric Services.

Provider Qualifications

License *(specify):*
Refer to provider qualifications under Specialized Psychiatric Services.

Certificate *(specify):*
Refer to provider qualifications under Specialized Psychiatric Services.

Other Standard *(specify):*
Contract standards.

Verification of Provider Qualifications

Entity Responsible for Verification:
State Operating agency

Frequency of Verification:
Every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Community Transition

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**

Service Definition *(Scope):*

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

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

Community transition services are reasonable costs (necessary expenses in the judgment of the state for an individual to establish his or her basic living arrangement) associated with moving from an institutional setting, facility-based setting (e.g., group home, licensed staff residential), provider operated setting (e.g., companion home) or private residence (e.g., parents' home) to a community setting (i.e., their own residence) and receiving services from a DDD certified residential habilitation services provider.

- Community transition services include:
  - Security deposits (not to exceed the equivalent of two month's rent) that are required to obtain a lease on an apartment or home;
  - Essential furnishings such as a bed, a table, chairs, window blinds, eating utensils and food preparation items;
  - Moving expenses required to occupy and use a community domicile;
  - Set-up fees or deposits for utility or service access (e.g., telephone, electricity, heating); and
  - Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy.

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

Community transition services do not include:

- Diversional or recreational items such as televisions, cable TV access, VCRs, MP3, CD or DVD players
- Computers whose use is primarily diversional or recreational.
- Community transition services are available only to individuals that are moving from an institution, facility-based setting (e.g., group home, licensed staff residential), provider operated setting (e.g., companion home), or private residence (e.g., parents' home) to a community setting (i.e., their own residence).
- Rent assistance is not available as a community transition service.
- Expenditures above $1,500 for community transition are allowed only by exception.

Rates for community transition are based upon local housing (e.g., rent deposit) and utility costs and the specific needs of the individual (e.g., for furnishings). Payment for community transition costs are made to the provider of residential habilitation services, who in turn makes payment directly to the landlord, utility, furniture vendor.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Residential Habilitation Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition

Provider Category:
Agency
Provider Type:
Residential Habilitation Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Refer to provider types and qualifications listed under Residential Habilitation.
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)
Frequency of Verification:
Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Environmental Accessibility Adaptations

HCBS Taxonomy:

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

Service Definition *(Scope):*

- Environmental accessibility adaptations provide the physical adaptations to the home required by the individual's plan of care needed to:
  (a) Ensure the health, welfare and safety of the individual; or
  (b) Enable the individual who would otherwise require institutionalization to function with greater independence in the home.
- Environmental accessibility adaptations may include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or installing specialized electrical and/or plumbing systems necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual.

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

The following service limitations apply to environmental accessibility adaptations:

- Prior approval by DDD is required.
- Environmental accessibility adaptations or improvements to the home are excluded if they are of general utility without direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc.
- Environmental accessibility adaptations cannot add to the total square footage of the home.
- Environmental accessibility adaptations do not include fences.

Rates are based upon bids received by potential contracts. All payments are made directly from the DDD to the provider of service.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Registered Contractor
Agency	Registered Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Individual

Provider Type:
Registered Contractor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Chapter 18.27 RCW (State law concerning the registration of contractor)
Chapter 19.27 RCW (State law concerning the State Building Code)

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Agency

Provider Type:
Registered Contractor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Chapter 18.27 RCW (State law concerning the registration of contractor)
Chapter 19.27 RCW (State law concerning the State Building Code)

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Individualized Techical Assistance

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Individualized technical assistance is assessment and consultation to the employment provider and/or client to identify and address existing barriers to employment. This is in addition to supports received through supported employment services or pre-vocational services for individuals who have not yet achieved their employment goal.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
1) Individualized technical assistance cannot exceed 6 months in an individual's plan year.
2) The individual must be receiving supported employment or pre-vocational services.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	individualized Technical Assistance
Agency	Individualized Technical Assistance

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individualized Techical Assistance

Provider Category:
Individual
Provider Type:
individualized Technical Assistance
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards

As stipulated in DDD policy concerning ITA provider qualifications), all providers shall meet the following qualifications:
D. Service providers must meet the following qualifications:

1. Ability to comply with all contractual requirements.
2. Have proof of criminal history background clearance in accordance with RCW 43.43.830-845 and RCW 74.15.030.
DDD requires the DSHS Background Check Central Unit (BCCU) be used to obtain background clearances;
3. Exhibit ability to successfully develop and implement a plan for providing services related to the employment
barrier that is based on the individual needs;
4. Assurance that potential conflicts of interest will not arise. Such a conflict will arise when the Individualized
Technical Assistance provider is a guardian, a family member, a legal representative or other decision maker for the
client. In this situation, the provider must document the measures taken specific to the situation to assure that a
conflict of interest does not exist; and
5. Provide proof of training or have confirmed knowledge of the following areas as applicable:

a. Client confidentiality;
b. DDD Policy 5.06, Client Rights;
c. DDD Policy 6.08, Mandatory Reporting Requirements Services Providers;
d. DDD Policy 4.11, County Services for Working Age Adults;
e. DDD Policy 15.03, Community Protection Standards for Employment and Day Program Services;
f. DDD Policy 5.17, Physical Intervention Techniques;
g. DDD Policy 5.14, Positive Behavior Support; and
h. DDD Policy 5.15, Use of Restrictive Procedures.

Verification of Provider Qualifications

Entity Responsible for Verification:
County
Frequency of Verification:
Every 2 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individualized Techical Assistance

Provider Category:
Agency
Provider Type:
Individualized Technical Assistance
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

As stipulated in DDD policy concerning ITA provider qualifications), all providers shall meet the following qualifications:
D. Service providers must meet the following qualifications:

1. Ability to comply with all contractual requirements.
2. Have proof of criminal history background clearance in accordance with RCW 43.43.830-845 and RCW 74.15.030.
DDD requires the DSHS Background Check Central Unit (BCCU) be used to obtain background clearances;
3. Exhibit ability to successfully develop and implement a plan for providing services related to the employment
barrier that is based on the individual needs;
4. Assurance that potential conflicts of interest will not arise. Such a conflict will arise when the Individualized
Technical Assistance provider is a guardian, a family member, a legal representative or other decision maker for the
client. In this situation, the provider must document the measures taken specific to the situation to assure that a
conflict of interest does not exist; and
5. Provide proof of training or have confirmed knowledge of the following areas as applicable:

a. Client confidentiality;
b. DDD Policy 5.06, Client Rights;
c. DDD Policy 6.08, Mandatory Reporting Requirements Services Providers;
d. DDD Policy 4.11, County Services for Working Age Adults;
e. DDD Policy 15.03, Community Protection Standards for Employment and Day Program Services;
f. DDD Policy 5.17, Physical Intervention Techniques;
g. DDD Policy 5.14, Positive Behavior Support; and
h. DDD Policy 5.15, Use of Restrictive Procedures.

Verification of Provider Qualifications

Entity Responsible for Verification:
County

Frequency of Verification:
Every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:
Sexual Deviancy Evaluation

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

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

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

Sexual deviancy evaluations are professional evaluations of sexual deviancy to determine the need for psychological, medical or therapeutic services. Sexual deviancy evaluations are available in all four waivers.

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

State regulations stipulate that:

(1) General considerations in evaluating clients. Providers shall: (a) Be knowledgeable of assessment procedures used;(b) Be aware of the strengths and limitations of self-report and make reasonable efforts to verify information provided by the offender;(c) Be knowledgeable of the client's legal status including any court orders applicable. Have a full understanding of the SSOSA and SSODA process and be knowledgeable of relevant criminal and legal considerations;(d)Be impartial; provide an objective and accurate base of data; and (e) Avoid addressing or responding to referral questions which exceed the present level of knowledge in the field or the expertise of the evaluator.

(2) Scope of assessment data.

Comprehensive evaluations under SSOSA and SSODA shall include a compilation of data from as many sources as reasonable, appropriate, and available. These sources may include but are not limited to:(a) Collateral information (i.e., police reports, child protective services information, criminal correctional history and victim statements);(b) Interviews with the offender;(c)Interviews with significant others;(d) Previous assessments of the offender conducted (i.e., medical, substance abuse, psychological and sexual deviancy);(e) Psychological/physiological tests;(f) If a report fails to include information specified in (a) through (e) of this subsection, the evaluation should indicate the information not included and cite the reason the information is not included; and(g) Second evaluations shall state whether other evaluations were considered. The decision regarding use of other evaluations prior to conducting the second evaluation is within the professional discretion of the provider. The second evaluation need not repeat all assessment or data compilation measures if it reasonably relies on existing current information. The second evaluation must address all issues outlined in subsection (3) of this section, and include conclusions, recommendations and a treatment plan if one is recommended.

(3) Evaluation reports:(a) Written reports shall be accurate, comprehensive and address all of the issues required for court disposition as provided in the statutes governing SSOSA and SSODA;(b) Written reports shall present all knowledge relevant to the matters at hand in a clear and organized manner;(c) Written reports shall include the referral sources, the conditions surrounding the referral and the referral questions addressed; and(d) Written reports shall state the sources of information utilized in the evaluation. The evaluation and written report shall address, at a minimum, the following issues:

(i) A description of the current offense(s) including, but not limited to, the evaluator's conclusion about the reasons for any discrepancy between the official and offender's versions of the offenses;(ii) A sexual history, sexual offense history and patterns of sexual arousal/preference/interest;(iii) Prior attempts to remediate and control offense behavior including prior treatment;(iv) Perceptions of significant others, when appropriate, including their ability and/or willingness to support treatment efforts;(v) Potentiators of offending behavior to include alcohol and drug abuse, stress, mood, sexual patterns, use of pornography, and social and environmental influences;(vi) A personal history to include medical, marital/relationships, employment, education and military;(vii) A family history;(viii) History of violence and/or criminal behavior;(ix) Mental health functioning to include coping abilities, adaptational styles, intellectual functioning and personality attributes; and(x) The overall findings of psychological/physiological/medical assessment when such assessments have been conducted.

(e) Conclusions and recommendations shall be supported by the data presented in the body of the report and include:

(i) The evaluator's conclusions regarding the appropriateness of community treatment;

(ii) A summary of the clinician's diagnostic impressions;

(iii) A specific assessment of relative risk factors, including the extent of the offender's dangerousness in the community at large;

(iv) The client's amenability to outpatient treatment and conditions of treatment necessary to maintain a safe treatment environment.

(f) Proposed treatment plan shall be described in detail and clarity and include:

(i) Anticipated length of treatment, frequency and type of contact with providers, and supplemental or adjunctive treatment;

(ii) The specific issues to be addressed in treatment and a description of planned treatment interventions including involvement of significant others in treatment and ancillary treatment activities;

(iii) Recommendations for specific behavioral prohibitions, requirements and restrictions on living conditions, lifestyle requirements, and monitoring by family members and others that are necessary to the treatment process and community safety;

(iv) Proposed methods for monitoring and verifying compliance with the conditions and prohibitions of the treatment program; and

(v) If the evaluator will not be providing treatment, a specific certified provider should be identified to the court. The provider shall adopt the proposed treatment plan or submit an alternative treatment plan for approval by the court, including each of the elements in WAC 246-930-330 (5)(a) through (d)(DOH admin.code concerning standards and documentation of tx).

(4) The provider shall submit to the court and the parties a statement that the provider is either adopting the proposed tx plan or submitting an alternate plan. The plan and the statement shall be provided to the court before sentencing.

Rates for sexual deviancy evaluation services are provider-specific as negotiated by DDD regional staff. All payments are made directly from the DDD to the provider of the evaluation.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Sex Offender Treatment Provider
Individual	Certified Sex Offender Treatment Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Sexual Deviancy Evaluation

Provider Category:
Agency
Provider Type:
Certified Sex Offender Treatment Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Chapter 246-930 WAC (Department of Health-DOH-administrative code concerning requirements for sex offender treatment providers)
Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Sexual Deviancy Evaluation

Provider Category:
Individual

Provider Type:
Certified Sex Offender Treatment Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Chapter 246-930 WAC (DOH administrative code concerning requirements for sex offender treatment providers)

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Skilled Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**

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

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

Service Definition *(Scope):*
Skilled nursing is continuous, intermittent, or part time nursing services.
- Services include nurse delegation services provided by a registered nurse, including the initial visit, follow up instruction, and/or supervisory visits.
- Services listed in the plan of care must be within the scope of the State's Nurse Practice Act.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The following limitations apply to receipt of skilled nursing services:
- Skilled nursing services require prior approval by DDD.
- The department and the treating professional determine the need for and amount of service.

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

Nurse delegation is an intermittent service. The Registered Nurse Delegator is required to visit and provide supervision to the registered or certified nursing assistant (NAR/CNA) at least once every ninety (90) days. If providing diabetic training, the RND must visit the client at least once a week for the first four (4) weeks. However, the RND may determine that some clients need to be seen more often.

The hourly rate for skilled nursing services is negotiated by DDD regional staff on a provider-specific basis. All payments are made directly from the DDD to the provider of service.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	LPN Skilled Nursing
Individual	RN Skilled Nursing
Agency	RN Skilled Nursing
Agency	LPN Skilled Nursing

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:
Individual
Provider Type:
LPN Skilled Nursing

Provider Qualifications

License *(specify):*
Chapter 246-840 WAC (DOH administrative code concerning requirements for practical and registered nursing)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:
Individual

Provider Type:
RN Skilled Nursing

Provider Qualifications

License *(specify):*
Chapter 246-840 WAC (Department of Health-DOH-administrative code concerning reuqirements for practical and registered nursing)

Certificate *(specify):*

Other Standard *(specify):*
Contract standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:
Agency

Provider Type:
RN Skilled Nursing

Provider Qualifications

License *(specify):*
Chapter 246-840 WAC (DOH administrative code concerning requirements for practical and registered nursing)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:
Agency

Provider Type:
LPN Skilled Nursing

Provider Qualifications

License *(specify):*
Chapter 246-840 WAC (DOH administrative code concerning requiremetns for practical and registered nursing)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:

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

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

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

Service Definition *(Scope):*

- Durable and nondurable medical equipment not available through Medicaid or the state plan which enables individuals to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live.
- This service also includes items necessary for life support; ancillary supplies and equipment necessary to the proper functioning of such items.

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

The following limitations apply to the receipt of specialized medical equipment and supplies:

- Prior approval by the department is required for each authorization.
- The department reserves the right to require a second opinion by a department selected provider.
- Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the Medicaid state plan.
- Items must be of direct medical or remedial benefit to the individual and necessary as a result of the individual's disability.
- Medications, prescribed or nonprescribed, and vitamins are excluded.

All rates are based upon the usual and customary charges for the specialized medical equipment/supplies. All payments are made directly from the DDD to the provider of the specialized medical equipment/supplies.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medical Equipment Supplier (Agency)

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Medical Equipment Supplier (Agency)

Provider Qualifications

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

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

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

Service Title:
Specialized Psychiatric Services

HCBS Taxonomy:

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

Service Definition *(Scope):*
Specialized psychiatric services are specific to the individual needs of persons with developmental disabilities who are experiencing behavioral health symptoms.

- Service may include any of the following:
  (a) Psychiatric evaluation,
  (b) Medication evaluation and monitoring,
  (c) Psychiatric consultation.

DDD works closely with the Division of Behavioral Health and Recovery Services (DBHR) to prevent

duplication of RSN/State Plan MH Services. DSHS's expectation is that any DDD eligible client who meets the DBHR access to care and medical necessity standards will receive mental health services through Regional Support Networks (RSNs) or Prepaid Inpatient Health Plans (PIHP). Individuals that do not meet access to care or medical necessity standards for the service type may be served under the crisis prevention and intervention contracts.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Specialized psychiatric services are excluded if they are available through other Medicaid programs.

The rates for specialized psychiatric services are negotiated with providers on a client-specific basis and are at or below the DSHS standard rate. All payments are made directly from the DDD to the provider of specialized psychiatric services.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Psychiatrist
Individual	Physician Assistant
Individual	Advanced Registered Nurse Practitioner
Agency	Psychiatrist
Agency	Physician Assistant
Agency	Advanced Registered Nurse Practitioner

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Psychiatric Services

Provider Category:
Individual

Provider Type:
Psychiatrist

Provider Qualifications

License *(specify):*
Chapter 18.71 RCW (State law concerning requirements for Physicians)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Psychiatric Services

Provider Category:
Individual
Provider Type:
Physician Assistant
Provider Qualifications
License *(specify):*
Chapter 18.71A RCW (State law concerning requiremetns for Physician Assistants)
Certificate *(specify):*
Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)
Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Psychiatric Services

Provider Category:
Individual
Provider Type:
Advanced Registered Nurse Practitioner
Provider Qualifications
License *(specify):*
RCW 18.79.050 (State law concerning "Advanced registered nursing practice" and exceptions)
Certificate *(specify):*
Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)
Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Psychiatric Services

Provider Category:
Agency
Provider Type:
Psychiatrist
Provider Qualifications
License *(specify):*
Chapter 18.71 RCW (State law concerning requirements for Physicians)
Certificate *(specify):*
Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)
Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Psychiatric Services

Provider Category:
Agency
Provider Type:
Physician Assistant
Provider Qualifications
License *(specify):*
Chapter 18.71A RCW (State law concenring requirements for Physician Assistants)
Certificate *(specify):*
Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)
Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Psychiatric Services

Provider Category:
Agency
Provider Type:
Advanced Registered Nurse Practitioner
Provider Qualifications
License *(specify):*
RCW 18.79.050 (State law concenring "Advanced registered nursing practice" and exceptions)
Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Staff/Family Consultation and Training

HCBS Taxonomy:

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

Service Definition *(Scope):*
State regulations stipulate that:

- Staff/family consultation and training is professional assistance to families or direct service providers to help them better meet the needs of the waiver person.
- Consultation and training is provided to families, direct staff, or personal care providers to meet the specific needs of the waiver participant as outlined in the individual's plan of care, including:
  (a) Health and medication monitoring,
  (b) Positioning and transfer,
  (c) Basic and advanced instructional techniques,
  (d) Positive behavior support; and
  (e) Augmentative communication systems.

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

- Expenses to the family or provider for room and board or attendance, including registration, at conferences are excluded as a service under staff/family consultation and training.

Unit rates are negotiated by DDD regional staff and are provider-specific. All payments are made directly from the DDD to the provider of service.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Occupational Therapist
Individual	Mental health counselor
Individual	Marriage and Family Therapist
Individual	Licensed Practical Nurse
Individual	Speech/Language Pathologist
Individual	Sex Offender Treatment Provider
Individual	Registered Nurse
Individual	Physical Therapist
Individual	Audiologist
Individual	Certified American Sign Language Instructor
Individual	Nutritionist
Individual	Social Worker
Individual	Psychologist
Individual	Certified Recreation Therapist
Individual	Certified Dietician
Individual	Registered or Certified Counselor
Agency	Staff Famly Consultation Agency Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Individual

Provider Type:
Occupational Therapist

Provider Qualifications

License *(specify):*
Chapter 246-847 WAC (DOH administrative code concerning requirements for Occupational Therapists)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Individual

Provider Type:
Mental health counselor

Provider Qualifications

License *(specify):*
Chapter 246-809 WAC (DOH administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Individual

Provider Type:
Marriage and Family Therapist

Provider Qualifications

License *(specify):*
Chapter 246-809 WAC (DOH administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Individual

Provider Type:
Licensed Practical Nurse

Provider Qualifications

License *(specify):*
Chapter 246-840 WAC (Department of Health-DOH-administrative code concerning requirements for Practical and Registered Nursing)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Individual

Provider Type:
Speech/Language Pathologist

Provider Qualifications

License *(specify):*

Certificate *(specify):*
WAC 246-828-105 (DOH administrative code concerning requirements for Speech-language pathology-minimum standards of practice)

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Individual

Provider Type:
Sex Offender Treatment Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Chapter 246-930 WAC (DOH administrative code concerning requirements for Sex Offender Treatment Providers)

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Individual

Provider Type:
Registered Nurse

Provider Qualifications

License *(specify):*
Chapter 246-840 WAC (DOH administrative code concerning requirements for Practical and Registered Nursing)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Staff/Family Consultation and Training

Provider Category:
Individual
Provider Type:
Physical Therapist
Provider Qualifications
License *(specify):*
Chapter 246-915 WAC (DOH administrative code concerning requirements for Physical Therapists)
Certificate *(specify):*
Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)
Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Individual
Provider Type:
Audiologist
Provider Qualifications
License *(specify):*
Certificate *(specify):*
WAC 246-828-095 (DOH administrative code concerning Audiology minimum standards of practice)
Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)
Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Individual
Provider Type:
Certified American Sign Language Instructor
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Individual

Provider Type:
Nutritionist

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Chapter 18.138 RCW (State law concerning requirements for Dietitians and Nutritionists)
Chapter 246-822 WAC (DOH administrative code concerning requirements for Dietitians or Nutritionists)

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Individual

Provider Type:
Social Worker

Provider Qualifications

License *(specify):*
Chapter 246-809 WAC (DOH administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Individual

Provider Type:
Psychologist

Provider Qualifications

License *(specify):*
Chapter 246-924 WAC (DOH administrative code concerning requirements for Psychologist)

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Individual

Provider Type:
Certified Recreation Therapist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Social and Health Services (State Operating Agency)
Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Individual
Provider Type:
Certified Dietician
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Chapter 18.138 RCW (State law concerning requirements for Dietitians and Nutritionists)
Chapter 246-822 WAC (DOH administrative code concerning requirements for Dietitians or Nutritionists)
Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)
Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Individual
Provider Type:
Registered or Certified Counselor
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Chapter 246-810 WAC (DOH administrative code concerning requirements for counselors)
Other Standard *(specify):*
Contract Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)
Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation and Training

Provider Category:
Agency
Provider Type:
Staff Famly Consultation Agency Provider
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Other Standard *(specify):*
An agency could employee any of the provider types listed above and the employees must meet the qualifications listed.
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)
Frequency of Verification:
Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Transportation

HCBS Taxonomy:

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

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

Service Definition *(Scope):*
Reimbursement for transporting a participant to and from waiver funded services specified in the participant's Individual Support Plan. Waiver transportation services cannot duplicate other types of transportation available through the Medicaid State Plan, EPSDT, or included in a provider's contract. Waiver transportation is provided in order for the waiver participant to access a waiver service, such as summer camp (respite service), when without the transportation they would not be able to participate.

Waiver transportation is different from Personal Care transportation in that it does not provide transportation to and from shopping or medical appointments.

Whenever possible, the person will use family, neighbors, friends, or community agencies that can provide this service without charge.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The following limitations apply to transportation services:

- Transportation to/from medical or medically related appointments is a Medicaid State Plan transportation service and is to be considered and used first.
- Transportation is offered in addition to medical transportation but cannot replace Medicaid State Plan transportation services.
- Transportation is limited to travel to and from a waiver service.
- Transportation does not include the purchase of a bus pass.
- Reimbursement for provider mileage requires prior approval by DDD and is paid according to contract.
- This service does not cover the purchase or lease of vehicles.
- Reimbursement for provider travel time is not included in this service.
- Reimbursement to the provider is limited to transportation that occurs when the individual is with the provider.
- The individual is not eligible for transportation services if the cost and responsibility for transportation is already included in the waiver provider's contract and payment.

The rate per mile is based upon historical reimbursement of state staff for transportation to and from meetings. The rate per mile is based on the Collective Bargaining Agreement (CBA) with the State Employees International Union (SEIU).

All payments are made directly from the DDD to the provider of service.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Transportation Provider
Agency	Transportation Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:
Individual

Provider Type:
Transportation Provider

Provider Qualifications

License *(specify):*
Chapter 308-104 WAC (State administrative code concerning Drivers Licenses)

Certificate *(specify):*

Other Standard *(specify):*
Chapter 308-106 WAC (State administratie code concerning mandatory insurance to operate a vehicle)

Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:
Agency

Provider Type:
Transportation Provider

Provider Qualifications

License *(specify):*
Chapter 308-104 WAC (State administrative code concerning Drivers Licenses)

Certificate *(specify):*

Other Standard *(specify):*
Chapter 308-106 WAC (State administrative code concerning mandatory insurance to operate a vehicle)

Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social and Health Services (State Operating Agency)

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

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

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

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☑ **As an administrative activity.** *Complete item C-1-c.*

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

DDD Case Resource Managers conduct case management functions on behalf of waiver participants.

Appendix C: Participant Services

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

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

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

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

(a) Anyone who has unsupervised access to individuals with developmental disabilities and children. "Child" is defined as anyone under 18 years of age. This includes volunteers; students; interns; licensed, certified or contracted providers and their current or prospective employees; a person who is at least sixteen years old, is residing in a foster home, relatives home, or child care home and is not a foster child; a relative other than a parent who may be caring for a child; prospective adoptive parents; and state staff.

State and federal (FBI) background checks are required on all long-term care workers (as defined in RCW 74.39A.009) for the elderly or persons with disabilities hired or contracted after January 1, 2012.

(b) Searches are through Washington State Patrol; and persons living in Washington less than three years are required to have a fingerprint check through the FBI. The DSHS Background unit also checks Adult Protective Services and Department of Health registers.

(c) The entity responsible for retrieving this information is the DSHS/Background Check Centralized Unit (BCCU). It is up to the hiring authority to make a decision based on the information that they have received from the BCCU.

(d) Relevant state laws, regulations and policies are: RCW 43.43.830 (concerning backgorund checks for individuals with access to children or vulnerable persons), RCW 43.43.837 (concerning fingerprint-based background checks), RCW 74.15.030(c)(concerning background checks for those with unsupervised access to children or individuals with a developmental disability) , RCW 74.39A.056 (concerning criminal history checks on long-term care workers), WAC 388-06 (DSHS administrative code concerning background checks) and DSHS Administrative Policy 18.63 (concerning employee background checks).

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

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

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

(a) The entities responsible for maintaining the abuse registry:

Under state authority, RCW 26.44 (state law concerning abuse of children), Child Protective Services (CPS) within the Children's Administration (CA) of the Department of Social and Health Services (DSHS) is responsible for recieving and investigating reports of suspected child abuse and neglect.

Under state authority, RCW 74.34 (state law concerning abuse of vulnerable adults), the Aging and Disability Services Administration (ADSA) receives reports and conducts investigations of abuse, neglect, exploitation and abandonment for clients enrolled with the Division of Developmental Disabilities. ADSA Residential Care Services (RCS) investigates abuse and neglect occurring in nursing homes, assisted living facilities, adult family homes, & supported living programs. ADSA Adult Protective Services (APS) investigates abuse and neglect involving adults residing in their own homes. Both APS and RCS forward final findings of abuse, neglect and exploitation to the DSHS Background Check Central Unit (BCCU).

The BCCU enters the information into their database used to screen all names submitted for a background check.

(b) The types of positions for which abuse registry screenings must be conducted:

Pursuant to WAC 388-06-0110 (concerning who must have background checks) and RCW 74.15.030 (state law concerning the powers and duties of the Secretary of DSHS, including backgound checks), all DDD direct hires and direct contracts which may involve unsupervised access to children or people with developmental disabilities require a background check through the BCCU which includes abuse registry screening.

Prior to providing contracted waiver services, the DSHS requires screening of individuals through the BCCU which includes the abuse registry findings. Per RCW 74.39A.050(8)(state law concerning quality improvement of long-term care services), no provider or staff, or prospective provider or staff, entered into a state registry finding him or her guilty of abuse, neglect, exploitation, or abandonment of a minor or a vulnerable adult as defined in Chapter 74.34 RCW (state law concerning abuse of vulnerable adults) shall be employed in the care of and have unsupervised access to vulnerable adults.

(c) The process for ensuring that mandatory screenings have been conducted:

As part of the background check process, the BCCU cross-checks all potential employees with a CA database that contains information on all individuals with a "found finding" of child abuse and/or neglect. DDD does not directly hire or contract with any provider that may have unsupervised contact with a child or vulnerable adult until a background check is cleared and placed into the individual’s file (DDD Policy 5.01, Background Checks). Contracted agency providers are required to conduct background checks on all of their employees, including all administrators, employees, volunteers, and subcontractors who may have unsupervised access to clients, pursuant to WAC 388-101-3250 (concerning background checks for the staff of certified provides of

community residential services and supports) and RCW 43.43.830 (which is state law covering the Washington State Patrol which concerns background checks for those with access to children or vulnerable adults). This is checked again by the state during contract renewal no less than every 3 years.

Appendix C: Participant Services

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

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

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

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

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

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

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

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

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

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

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

As described in Washington Administrative Code Chapter 388-845:
The following limitations apply to providers for waiver services:
(1) The client's spouse cannot be their paid provider for any waiver service.
(2) The client's natural, step, or adoptive parent cannot be their paid provider for any waiver service with the exception of:
(a) Transportation to a waiver service; or
(b) Residential Habilitation services per WAC 388-845-1510 if their parent is certified as a residential agency per chapter 388-101 WAC.

The following controls are in place to ensure payments are made only for services rendered:
- Annual Individual Support Plans
- CRM monitoring of plan
- Annual ISP audits
- Supervisory file reviews
- National Core Indicator interviews
- Individual Support Plan surveys

To ensure the safety of waiver participants the state instructs Case Managers to locate a third party to supervise providers when the provider is a guardian.

Other policy.

Specify:

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

The State of Washington allows for continuous open enrollment of most qualified providers. Provider qualifications are available to the public on-line per Washington Administrative Code (WAC). Waiver enrollees may select qualified providers at any time during the waiver year. Most providers may enroll at any time during the year.

As specified in Washington Administrative Code (WAC) 388-101-4000 (Community Protection-Staff training), the community protection residential habilitation service provider must ensure that community protection program staff receive training specific to:
(1) Community protection within ninety calendar days of working with a community protection client; and
(2) The needs, supports, and services for clients to whom they are assigned.

Counties must solicit providers a minimum of every four years by issuing a request for interest (RFI), and if responses are received, a request for qualification (RFQ). Some counties allow continuous open enrollment of providers.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
a.i.a.1: The percentage of waiver service providers requiring licensure, which initially met and continued to meet contract standards, which includes appropriate licensure. Numerator= All waiver service providers that met contract standards, including licensure. Denominator= All waiver service providers that require licensure.

Data Source (Select one):
Other
If 'Other' is selected, specify:
All Contracts Database (ACD)

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
a.i.a.2 The percentage of waiver supported living providers requiring certification, who initially met and continued to meet DDD contract standards, which include appropriate certification. Numerator= All supported living providers that met certification standards. Denominator= All supported living providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Verification of provider certification in Residential Care Services (RCS) database.

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

		Confidence Interval =
☑ **Other** Specify: DDD Residential Program Managers.	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.b.1(a): The percentage of waiver files reviewed for which all authorized providers met DDD contract standards. Numerator= All files reviewed for which 100% of authorized providers met contract standards. Denominator= All files reviewed for compliance with contract standards.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Compliance and Control Team within DDD.	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
a.i.b.1(b): The percentage of non-licensed/non-certified waiver service providers who initially met and continued to meet DDD contract standards. Numerator= All non-licensed/non-certified waiver service providers who initially met and continued to meet DDD contract standards. Denominator= All non-licensed/non-ceertified waiver service providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
All Contracts Database (ACD)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
a.i.c.1(a): The percentage of cae file reviews, for which authorized providers met state training requirements as verified by valid licenses and contracts. Numerator= Files reviewed for which an authorized provider met state training requirements. Denominator= All files reviewed.

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

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

		☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Control and Compliance Team within DDD	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
a.i.c.1(b): The percentage of licensed waiver service providers who meet state training requirements as verified by valid licenses and contracts. Numerator= Waiver service providers requiring licensure who meet state training requirements. Denominator= Waiver service providers requiring licensure and training.

Data Source (Select one):
Other
If 'Other' is selected, specify:
All Contracts Database (ACD)

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

Data Aggregation and Analysis:

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

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

Performance Measure:
a.i.c.2: The percentage of waiver service providers who don't require licensure who meet state training requirements as verified by valid contracts. Numerator= All providers of waiver services who don't require licensure who meet state training requirements as verified by valid contracts. Denominator= All providers of waiver services who don't require licensure.

Data Source (Select one):
Other
If 'Other' is selected, specify:
All Contracts Database (ACD)

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
a.i.a.1; and a.i.b.1(b): The Contracts Program Manager produces an annual report comparing claims data against the All Contracts Database (ACD) to verify that providers of service to all clients meet contract standards, including licensure and other requirements, as verified by a valid contract.

a.i.a.2: The Residential Program Manager verify annually that that supported living providers have current certification based on Residential Care Services (RCS) records of provider certification.

a.i.b.1(a) and a.i.c.1(a): The QCC Team completes an audit of randomly selected files on a waiver-specific basis across a two-year period. The list for the QCC Team audit is generated to produce a random sample representative of each waiver with a 95% confidence level and a confidence interval of +/-5%. The findings from these reviews are collected in a database. All findings are expected to be corrected within 90 days. Corrections are monitored by QCC Team members.

As a part of the QCC audit, the team checks to see that providers of service to waiver participants continue to meet contract standards, which include appropriate licensure, certification and other standards, as verified by a valid contract in the Enterprise All Contracts Data Base.

a.i.c.1(b) and a.i.c.2: DDD maintains provider contract records in the All Contracts Database (ACD) that verifies providers have met ongoing training requirements prior to contract renewal. ACD reports are run annually to verify completion of training requirements.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Contracts Reports:
a.i.a.1; a.i.b.1(b); a.i.c.i(b); and a.i.c.2:
The results of the annual report comparing claims data against the ACD are shared with the regions for immediate follow up. Providers without a valid contract or the necessary training requirements are reviewed to determine the appropriate course of contract action. Services are terminated for those without valid contracts.

a.i.a.2: The results of the annual review comparing RCS certification records with support living provider contracts are shared with the regions for immediate follow up. Contracts for providers without current certification are terminated and immediate action is implemented for the provider to obtain certification.

Waiver File Reviews (Annual QCC audit):
a.i.b.1(a) and a.i.c.1(a):
First, Individual findings are expected to be corrected within 90 days. Regional management and QCC are available to provide individualized support and assistance with these corrections. QCC staff monitors to ensure corrections occur.

Next, findings are analyzed by management. Based on the analysis, additional necessary steps are taken. For example:

- Annual Waiver Training curriculum is developed in part to address audit findings
- Policy clarifications occur as a result of audit findings.
- Analyses of findings assist regions to recognize personnel issues.
- Analysis of audit finding may impact format and instructions on forms.
- Analysis of findings has led to revision in Waiver WAC to clarify rule.
- Analysis of findings has led regions to revise regional processes.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

- **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- **Applicable** - The State imposes additional limits on the amount of waiver services.

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

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

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

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

The amount of employment support will be based on the following items (across all waivers):
Client Employment Acuity is determined through the DDD assessment. Acuity reflects conditions typically related to the individuals disability that are not likely to change, and are generally not impacted by outside factors. Client acuity is determined as either “High”, “Medium” or “Low” as defined within WAC 388-828.

Support level High –
- Requires support in the community at all times to maintain health and safety.
- Experiences significant barriers to employment or community participation.
- Requires frequent supervision, training, or full physical assistance with community activities most or all of the time.

Support Level Medium -
- Independent in the community some of the time and requires moderate support to obtain or maintain employment.
- Able to maintain health and safety in the community for short periods of time.
- May need some supervision, training, or partial physical assistance with community activities.
- May need regular monitoring or prompting to perform tasks.

Support Level Low –
- Generally independent in the community and requires minimal support to obtain or maintain employment.
- Able to communicate with others effectively and can maintain personal health and safety most of the time without supervision.
- May be able to independently transport self in the community and does not require physical assistance in community activities.
- Able to perform tasks with minimal or occasional monitoring or prompting.

Employment Algorithm Components
A combination of the following acuity scales and assessment items provided the most accurate determination of a person's employment acuity level:
- Activities of Daily Living (See WAC 388-828-5460 & WAC 388-828-5480)
- Behavioral Support (See WAC 388-828-5640)
- Interpersonal Support (See WAC 388-828-5800 & WAC 388-828-5820)
- Environmental Support (See Draft WAC 388-828-9230 & WAC 388-828-9235)
- Level of Monitoring (See WAC 388-828-5060(1))
- Employment Support (See WAC 388-828-4260 & WAC 388-828-9260)
- Completing tasks with acceptable speed (See WAC 388-828-5800 & WAC 388-828-9255)
- Completing tasks with acceptable quality (See WAC 388-828-5800 & WAC 388-828-9260)
- Medical Support (See WAC 388-828-5700)
- Seizure support (See Draft WAC 388-828-9270 & WAC 388-828-9275)

2. Client work history is determined by looking back over a 12-month period and is categorized into three main
groupings:
- Continuous Employment – Received wages 9 consecutive month of the 12-month period
- Intermittent/Recent Employment – Received wages in at least one month of the 12-month period
- Not employed or unemployed last 12 months – No wages reported as earned during a 12-month period (subminimum wages fall to not employed)

The range of support hours the client receives will be dependent upon the individuals Employment Acuity, work history and phases of employment

☐ **Other Type of Limit.** The State employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

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

1. Washington State submitted their Statewide Transition Plan for New HCBS Rules on March 6th, 2015. In the Transition Plan, the state documented the results of the state assessment of HCBS settings. From the Transition plan:

"ALTSA and DDA reviewed the requirements for HCBS settings and identified settings that fully comply with the

requirements, settings that will comply with the requirements after implementing changes, and settings that do not or cannot meet the HCBS requirements. The review included (1) an analysis of (a) state laws, (b) rules, (c) policies, (d) processes, and (e) forms/tools in relation to the new federal HCBS requirements and (2) an identification of changes that are necessary to achieve and maintain compliance with the federal HCBS requirements. The state solicited input from the state Long-Term Care Ombuds, stakeholders, and clients as part of this analysis. The state conducted on site visits of all adult day service centers, all settings presumed to be institutional, all group training homes, and one residential setting identified by a stakeholder as potentially not meeting the characteristics of an HCB setting. The review details are in the appendices."

As a result of that analysis, the following services for Community Protection Waiver participants were determined to involve settings that fully comply with the CMS requirements for a HCB setting: (1) supported living; (2) individual supported employment work sites; (3) group supported employment work sites; (4) community healthcare providers; (5) dental providers; (6) behavioral health crisis bed diversion services; (7) specialized psychiatric services; (8) behavior support and consultation; and (9) transportation providers.

Each setting was evaluated against the HCBS characteristics including: (1) The setting is integrated in, and supports full access of individuals receiving Medicaid HCBS to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS; (2) The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting; (3)An individual's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected; (4) Individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented; (5) Individual choice regarding services and supports, and who provides them, is facilitated; (6) Individuals have a choice of roommates in the setting; (7) Individuals have the freedom to furnish and decorate their sleeping or living units; (8) Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time; (9) Individuals are able to have visitors of their choosing at any time; (10) The setting is physically accessible to the individual; (11) The unit or room is a specific physical place that can be owned, rented or occupied under another legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law of the State, county, city or other designated entity.

2. The State reviews these settings at least annually during the LOC assessment to ensure that services are being delivered in an environment that meets State and federal HCB setting requirements.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Individual Support Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the State**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☑ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

  Specify qualifications:

- ☐ **Social Worker**

  Specify qualifications:

- ☐ **Other**

  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Approximately 60 days prior to the Individual Support Plan the CRM contacts the individual and his/her representative by phone and letter.

During the phone conversation the CRM describes the Individual Support Plan process and confirms per policy 5.02 (Necessary Supplemental Accommodation) the individual has an identified representative. In addition, the individual is asked who else they would like to have participate and/or contribute.

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Individual Support Plan (ISP) is the planning document produced for all clients receiving paid services, including waiver clients.

The DDD Assessment provides:

- An integrated, comprehensive tool to measure support needs for adults and children.
- An improved work process to support case management services because the system:
  - o Identifies the level of support needed by a client;
  - o Indicates whether a service level assessment is needed; and
  - o Identifies a level of service to support the client's assessed need.
- Detailed information is gathered regarding client needs in many life domains. This allows CRM's to make more effective service referrals.
- Health and welfare needsidentified in the assessment automatically populate the ISP as needs that must be addressed.
- Clearer information for executive management and legislators on the overall needs of people with developmental disabilities.
- A nationally normed assessment for adults developed by the AAMR.

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

- The Individual Support Plan (ISP) is developed by the DDD Case-Resource Manager (CRM)
- Participants or contributors to this plan consist of:
  - o The individual,
  - o Their legal representative (if applicable),
  - o Providers, and
  - o Anyone else the individual would like to have participate or contribute (family, friends, etc…)
- The ISP is completed at least once every 12 months. Planning for the ISP begins 60 days in advance of the due date.

(b) The types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status.

- The DDD Assessment which is administered by the DDD CRM provides the internal assessment and contains the following modules which assess for participant needs preferences, goals and health status:

1. The Support Assessment module contains:
   a. The Supports Intensity Scale Assessment (which includes the ICF/ID Level of Care for individuals age 16 and above);
   b. ICF/ID Level of Care Assessment for individual age 15 and under;
   c. Protective Supervision Scale;
   d. Caregiver Status Scale;
   e. Current Services Scale;
   f. SIS Behavior Scale; and
   g. SIS Medical Scale.

2. The Service Level Assessment module contains:
   a. Personal Care assessment tool;
   b. Employment Support Assessment tool;
   c. Sleep Assessment tool; and
   d. Mental Health Assessment tool;
   e. Equipment tool;
   f. Medication Management tool;
   g. Medication tool;
   h. Seizure & allergies tool.

3. The Individual Support Plan module contains:

a. Service Summary tool;
b. Support Needs tool;
c. Finalize Plan tool;
d. Environmental Plan tool;
e. Equipment tool;
f. DDD Referral tool;
g. Plan review tool;
h. Supported Living Rate Calculator;
i. Foster Care Rate Assessment Calculator.

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

(c) How the participant is informed of the services that are available under the waiver.

Participants are informed of services available under the Waiver by:

1. The DDD HCBS Waiver Brochure and Waiver "Facts" which is enclosed with the letter confirming the ISP meeting. The letter, Fact sheet and brochure are sent approximately 60 days prior to the ISP meeting. The DDD HCBS Waiver Brochure identifies waiver services.
2. During the course of the ISP meeting service options are discussed and described.
3. Washington Administrative Code (WAC) fully defines services available under the waiver and is made available upon request and via the DDD internet Website

(d) The plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences.

- Participant goals:
  - o There is a screen in the DDD assessment that allows for the documentation of participant goals.
- Participant needs (including health care needs):
  - o Health and welfare needs are identified throughout the course of the assessment on multiple screens (please see section b above). Health and welfare needs are also identified by additional documentation submitted as part of the ISP process (i.e. medical reports).
- Preferences:
  - o Participant preferences are identified as requests for service. This is documented in the body of the assessment as well as in the ISP.

(e) How Waiver and other services are coordinated:

Waiver and other services are coordinated by the CRM

- Services identified to meet health and welfare needs are documented in the ISP.
- Providers receive a copy of the ISP. This assists them to not only understand their role in the individual's life but also the supports others are giving.
- The CRM monitors the ISP to ensure health and welfare needs are being addressed as planned.

(f) How the plan development process provides for the assignment of responsibilities to implement and monitor the plan.

- The assessment identifies health and welfare needs.

o The identified needs populate the ISP.
- Business rules require each identified need is addressed.
o When an identified need requires a Waiver funded service the CRM is required to identify the specific provider and the service type that will address this need.
- The CRM is required to provide sufficient documentation to allow the provider and the participant to know what the provider responsibilities are.
o When a provider or service has not been identified the plan reflects the steps in place to identify either the service or the provider.
- When the service or provider is identified the ISP is amended to reflect the updated plan.

• The CRM provides oversight and monitoring of the ISP.

(g) How and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

• Per WAC 388-845-3075:
o An individual may request a review of his/her plan of care at any time by calling his/her case manager. If there is a significant change in conditions or circumstances, DDD must reassess the plan and amend the plan to reflect any significant changes. This reassessment does not affect the end date of the annual ISP.

• Updates or amendments to the currently effective version of the Individual Support Plan (ISP) are tracked in the system.
o When a Service Level Assessment is moved from Pending to Current status, the ISP version attached to that assessment will lock (so a record is kept of the version that the client/representative has signed off on).
o Amendments do not change the Plan Effective date.

• Each subsequent change to the ISP is saved. There are two types of amendments—those that require a new Service Level Assessment and those that do not. Examples would be:
ISP Amendment With New Assessment
o Change in status of client in key domain (behavior, medical, caregiver, ADL, etc.)
o Change of provider for residential service (the client physically moves)
o Change in a paid service

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Risk Assessment and Mitigation occurs via the DDD Assessment and ISP. The DDD assessment takes a comprehensive approach to assessing for risk and provides a mechanism for allowing the case manager and the individual to identify risks and develop a strategy to mitigate identified risk.

Health, welfare and safety needs are evaluated throughout the Support Assessment and Service Level Assessment modules in the DDD Assessment. They are then addressed in planning via formal referrals, authorized paid DDD Services and other documented support activities in the ISP.

The DDD Assessment evaluates risk by assessing for the following:
- Unstable/potentially unstable diagnosis
- Caregiver training required
- Medication regimen affecting plan
- Immobility issues affecting plan
- Nutritional status affecting plan
- Current or potential skin problems
- Skin Observation Protocol
- Alcohol/Substance Abuse
- Depression
- Suicide
- Pain
- Mental Health
- Legal
- Environmental
- Financial
- Community Protection
    - Community Protection criteria have been developed to identify clients not already on the CP waiver, but who are exhibiting some extreme behaviors that could pose a public safety threat.

When risk areas are identified they populate a “referral” screen in the ISP. The CRM documents the plan/response to each item that populates the referral screen.

Emergency planning is an expected component of the ISP. Back up caregivers and emergency contacts are identified during the client's assessment and can be updated at any time. Back up and emergency plans are required in WAC for all residential providers. Arrangements for back-up plans vary from individual to individual. In some situations a back-up plan may be a family member. In others, a back up plan may include a paid provider stepping in to assure health and welfare needs are addressed during times of crisis. The client always has the choice of an ICF/ID if he/she feels needs are not being met in the community.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Participants will be given free choice of all qualified/approved providers of each service approved in his/her plan. During the course of the ISP process the participant is advised they have a choice of providers. The assessment meeting includes an Asessment Wrap-up checklist that the client and/or her/his representative signs. One of the items on the checklist is a statement verifying that the individual understands that s/he has a choice of and can change provider(s).

The CRM/Social Service Specialist will provide information to access appropriate referral registries, contract database list and/or websites to facilitate access to provider lists and assist with the contracting process.

Other Provider types

o Lists of provider of specific services can be generated out of the Agency Contracts Data Base (ACD) maintained by DSHS. Provider recruitment is ongoing and contract referrals are accepted on a continual basis.

* DDD Internet page maintains a supported living provider locator.
* Contractors for Environmental Adaptations are listed by Labor & Industries, along with information about

their license and any actions taken against them. Families may choose from this broad list of contractors and refer to DDD for contracting. DDD also maintains a list of contractors.

* Provider One maintains an online search engine open to the public for providers of therapy, counseling, and other services.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

DDD has a comprehensive audit process. In addition, DDD participates in the National Core Indicators Survey and initiates an ISP survey. Data is gathered and analyzed and necessary steps are taken to correct areas of concern.

DDD audit process:
There are two opportunities throughout the course of a year for files to be reviewed. The same standard protocol is used for each review. All files reviewed are selected by random sampling. Supervisors review one file per ternary period per CRM. The QCC team completes an annual audit of randomly selected files. The list for the annual QCC team audit is generated to produce a random sample with a 95% confidence level and a +/- 5 confidence interval.

The findings from these reviews are collected in a database. All findings are expected to be corrected within 90 days. Corrections are monitored by QCC. Findings are analyzed by management. Based on the analysis necessary steps are taken.
For example:

- Annual Waiver Training curriculum is developed in part to address audit findings
- Policy clarifications occur as a result of audit findings.
- Analyses of findings assist regions to recognize personnel issues.
- Analysis of audit finding may impact format and instructions on forms
- Analysis of findings has led to revision in Waiver WAC to clarify rule.
- Analysis of findings has led regions to revise regional processes.

The National Core Indicators Survey:
Washington State’s Division of Developmental Disabilities (DDD) participates in a national study that assesses performance and outcome indicators for state developmental disabilities service systems. This study allows the division to compare its performance to service systems in other states and within our state from year to year.

There are currently 60 performance and outcome indicators to be assessed covering the following domains:

- Consumer Outcomes
- System Performance
- Health, Welfare, & Rights
- Service Delivery System Strength & Stability

In addition, DDD has added some waiver specific questions to assist with assuring ISPs are implemented as written and that health and welfare needs are being addressed. Findings are analyzed by management and shared with stakeholders. The Washington State Developmental Disabilities Council (DDC) participates in the survey process-both in visiting clients and analyzing results.

ISP Survey:
An Assessment Meeting Wrap-up form is given to each waiver participant at the conclusion of the ISP planning meeting. This form gives participants an opportunity to respond to a series of questions about the ISP process.

A ISP Meeting survey is mailed to waiver participants within one month of the ISP planning meeting. This survey gives participants an opportunity to respond to a series of questions about the ISP process. The survey is mailed from Central Office based on a random sample representative of each waiver with a 95% confidence level and a confidence interval of +/-5%. Information collected is analyzed annually at the Waiver Oversight Committee.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

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

Specify:

Copies of the signed ISP are kept in the client files, which are maintained in the DDD regional offices.

Electronic copies of the ISP are maintained in the CARE platform.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

The regional DDD Case Resource Manager (CRM) provides the primary oversight and monitoring of the ISP. The DDD CRM authorizes the Waiver Services identified as necessary to meet health and welfare needs in the ISP. The DDD CRM monitors service provision no less than two times per year. Service provision is monitored by at least one face to face client visits and an additional contact with the client/legal representative which can be completed by telephone or face to face. Continuous monitoring also occurs by contacting providers; reviewing progress reports submitted by providers and reviewing additional assessments (e.g. IEP's, psychological evaluations, Occupational Therapy evaluations etc..). If the DDD CRM finds that the ISP is not meeting the individual's needs the ISP will be revised/amended. All monitoring is documented in the Service Episode Record section of the electronic DDD Assessment.

At the time of the annual review, the CRM is required to review the effectiveness of last year's plan with the

individual and/or their legal representative. This review is a required step before the DDD Assessment will allow the CRM to create a new assessment. All plans are expected to address emergency preparedness such as: back-up caregivers, evacuation plans, what to do in case of natural disaster etc. The plan review process provides an opportunity to review the effectiveness of these plans.

In addition to DDD CRM monitoring activities, the following activities occur:
- Sampling of waiver case files are reviewed by Quality Control Coordinators and DDD supervisors.
  - o Quality Control Coordinators review annually a statewide audit of a random sample of waiver files.
  - o DDD Supervisor complete one waiver file review per DDD Case Resource Manager/Social Service Specialist per ternary period.

Specifically, waiver case files are reviewed for the following evidence:
- The ISP was completed within 12 months.
- The individual was given a choice between waiver services and institutional care.
- The client meets ICF/ID level of care.
- The client meets disability criteria.
- The client is financially eligible.
- All of the identified health and welfare needs have been addressed in the ISP.
- Services have been authorized in accordance with the service plan.
- Waiver services or appropriate monitoring activities are occurring every month.
- All authorized services are reflected in the plan.
- All providers are qualified to provide the services for which they are authorized.
- The client was given a choice of qualified providers.
- Appeal rights and procedures have been explained.

The National Core Indicators Survey (NCI) face to face interviews :
Washington State's Division of Developmental Disabilities (DDD) participates in a national study that assesses performance and outcome indicators for state developmental disabilities service systems. This study allows the division to compare its performance to service systems in other states and within our state from year to year.

There are currently 60 performance and outcome indicators to be assessed covering the following domains:
- Consumer Outcomes
- System Performance
- Health, Welfare, & Rights
- Service Delivery System Strength & Stability

In addition, DDD has added some waiver specific questions to assist with assuring ISPs are implemented as written and that health and welfare needs are being addressed.

Examples of waiver specific questions:
- If you need to change your child's services, do you know what to do?
- Do the services and supports offered on your Plan of Care meet your child's and family's needs?
- Did you (did this person) receive information at your (his/her) plan of care meeting about the services and supports that are available under your (his/her) waiver?

Findings are analyzed by management and shared with stakeholders. The Washington State Developmental Disabilities Council (DDC) participates in the survey process- both in visiting clients and analyzing results.

Assessment Meeting Wrap-up and ISP Survey:
An Assessment Meeting Wrap-up is given to each waiver participant at the conclusion of the ISP planning meeting. The Wrap-up survey gives participants an opportunity to respond to a series of questions about the ISP process. After the assessment is finalized, Central Office sends an ISP survey to a stastically-valid random sample

of waiver participant with a return envelope to allow for an anonymous submission to Central Office.

Questions on the ISP survey:
- Did you get to choose who came to your meeting?
- Did your Case Manager discuss any concerns you have with your current services?
- Were your concerns addressed in your new support plan?
- Did you receive information about what services are available in your waiver to meet your assessed needs?
- Were you given a choice of services that are available in your waiver to meet your identified needs?
- Were you given a choice of service providers?
- Were your personal goals discussed in developing your plan?
- Do you feel like your health concerns are addressed to your satisfaction?
- Do you feel like your safety concerns are addresssed adequately?
- Did you receive information regarding planning for emergencies, such as an earthquake or other natural disaster?
- Do you know who to contact if your needs change before the next assessment?
- Do you know you have a right to appeal decisions made by DDD?
- Did your case manager explain how to use your Planned Action Notice (PAN) to appeal a service decision in your support plan if you disagree with the decision?

Residential Care Services (RCS) certifies DDD residential providers.
- o These providers are evaluated at a minimum of every two years.
- o A component of the RCS evaluation process is a review of the ISP to ensure the agency is implementing the plan as written.

b. Monitoring Safeguards. *Select one:*

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
a.i.a.1(a): The percentage of Individual Support Plans (ISPs) conducted for wvr participants that address their assessed health and welfare needs through the provision of wvr svcs or other means. Numerator= Waiver participants' ISPs reviewed that address all assessed health and welfare needs and personal goals through the provision of waiver svces or other means.

Data Source (Select one):
Other
If 'Other' is selected, specify:
This requirement is system-enforced by CARE.

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

Data Aggregation and Analysis:

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

Performance Measure:
a.i.a.1(b): The percentage of Individual Support Plans (ISPs) conducted for waiver participants that personal goals were identified. Numerator= Waiver participants with identified personal goals addressed in their service plan. Denominator= Total number of waiver participants.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
a.i.a.1(c): The percentage of families reporting through the NCI survey that their child's ISP addresses their health and welfare needs. Numerator= Families reporting that the ISP meets their child's needs. Denominator= Families responding to the NCI survey.

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

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

☑ **Other** Specify: Quality Assurance Team within DDD.	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Representative sample of 95% +/- across all DDD HCBS Aivers.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
a.i.a.2: To monitor ongoing waiver eligibility, the percentage of ISPs with monthly waiver service provision or monitoring by the case manager during a break in service. Numerator= Waiver ISPs reviewed with monthly waiver service provision or monitoring by the case manager during a break in service. Demoninator= All waiver ISPs reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Control and Compliance (QCC) Team within DDd.	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
a.i.a.3: The percentage of waiver recipients' ISPs with critical indicators triggered in the assessment that were addressed in the ISP. Numerator= Number of ISPs in which all identified critical indicators were addressed. Demoninator= Total number of waiver recipients' ISPs.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Control and Compliance (QCC) Team within DDD.	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
a.i.b.2: The percentage of waiver participant records containing the "ISP Wrap-up" which includes verification that the policy and procedures were followed in the development of the ISP. Numerator= All waiver participant records reviewed that included the "ISP Wrap-up". Denominator= All waiver participant records reviewed.

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

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

☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Control and Compliance Team within DDD	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
a.i.b.3: The percentage of families reporting through NCI surveys that they are involved in the creation of their waiver participant's ISP. Numerator= All waiver participants or family members responding to the NCI survey and reporting involvement in the creation of the ISP. Denominator= All waiver participant or waiver participant family members responding to the NCI survey.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Quality Assurance Team within DDD	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Representative sample 95%+/- across all HCBS Waivers.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
a.i.c.1: The percentage of annual ISPs for waiver participants that are completed before the end of the twelfth month following the initial ISP or the last annual ISP. Numerator= The number of waiver ISPs that are completed before the end of the twelfth month. Denominator= All waiver ISPs completed.

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

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

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Control and Compliance (QCC) Team within DDD.	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
a.i.c.2: The percentage of waiver participants and family members responding to the ISP Meeting Survey who report knowing what to do if their needs change before the next annual ISP meeting. Num= All ISP Meeting Survey respondents who report knowing what to do if their needs change before the next ISP. Denom= All waiver participants and family members responding to the ISP Meeting Survey.

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

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

		100% of those responding to the ISP Meeting Survey.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
a.i.d.1: The percentage of waiver participants and family members responding to the NCI survey who report satisfaction with the development and implementation of their ISPs. Numerator= All respondents reporting satisfaction regarding the development and implementation of their ISPs. Denom= All waiver participants and family members responding to the NCI survey.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Quality Assurance Team within DDD.	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Random sample 95%+/- across all HCBS Waivers.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
a.i.d.2: The percentage of waiver ISPs with services that are delivered in accordance with the type, scope, amount, duration, and frequency as specified in the ISP. Numerator= All waiver ISPs with services delivered in accordance with the ISP specifications. Denominator= All waiver ISPs reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Control and Compliance Team within DDD	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
a.i.d.3: The percentage of waiver ISPs with services that are delivered within 90 days of the ISP effective date or as specified in the ISP. Numerator= All waiver ISPs with services delivered within 90 days or as specified in the ISP. Denominator= All waiver ISPs reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Control and Compliance Team within DDD	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
a.i.d.4: The percentage of waiver ISPs with service authorizations in place for waiver funded services identified in the ISP that should have occurred in the last 3 months. Numerator= All waiver ISPs with service authorizations for waiver funded services that should have occurred in the last 3 months. Denominator= All waiver ISPs reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify:	☑ **Annually**	☐ **Stratified**

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

Data Aggregation and Analysis:

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

Performance Measure:
a.i.d.5: The percentage of waiver clients with current services authorized in SSPS or CMIS/County Services screen identified in the ISP. Numerator= Waiver applicants with current services authorized or identified in the ISP. Denominator= Waiver applicants with current services authorized.

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

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

		☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Control and Compliance (QCC) Team within DDD.	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
a.i.e.1: The percentage of waiver participant records that contain a signed voluntary participation statement in lieu of institutional care. Numerator= All waiver participant records including a voluntary participation statement. Denominator= All waiver participant records.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Control and Compliance Team within DDD	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
a.i.e.2: The percentage of waiver participant records that contain the annual updated ISP Wrap-up, which includes verification that the waiver participant had a choice of qualified providers. Numerator= All waiver participant records including the annual ISP Wrap-Up. Denominator= All waiver participant records.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Control and Compliance Team within DDD	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
a.i.a.2; a.i.a.3; a.i.b.2; a.i.c.1(2); a.i.d.2; a.i.d.3; a.i.d.4; a.i.d.5; a.i.e.1; a.i.e.2
The QCC Team completes an audit of randomly selected files on a waiver-specific basis across a two-year period. The list for the QCC Team audit is generated to produce a random sample representative of each waiver with a 95% confidence level and a confidence interval of +/-5%. The findings from these reviews are collected in a database. All findings are expected to be corrected within 90 days. Corrections are monitored by QCC Team members.

A valid sample is produced for the QCC audit. The remaining file review is strictly an additional measure to assist with ongoing quality assurance.

The audit protocol includes (among others) the following questions with a target of 100% compliance.
"Have all identified waiver funded services been provided within 90 days of the annual ISP effective date?"
"Is there a SSPS or County authorization for all Waiver funded services identified in the current ISP that should have occurred in the three (3) months prior to this review?"
"Are all the current services authorized in SSPS or CMIS/County Services Screen identified in the ISP?"
(Authorizations are audited as a proxy for claims data. The SSPS electronically prevents a provider from claiming payment for an amount and rate higher than what is authorized.)
"Are the authorized service amounts equal or less than the amounts identified in the

ISP?"
"Is the effective date of This Year's annual ISP no later than the last day of the 12th month of the previous annual ISP effective date?"
"Is there evidence that the Wrap-Up disucssoin occurred at the DDD annual or iniital assessment?"
"Is there a signed Voluntary Participation statement from the annual or initial assessment in the client file?"

a.i.a.1(b): The DDD assessment allows for entry and addressing of personal goals. An annual report is generated at Central Office to identify assessments with one or more personal goals to verify personal goals are acknowledged and addressed.

Data are available in a computer-based system which provide 100% analysis of individual results.

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

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

a.i.c.1(1): Monthly reports are prepared for a review of the progress toward achieving 100% timely assessments of need. The data is analyzed by comparing the actual number of assessments completed on time to the regional monthly targets and to the assessments that were due. Regional waiver coordinators review Assessment Activity Reports on a monthly basis and send information to case managers for follow up to promote timeliness of assessments.

a.i.c.2: ISP Meeting Survey:
A ISP Meeting survey is mailed to waiver participants within one month of the ISP planning meeting. This survey gives participants an opportunity to respond to a series of questions about the ISP process. The survey is mailed from Central Office based on a random sample representative of each waiver with a 95% confidence level and a confidence interval of +/-5%. Information collected is analyzed annually at the Waiver Oversight Committee.

Question: "Do you know who to contact if your needs change before the next assessment?"

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Waiver File Reviews (Annual QCC audit):
a.i.a.2; a.i.a.3; a.i.b.2; a.i.c.1(2); a.i.d.2; a.i.d.3; a.i.d.4; a.i.d.5; a.i.e.1; a.i.e.2:
Findings from QCC Team and Supervisor file reviews are analyzed by management, and based on the analysis necessary steps are taken to increase compliance. For example:

- Annual Waiver Training curriculum is developed in part to address audit findings.
- Policy clarifications occur as a result of audit findings.
- Analyses of findings assist regions to recognize personnel issues.
- Analysis of audit finding may impact format and instructions on forms.
- Analysis of findings has led to revision in Waiver WAC to clarify rule.
- Analysis of findings has led regions to revise regional processes.

The National Core Indicators Survey:
a.i.a.1(c); a.i.b.3; a.i.d.1:
Washington State's Division of Developmental Disabilities (DDD) participates in a national study that assesses performance and outcome indicators for state developmental disabilities service systems. This study

allows the division to compare its performance to service systems in other states and within our state from year to year.

There are currently 60 performance and outcome indicators to be assessed covering the following domains:
• Consumer Outcomes
• System Performance
• Health, Welfare, & Rights
• Service Delivery System Strength & Stability

In addition, DDD has added some waiver specific questions to assist with assuring ISPs are implemented as written and that health and welfare needs are being addressed. Findings are analyzed by management and shared with stakeholders. The Washington State Developmental Disabilities Council (DDC) participates in the survey process both in visiting clients and analyzing results.

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

• Annual Waiver Training curriculum is developed in part to address audit findings.
• Policy clarifications occur as a result of audit findings.
• Analysis of audit finding may impact format and instructions on forms.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

Waiver clients have rights under Medicaid law, state law (RCW) and state rules (WAC) to appeal any decision of DDD affecting eligiblity, service, or choice of provider.

During entrance to a waiver, an individual is given administrative hearing rights via the DDD HCBS Waiver Brochure (DSHS #22-605). The Case Resource Manager (CRM) discusses administrative hearing rights at the time of the initial and annual ISP meeting, and Planned Action Notices (PAN) are attached to the ISP when it is sent to the individual and their designee (the individual who has been designated to assist the client with understanding and exercising their administrative hearing rights) for signature.

When the department makes a decision affecting eligibility, level of service or denial or termination of provider, a Planned Action Notice (PAN) must be sent within 5 working days of the decision. The notice is sent to the client and their designee. The PAN provides the effective date of the action, the reason and applicable WAC, appeal rights, and time lines for filing appeals. Individuals have up to 90 days to appeal a department decision. If an individual wishes to maintain services during the appeal process, they must ask for an administrative hearing within the ten-day notice period. If the tenth day falls on a weekend or holiday, they have until the next business day to ask for an administrative hearing. If the tenth day happens before the end of the month, they have until the end of the month to ask for a fair hearing and still be able to get continued benefits.

A client or their designee may request an administrative hearing orally or in writing. Client appeals are heard and decided by Administrative Law Judges (ALJs) through an administrative or "fair" hearing. Attorney representation is not required but is allowed. The client or their representative may present the client's case or have an attorney present the case. DSHS employees may not represent the client at an administrative hearing.

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

DDD uses a variety of PANs to communicate decisions. All PANs include relevant administrative hearing rights and comply with Medicaid requirements.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

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

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

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

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

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

ADSA/DDD operates the grievance/complaint system.

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

DDD provides participants with administrative hearing rights and a complaints/grievance process. The Complaints/Grievance process is not a pre-requisite to an administrative hearing, rather this policy provides participants with an opportunity to address those issues that are not dealt with through the administrative hearing process. DDD policy 5.03 Client Complaint/Grievances clearly delineates those issues that may be addressed in this manner and those issues that should be addressed through processes such as the administrative hearing process. Participants are informed of both processes via brochures, DVDs, WAC, policy and their Case Resource Manager.

DDD policy 5.03 Client Complaint/Grievances provides waiver participants an opportunity to address problems outside the scope of the adminitrative hearing process. DDD has also worked with the Developmental Disabilities Council to produce a video to assist individuals and their representatives with understanding how to work with the department to resolve complaints/grievances.

This policy applies to all DDD Field Services offices, State Operated Living Alternatives (SOLA), and Residential Habilitation Centers (RHC).

POLICY

A. DDD staff will strive to address grievances/complaints at the lowest level possible. Complaints can be received and addressed at any level of the organization. However, the

complaint will be referred back to the Case Resource Manager for action unless the complainant specifically requests it not be.

B. Legal authorization from the client or a personal representative is required to share information with persons outside of DSHS unless otherwise authorized by law. Authorization from the client is not required when responding to correspondence assignments or inquiries from the Governor's Office as part of administration of DSHS programs.

C. Communication to complainants will be made in their primary language if needed.

D. DDD will maintain an automated complaint tracking database to log and track complaints as specified in the Procedures section of this policy. The DDD also tracks complaints in service episode records (SERs) in the CARE system.

PROCEDURES

A. The following procedures describe the handling of client complaints at four levels:

1. Case Resource Manager Level;
2. Supervisor Level;
3. Regional Administrator (RA) Level; and
4. Central Office Level

B. Complaints concerning services in the DDD Residential Habilitation Centers (RHCs) and State Operated Living Alternatives (SOLA) will be directed to the Regional Administrator in the respective region.

C. Case Resource Manager Level

1. Case Resource Managers (CRM) solve problems and resolve complaints as a daily part of their regular case management activities. This activity will be documented in the client record as appropriate in SER's. The Complaint SER's code will be used to identify Complaints and any resolution to the complaint.

2. If the complainant does not feel that the complaint or problem has been resolved, and he/she wants to have the complaint reviewed by a supervisor, the CRM will give his/her supervisor's name and telephone number to the complainant.

D. Supervisor Level

1. Upon receipt of an unresolved complaint at the CRM level, the supervisor has ten (10) working days to attempt to resolve the issue. If the response will take longer than 10 days, the supervisor will make an interim contact with the complainant and give a reasonable estimated date of response.

2. If resolution is reached, the supervisor will

document the outcome in the client record.

3. If the complainant still does not feel that the complaint/problem has been resolved, and he/she wants to have the complaint reviewed by the RA, the supervisor will give the RA's name and telephone number to the complainant. The supervisor will also enter the complaint information in the automated DDD Complaint Tracking (CT) database.

E. Regional Administrator Level

1. Upon receipt of an unresolved complaint, the RA will assign a staff to investigate and resolve the issue within 10 working days. If the response will take longer than 10 working days, the RA or designee will make an interim contact with the complainant and give a reasonable estimated date of response.

2. If resolution is achieved, the assigned Regional staff will:

a. Document the outcome in the CT database and the client record; and

b. Notify the complainant and all parties involved and document the notification in the client record.

3. If the matter is not resolved, and the complainant wants a review by DDD Central Office, the RA or designee will document the outcome in the CT database and give the name and telephone number of the Chief, Office of Quality Programs and Services (OQPS) to the complainant. The RA should also notify the OPQS Chief by phone or email of the potential contact.

F. Central Office Level

1. Upon receipt of an unresolved complaint, the OQPS Chief or designee will ensure the complaint has been entered in the database and has ten (10) working days to investigate and resolve the issue. If the response will take longer than ten (10) days, the OQPS Chief will make an interim contact with the complainant and give a reasonable estimated date of response.

2. The OQPS Chief will document the outcome in the CT database and notify the complainant and all parties involved. The OQPS Chief will send a written summary to the Region for inclusion in the client record.

G. Complaint Tracking Database

1. Entries in the CT database must include:
a. Date the complaint was received;
b. Name and phone number of person receiving the complaint;
c. Complainant name, contact number, and

relationship to client;
d. Client name and identification number;
e. The specific complaint;
f. Who the complaint was assigned to;
g. Due date; and
h. Outcome.

2. The OQPS will review complaints entered in the CT database during its monitoring review cycle. Regional Quality Assurance Managers will conduct periodic regional reviews of complaints and status.

Please note, the following types of complaints are outside the scope of this policy as they are addressed through separate processes:

1. Allegations of abuse, neglect, exploitation, abandonment, financial exploitation of a child or vulnerable adult. These must be directed immediately to Adult Protective Services (APS), the Complaint Resolution Unit (CRU), or Child Protective Services (CPS), as appropriate.

2. Client disputes about services that have been denied, reduced, suspended, or terminated. These are resolved through the Fair Hearing procedure.

3. Client disputes about services that have been requested or authorized through an exception to rule (ETR) that have been denied, reduced, or terminated.

4. Complaints received from DSHS Constituent Services. These will be handled according to the requirements of DSHS Administrative Policy 8.11, Complaint Resolution and Response Standards.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

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

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

Alleged or suspected abuse, neglect, exploitation or abandonment is required by law to be reported to DSHS immediately. State law also requires any sexual or physical abuse to be reported to law enforcement. All DSHS employees and their contracted providers are mandated reporters per RCW 74.34 ("Abuse of vulnerable

Adults"). Residential Care Services (RCS) is the designated DSHS authority for abuse and neglect investigations involving client's in residential programs. Adult Protective Services (APS) investigates incidents involving vulnerable adults residing in their own homes. Abuse and neglect incidents are reported to the Department via state-wide and regional abuse reporting lines.

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

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

- Abuse
- Neglect
- Exploitation
- Abandonment
- Death
- Medication Errors
- Emergency Use of Restrictive Procedures
- Serious Injuries
- Criminal Activity
- Hospitalizations
- Missing clients
- Mental Health Crisis
- Serious Property Destruction

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

1. Known media Interest or litigation must be reported to Regional Administrator & CO within 1 hour. If issue also meets other incident reporting criteria, follow with Electronic IR within 1 working day.
2. Death of a RHC or SOLA client.
3. Suspicious deaths (suspicious or unusual).
4. Natural disaster or conditions threatening the operations of the program or facility
5. Alleged sexual abuse of a client by a DSHS employee, volunteer, licensee or contractor
6. Clients missing from SOLA or RHC in cases where a missing person report is being filed with law enforcement
7. Injuries resulting from abuse/neglect or unknown origin requiring hospital admission
8. Client arrested with charges or pending charges for a violent crime

B. Electronic IR Database Within 1 Working Day

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

investigation
10. Criminal activity against clients by others resulting in a case number being assigned by law enforcement

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The Division of Developmental Disabilities works jointly with Aging Administration and the DSHS Communications Division on education efforts for clients, families and providers associated with DSHS. DSHS also started an "End Harm" campaign several years ago. Washington State has designated November as "Vulnerable Adult Awareness Month".

DDD participates in this campaign which is aimed at shedding light on abuse and educating the general public as well as DSHS staff and consumers. A statewide number 1-866-EndHarm was implemented several years ago. Anyone can call this number to report any type of abuse or neglect against a vulnerable person 24 hours per day and 7 days per week. The End Harm toll free number is promoted via news releases, the internet, DDD's Director's Corner and ADSA publications. Participants receive information at least annually during their annual assessment about how to report any type of abuse or neglect of a vulnerable adult or child. The End Harm number is identified on the Meeting Wrap up form that is reviewed at the end of each annual assessment. Most residential programs have abuse and neglect reporting numbers posted in the participant's homes. Every DDD Case Resource Manager (CRM) receives mandatory reporter/incident management training as a component of DDD Core Training.

All providers receive mandatory reporter training. Individual and AFH/ARC providers receive training via the Fundamentals of Caregiver training. DDD residential program employees receive training from their employer.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Under state authority, Aging and Disability Services Administration/ Residential Care Services (RCS) is the designated DSHS authority to investigate incidents of abuse (physical, mental, sexual and exploitation of person), abandonment, neglect, self-neglect and financial exploitation in residential programs. If a named alleged perpetrator is found to have committed abuse (physical, mental, sexual and exploitation of person), abandonment, neglect, self-neglect and financial exploitation, their name and the nature of the finding is submitted to any known employer and the Background Check Central Unit (BCCU).

In addition to investigating alleged named perpetrators, RCS reviews provider systems to see if a failed practice contributed to any finding of abuse, neglect, abandonment, self-neglect, and financial exploitation. If failed provider practice is identified, RCS will issue a citation to the provider under the appropriate section of Certified Community Residential Services and Supports WAC 388-101, Adult Family Home WAC 388-76 and Assisted Living Licensing Rules 388-78A. The provider must submit and implement a corrective action plan, which is subject to on-site verification by RCS.

RCS will document their conclusion of their investigations in FAMLINK. RCS sends the Statement of Deficiencies to providers within 10 days and will document their conclusion of their investigations in FAMLINK within 15 days of the last day of data collection. For each allegation, the RCS investigators completes data entry into the RCS complaint investigation tracking systems and are required to record a data-qualifier in relation to the decision of the substantiated or unsubstantiated finding. Those qualifiers are as follows for substantiated investigations:
• Federal deficiencies related to the allegation are cited
• State deficiencies related to the allegation are cited
• No deficiencies related to the allegation are cited, or
• Referral to appropriate agency

For "unsubstantiated" investigations, the following qualifiers are used:
• Allegation did not occur
• Lack of sufficient evidence
• Referral to appropriate agency

When a provider practice investigation is completed, RCS determines whether:

- The allegations are substantiated or unsubstantiated;
- The facility or provider failed to meet any of the regulatory requirements; and,
- The provider practice or procedure that contributed to the complaint has been changed to achieve and/or maintain compliance.

RCS utilizes a centralized statewide intake unit for the purpose of receiving reports of alleged abuse, neglect and financial exploitation for all licensed and certified Long Term Care residential providers. Referrals from the DDD incident reporting system, reports from the public and reports from mandated reporters are received and processed through this unit. RCS Field investigators receive prioritized referrals from the centralized intake unit and respond by conducting on-site investigations

RCS is centrally located in Olympia. RCS investigates licensed or certified residential providers. RCS prioritizes reports for investigation based upon on the severity and immediacy of actual or potential harm. Complaint investigation response times are 2 days, 10 days, 20 days, 45 days, or 90 days and Quality Reviews. For allegations that involve named individuals that may have perpetrated abuse, neglect, or misappropriation of residents funds, response times are 10 days, 20 days, 30 days, or 60 days. All of these categories require an on-site investigation, except for the Quality Review category. Any situation that involves imminent danger is reported to law enforcement immediately. Referrals are also made to any state agency which has regulatory authority over the named alleged perpetrator. Any report received from a public caller is assigned an on-site investigative response time.

Under state authority, Aging and Disability Administration/Home and Community Services Division, Adult Protective Services (APS) receives reports and conducts investigations of abuse (physical, mental, sexual and exploitation of person), abandonment, neglect, self-neglect and financial exploitation.

APS administration is located in Olympia and APS investigators are located in regional offices throughout the state. Investigations are prioritized based on the severity and immediacy of actual or potential harm. Emergent issues are referred to 911. The APS investigator meets face to face with the alleged victim within 24 hours for all reports categorized as “high”; within five working days for a “medium” priority report; and within ten working days for a “low” priority report. A shorter response time may be assigned on a case by case basis.

APS investigations are completed within 90 days of assignment unless necessary investigation or protective services activity continues. If a case remains in "investigating" or "investigation pending" status 90 days after intake, APS supervisors review the case at least every 30 days thereafter for the duration of the case.

The participant or the participant’s representative is informed of the results of the investigation. For unsubstantiated results the participant/representative receives verbal notification at the end of the investigation. For substantiated results, the participant receives verbal notification (written when requested) at two stages throughout the investigation; (1) when a determination by the investigator to recommend that the allegation be substantiated and (2) when this determination has been reviewed by the regional reviewing authority.

DDD requires all contracted residential providers to report a broader scope of serious and emergent incidents to the Division per DDD policy 6.12 Residential Reporting Requirement including Abuse/Neglect Reporting. Division staff are required to input serious and emergent incidents defined in policy 12.01, Incident Management into an electronic incident reporting system. Please see section G-1 for detail.

RCS is using the FamLink system to document investigation activites including intake of complaints and outcome reports. APS will be using the FamLink system beginning in June of 2013. There is an electronic connection between the FamLink and the CARE system to notify case managers of a) complaints that are referred for investigations and b) investigation outcomes. This is an electronic notification that will be identified in the client's CARE record.

ADSA will receive nightly data feeds from FamLink that will be used in this ADSA reporting system. FamLink information will be reviewed to determine if client information matches DDD waiver clients who are identified in CARE. DDD will use the ADSA reporting system to address specific programmatic and provider issues from the outcomes of the waiver clients who were involved in investigations by Residential Care Services (RCS) (and later APS) for whom a report of abuse, neglect, abandonment, or financial exploitation was substantiated. The data are broken out by type of incident and provider type.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Residential Care Services is responsible for overseeing the certification of all certified residential programs. Mandatory reporting, and mandatory reporter training are among the standards they evaluate per Washington Administrative Code. Certification occur a minimum of every two years, but the certification length can be reduced depending on the regulatory concerns.

RCS Field Managers (supervisors) review prioritized complaints assigned from the centralized intake unit. As needed, supervisors work directly with investigative staff in developing investigative plans and may assist investigators with coordination activities.

The RCS Assistance Director and the QA Administrator receive copies of serious and immediate complaint intakes at the same time that the initial referrals are sent from CRU to the field. Both of these individuals monitor the progress of investigative response to these incidents.

RCS Field Managers review the results of all investigated complaints; ensure that investigation activities were thorough and complete and that no follow-up activities are required. Field Managers also make recommendations to HQ and assist with coordination of enforcement activities.

RCS provider practice substantiation rates are monitored by DDD through data pulled from FamLink. Trends and patterns are identified and analyzed to determine if substantiated areas of non-compliance negatively impacted waiver clients living in the licensed or certified setting. Analyses include a review of the general scope and severity of the non-compliance, and whether or not RCS enforcement processes resulted.

RCS is using the FamLink system to document investigation activites including intake of complaints and outcome reports. APS will be using the FamLink system beginning in June of 2013. There is an electronic connection between the FamLink and the CARE system to notify case managers of a) complaints that are referred for investigations and b) investigation outcomes. This is an electronic notification that will be identified in the client's CARE record.

The Division of Developmental Disabilities requires serious and emergent incidents to be entered into a statewide electronic incident reporting system per DDD Policy. Incidents are entered into the system by DDD CRMs and Social Service Specialists with notification sent to appropriate staff.

Adult Protective Services is a state wide program within the state single Medicaid agency. The intakes, investigations and protective services performed by APS are continuously monitored at both the state and the regional levels. For example:

- o Regional supervisors and program managers conduct on-going quality assurance audits of APS case records.

- o The APS program has implemented a statewide QA monitoring process that includes record reviews and a formal in-person skills evaluation conducted by a supervisor during an actual APS investigation.

- o Several reports based on data pulled from the statewide APS data base are routinely generated and evaluated no less than annually by program managers and upper management at the state office.

- o The regions have and use a report system tool that enables them to create customized reports pulled from the statewide data base to track, monitor and evaluate implementation of APS in their region.

- o APS also routinely reports some aspects of program performance to the Governor for her review (Government Management Accountability and Performance).

- o Data is used to develop statewide training for case managers and the community on adult protective services and how to recognize and prevent instances or re-occurrences of abuse, neglect and exploitation.

Regional Quality Assurance staff in all three regions provides ongoing monitoring of the Incident Reporting system. The Central Office Incident Program Manager is responsible for the monitoring and oversight of all significant incidents. A Central Office Incident Report team meets monthly to review aggregate data, trends and

patterns and staff incidents of particular concern.

Aggregate data analyzed by the DDD Central Office is also sent out to the regions for follow up. Regional analysis is tracked in G-Map format and discussed at the Regional Ternary Quality Assurance Meeting. Best practices and significant issues are presented to Full Management Team three times per year.

Information and findings are communicated to the Medicaid agency at least quarterly via the Medicaid Agency Waiver Management Committee.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Division of Developmental Disabilities (DDD) has the following policies that promote safeguards and directions regarding use of restrictive procedures which includes the use of restraints. When a client's behavior presents a threat of injury to self or others, or threatens significant damage to the property of others, steps must be taken to protect the client, others, or property from harm. It is expected that supports described in DDD Policy 5.14, Positive Behavior Support will be used to lessen the behaviors and to eliminate the need for restrictive practices.
These policies apply to all clients who receive services from DDD certified residential provider, State Operated Living Alternatives (SOLA), Companion Homes, and individual receiving services from a contracted Behavior Support and Consultation provider and services provided by counties that are funded by DDD.

DDD Policy 5.15 Use of Restrictive Procedures provides direction and requirements on the use of all restrictive procedures (which includes use of mechanical and physical restraints). This policy identifies additional monitoring physical or mechanical restraint procedures for provider staff during the use of restraints. If a restrictive procedure is used then the PBSP must document the use of the restrictive procedure. The PBSP and FA are provided to the case manager for their review and kept in client's file. Prior to implementing the PBSP, the provider must provide a copy of the FA, PBSP.

DDD Policy 5.17 Physical Intervention Techniques describes physical or mechanical restraints that permitted and prohibited in the provision off DDD services. Physical and mechanical restraints are only consider when a person's behavior presents a threat of injury to self or others, threatens significant damage to the property of others and steps must be taken to protect the person, others, or property from harm. This policy describes the circumstances under which the permitted interventions may be used, the requirements that must be met before they may be used, and the requirements for documenting and monitoring their use. In addition please refer this policy to identify non-physical interventions that are allowed without PBSP.

DDD policy 5.15 allow for the following restraints for the purpose of protection:

Mechanical restraint means applying a device or object, which the client cannot remove, to the client's body that restricts his/her free movement. Mechanical restraint to limit the client's free movement or to prevent the client form self-injury (e.g. helmet, arms splints, etc.)

Physical restraint means physically holding or restraining all or part of a client's body in a way that restricts the client's free movement. This does not include briefly holding, without undue force, a client in order to calm him/her, holding a client's hand to escort the client safely from one area to another, or using seatbelts for wheelchair safety. (See also policy 5.17)

DDD policy 5.15 permits the restraints identified below only by exception to policy and approved by Division Director. Use of these procedures requires a PBSP and ETP:

Restraint chairs, Restraint board, Exclusionary time out means placing a client alone in a room in which no reinforcement is available and from which the client is prevented from leaving (Exclusionary time out also permitted by policy 5.20)

DDD policy 5.15 allow the following restraints only by written approval of the DDD regional administrator and PBSP (physical interventions described above may be used only as part of an approved physical intervention system/curricula):

a. The use of seat belt locks in vehicles to transport individuals whose challenging behaviors DDD impede their safe travel.

b. Person seated on furniture and physically restrained by two persons sitting on either side and

c. Person sitting on the floor and being physically restrained by one or more persons.

DDD Policy 5.15 and 5.17 identifies restraint methods prohibited to be used by providers.(Please refer to DDD policy 5.17 for complete list of restraints that DDD prohibits):

Physical or mechanical restraint in a prone position means the client is being restrained while lying on his/her stomach. This procedure is prohibited.

Physical restraint in a supine position means the client is being restrained while lying on his/her back. This procedure is prohibited.

DDD Policy 5.17 allows the physical restraints identified below are only with a written PBSP that specifically includes instructions for their use:

1. Hand, arm, and leg holds;
2. Standing holds;
3. Physically holding and moving a person who is resisting; and
4. Head holds (Note: physical control of the head is permitted only to interrupt biting or self-injury such as head banging).

DDD Policy 5.17 physical restraints permitted Only by Exception to Policy (ETP) approved by DDD Regional Administrator and identified in PBSP:

a. Person seated on furniture and physically restrained by two persons sitting on either side. And

b. Person sitting on floor and being physically restrained by one or more persons.

2. The physical interventions described above may be used only as part of an approved physical intervention system/curricula.

3. As part of the approval process, there must be a written assessment by a physician that the physical restraint to be used is not contraindicated for the person due to physical or other medical conditions. Refer to DDD Policy 5.15,

Use of Physical Interventions during Medical and Dental Treatment

The use of permitted physical interventions during medical or dental treatment is allowable if under the direction of a physician or dentist, consistent with standard medical/dental practices, and necessary to complete a medical or dental procedure. Efforts must be made to familiarize the client with the medical/dental procedure so that the least restrictive physical intervention is needed.

DDD Policy 5.17 addresses the following requirements:

Documentation and Approval of Restrictive Physical Interventions

1. Prior to implementing restrictive physical interventions, the client and the client's legal representative must be involved in discussions regarding the perceived need for physical intervention. The level of notification that parents and/or legal representatives desire when physical interventions are used should also be determined at this time and noted in the client's PBSP.

2. The facility or agency must provide documentation on the proposed intervention and approval for its use, according to the requirements set forth in DDD Policy 5.15, Use of Restrictive Procedures.

All staff using physical interventions must have prior training in the use of such techniques according to the facility or agency's policy and procedures. With all training on the use of physical interventions, staff must also receive training in crisis prevention techniques and positive behavior support.
a. The contracted residential provider must ensure that these staff completes an annual review of de-escalation and physical intervention techniques.
2. A trained person must be present whenever possible to supervise and observe during use of restrictive physical interventions. Designated staff observers must receive training in observation and supervision of physical restraints (e.g., signs of duress, fatigue, etc.).
3. Each facility or agency must make provisions for a post-analysis (i.e., what could have been done differently) whenever restrictive physical interventions are implemented in emergencies or when the frequency of use of the intervention is increasing. The client, staff and supervisor involved, and other team members must participate, as appropriate, and documented in the client's file.

Monitoring Restrictive Physical Interventions
Procedural requirements for monitoring restrictive physical interventions are described in DDD Policy 5.15, Use of Restrictive Procedures, including:
1. Documenting the use of interventions;
2. Incident reporting; and
3. Data monitoring and review.

Components of a Physical Intervention Techniques System
This section describes the necessary components of any physical intervention techniques system used by a facility or agency.
1. Physical intervention systems must include, at a minimum, the following training components:
a. Principles of positive behavior support, including respect and dignity;
b. Communication techniques to assist a client to calm down and resolve problems in a constructive manner;
c. Techniques to prevent or avoid escalation of behavior prior to physical contact;
d. Techniques for staff to use in response to their own feelings or expressions of fear, anger, or aggression;
e. Techniques for staff to use in response to the client's feelings of fear or anger;
f. Caution that physical intervention techniques may not be modified except as necessary in consideration of individual disabilities, medical, health, and safety issues. An appropriate medical/health professional and the facility or agency certified trainer must approve all modifications;
g. Evaluation of the safety of the physical environment at the time of the intervention;
h. Use of the least restrictive physical interventions depending upon the situation;
i. Clear presentation and identification of prohibited and permitted physical intervention techniques;
j. Discussion of the need to release a client from physical restraint as soon as possible;
k. Instruction on how to support physical interventions as an observer and recognize signs of distress by the client and fatigue by the staff; and
l. Discussion of the importance of complete and accurate documentation.
2. Staff receiving physical intervention techniques training must complete the course of instruction and demonstrate competency before being authorized to use the techniques with clients.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The State Operating Agency through the Aging and Disability Services Administration is responsible for detecting the unauthorized use of restrictive interventions.

Under state authority RCW 74.34, the Aging and Disability Services Administration (ADSA) receives reports and conducts investigations of abuse, neglect, exploitation and abandonment for clients enrolled with the Division of Developmental Disabilities. ADSA Residential Care Services (RCS) investigates abuse and neglect occurring in nursing homes, assisted living facilities, adult family homes, & supported living programs. ADSA Adult Protective Services (APS) investigates abuse and neglect involving adults residing in their own homes.

DDD detects use of unauthorized restrictive intervention through:

- Reports submitted to Adult Protective Services,
- Reports submitted to Residential Care Services,
- Reports received in the DDD Incident Reporting system,
- The face to face DDD Assessment process conducted yearly and at times of significant change,
- The DDD grievance process, and
- DDD Quality Assurance activities that include face to face interviews of clients and review of complaints.

RCS is the FamLink system to document investigation activites including a) intake of complaints and b) outcome reports. APS will be using the FamLink system beginning in June of 2013. There is an electronic connection between the FamLink and the CARE system to notify case managers of a) complaints that are referred for investigations and b) investigation outcomes. This is an electronic notification that will be identified in the client's CARE record.

Division Policies 5.15,5.17 and 5.2 (see G-2, b, i) specify the requirements for using and documenting use of any type of restraint (mechanical or pharmacological). Only the least restrictive intervention needed to adequately protect the client, others, or property may be used, and terminated as soon as the need for protection is over. Approved restraint use must be fully documented and reviewed at least monthly by the residential provider and at least quarterly by the client's interdisciplinary team. Any emergency use of a restraint requires an incident report to division headquarters where it is reviewed by the Incident Management Program Manager.

Residential Care Services Division has contracted evaluators who evaluate the residential agencies/programs at least once every two years. Their review always includes any use of restraints, restrictive procedures, or use of psychoactive medications.

Quality Control Compliance (QCC) staff yearly review the positive behavior support plans (PBSPs) of a sample of waiver clients. One focus is on instances when the PBSP includes retraint that requires approval through an exception to rule (ETR). When the QCC team identifies PBSPs requiring an ETR that did not have an ETR, the QCC team verifies that individual corrective action was completed within 90 days and reports to management on systems issues.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Division of Developmental Disabilities (DDD) has the following policies that promote safeguards and directions regarding use of restrictive procedures. When a client's behavior presents a threat of injury to self or others, or threatens significant damage to the property of others, steps must be taken to protect the client, others, or property from harm. It is expected that supports described in DDD Policy 5.14, Positive Behavior Support will be used to lessen the behaviors and to eliminate the need for restrictive

practices.
These policies apply to all clients who receive services from DDD certified residential provider, and individual receiving services from a contracted Behavior Support and Consultation provider and services provided by counties that are funded by DDD.

DDD Policy 5.14 describes the division's general approach to promoting quality of life and adaptive behavior through the DDD Residential Service Guidelines and the County Guidelines and by providing positive behavior support for individuals with challenging behaviors.

DDD Policy 5.15 describes which restrictive procedures are allowed and which are prohibited, the circumstances under which allowed restrictive procedures may be used, the requirements that must be met before they may be used, and the requirements for documenting and monitoring their use. For clarification, procedures that are not restrictive and do not require Positive Behavior Support Plans (PBSP) are also described.

Policy 5.15 permits the following restrictive procedures without an ETP:
The procedures listed below require a Positive Behavior Support Plan (PBSP) as specified in this policy (see Procedures, Section A
1. Protective restrictive procedures have one or more of the following characteristics:
a. Interrupting or preventing behaviors that are dangerous or harmful to the client or others;
b. Interrupting or preventing behaviors that cause significant emotional or psychological stress to others; and/or
c. Interrupting or preventing behaviors that result in significant damage to the property of others.
2. Permitted restrictive procedures for the purpose of protection include, but are not limited to:
a. Requiring a client to leave an area with physical coercion (i.e., physically holding and moving the client with force) for protection of the client, others, or property.
b. Using door and/or window alarms to monitor clients who present a risk to others (e.g., sexually or physically assaultive).
c. Necessary supervision to prevent dangerous behavior.
d. Taking away items that could be used as weapons when the client has a history of making threats or inflicting harm with those or similar items (e.g., knives, matches, lighters, etc.).
e. Removing client property being used to inflict injury on one's self, others, or property. Removing property belonging to others is not a restrictive procedure.

DDD Policy 5.15 permits for restriction identified below when approved at the Regional Administrator Level
Where noted below, an ETP is not required for Community Protection Program (CPP) participants if the restriction is included in the client’s professional Treatment Plan. Refer to DDD Policies 15.01 through 15.05 regarding the Community Protection Program for further information.
The following restrictive procedures require the prior written approval of the DDD Regional Administrator:
a. Controlling food consumption for individuals who have behavioral issues (e.g., stealing food, running away to get food, being assaultive when denied food, etc.) related to unrestricted access to food when:
i. A long-term threat exists to the client’s health, as determined in writing by a physician; or
ii. A short-term threat exists (e.g., eating raw meat, uncontrolled intake of water, etc.); or
iii. It is necessary for assisting the client to live within his/her budget.
An ETP is required whenever a client’s food or kitchen is locked up and not accessible to the client without staff assistance.
Note: If the client understands and complies with his/her dietary restrictions (i.e., does not exhibit any challenging behaviors in response) and the client’s food and kitchen/kitchen areas do not need to be secured, a PBSP is not required. For example, a person with diabetes who is on a special diet due to diabetes, but who complies willingly with the diet and for whom it is not necessary to lock up food or areas of the kitchen.
b. Requiring a client to wear any electronic monitoring device on his/her body to monitor the client’s behavior. The client and his/her legal representative must give consent if there is no court order.
c. Administration of medications prescribed for the purpose of diminishing sexual desire. An ETP is not required for clients who are their own guardians and are competent to make this decision for themselves. See Section K of policy 5.15 for additional information and requirements.
d. Removal of client property where risk of damage to property or injury to a client is not an issue (e.g., taking the client’s TV away for swearing at a caregiver).
e. Regulating or controlling a client’s money in a manner which the client and/or his/her legal

representative object to. See also Section I.2 of this policy regarding money management.
f. Restricting access to certain populations, areas, or public places (ETP not required for CPP Participants).
g. The use of locks on doors, gates, and fences that prevent independent egress from the residence and/or yard. Keyed locks where you must use a key from inside to exit must be avoided whenever possible. If a keyed lock must be used, the ETP must include a safety plan for its use in case of an emergency.
h. The use of seat belt locks in vehicles to transport individuals whose challenging behaviors impede their safe travel (e.g., unlocking regular seat belts and opening vehicle doors while in operation, etc.).
i. Restrictions on free association and communication, such as access to pornography, telephones, the Internet, written communication, communication devices and interactions with others (e.g., limiting 900 calls/telephone service, supervising telephone usage to monitor behavior, etc.ETP not required for CPP Participants).
j. Restricting access to alcohol.(ETP not required for CPP Participants).
k. Routine search (i.e., a planned or scheduled search) of a client and/or his/her home and possessions. Without a court order or as a condition of community supervision, the client and his/her legal representative must consent to the procedure. A legitimate and significant reason to conduct the search must exist.(ETP not required for CPP Participants).

Treatment of Sexual Deviancy
Appropriate treatment of individuals with a history of sexual assault or inappropriate sexual behaviors, or individuals who have committed illegal acts of a sexual nature, may involve certain restrictions as part of their professional individualized Treatment Plan (TP). In these cases, for Community Protection Program participants, some restrictive procedures may be allowed for other than protective purposes if recommended by a Certified Sex Offender Treatment Provider (SOTP), or an Affiliate SOTP working under the supervision of a Certified SOTP.
The client must consent to the procedures as part of his/her therapeutic treatment. Refer to DDD Policy 15.02, Community Protection Program Services, and DDD Policy 15.04, Community Protection Program Residential Services, for specific requirements.

DDD Policy 5.19 require provider to communicate with case manager when a restrictive procedure is planned for. Such communication must be made in writing and documented in client's assessment.
Before implementing restrictive procedures, the client and his/her legal representative must be involved in discussions regarding the perceived need for restrictive procedures including:
The specific restrictive procedures to be used;
The perceived risks of both the client's challenging behavior and the restrictive procedures;
The reasons which justify the use of the restrictive procedures; and
The reasons why less restrictive procedures are not sufficient.
B. Necessary Documentation for Use of Restrictive Procedures
1. A written Functional Assessment (FA) of the challenging behavior(s) that the restrictive procedures address.
2. Based on the FA, a written PBSP that will be implemented to reduce or eliminate the client's need to engage in the challenging behavior(s). Refer to DDD Policy 5.14, Positive Behavior Support, for more information and requirements regarding
The PBSP must include:
a. A description of the restrictive procedure that will be used, when and how it will be used, and clear criteria for termination;
b. A plan for recording data on the use of the procedure and its effect (each use of the restrictive procedure must be documented). The plan must specify the type and frequency of data collection; and
c. A description of how the program or interdisciplinary team (IDT) will monitor the outcomes of implementing the PBSP and evaluate the continued need for the restrictive procedure.
Approval Process
Prior to implementation, the proposed PBSP must be approved as follows:
1. For community residential and county employment/day programs:
a. All PBSPs involving restrictive procedures require the written approval of the agency administrator or staff who have designated approval authority; and
b. PBSPs that require an ETP or involve physical or mechanical restraints require written approval by the client and/or legal representative. The client's approval should be sought to the extent he/she understands what is being proposed.
c. Approval must be documented on a form that lists the risks of the challenging behavior and the risks of the restrictive procedure, explains why less restrictive procedures are not recommended, and indicates

alternatives to the recommendation. Space must be provided for the client and/or legal representative to write comments and their opinions regarding the plan. See DSHS 15-385, Consent for Use of Restrictive Procedures Requiring an ETP.
Distribution of PBSPs
1. A copy of the client's current PBSP must be available in the client's home for employees to access.
2. The residential provider must send a copy of the client's PBSP to the employment or day program provider if the client is receiving these services. The employment/day program provider must implement the PBSP as written and communicate with the residential provider regarding any proposed modifications for use in the employment/day program setting.
3. If the employment/day program develops a PBSP for the client, they should consult with the residential provider and send a copy of the final PBSP to the DDD CRM and the client's residential provider.
Data Monitoring of Restrictive Procedures
1. Program staff responsible for PBSPs must review the plan at least every thirty (30) days.
2. If the data indicates progress is not occurring after a reasonable period, but no longer than six (6) months, the PBSP must be reviewed and revisions implemented as needed.
3. At least annually, the approving authorities must re-approve restrictive procedures that require ETPs or involve physical or mechanical restraint.

DDD Policy 5.15 allows for Emergency Use of Restrictive Procedures
1. Emergencies may occur in which a client's behavior presents an immediate risk to the health and safety of the client or others, or a threat to property. In such situations, restrictive procedures permitted in this policy may be used for protective purposes. However, the least restrictive procedures that will provide adequate protection must be used, and terminated as soon as the need for protection is over. No procedures that require an ETP may be used in an emergency other than those described in section '4' below.
2. An incident report must be submitted to the DDD CRM or the RHC superintendent or designee for each incident leading to the use of emergency restrictive procedures, in accordance with procedures for reporting incidents.
3. If the same restrictive procedure is used on an emergency basis more than three (3) times in a six (6) month period, a functional assessment must be conducted and, if warranted, a PBSP developed.
4. For individuals who pose an immediate danger to self or others, it is acceptable to initiate the following procedures/interventions immediately without a PBSP or ETP if there is reasonable justification:
a. Restricted access (see Policy 5.15 Section H.3.f);
b. Necessary supervision (see Policy 5.15 Section G.2.c; and
c. The use of a seated restraint as described in Policy 5.15 Section H.3.m (a and b) as long as staff implementing the restrictive physical intervention have been previously trained in its application and otherwise meet the requirements of DDD Policy 5.17, Physical Intervention Techniques.
Once the provider notifies DDD of this action, the RA or designee must subsequently approve or disapprove within three (3) working days. Approval must be written with a brief statement of the problem and reason for the restriction. A written PBSP, and ETP request if necessary, must be completed within 45 days.
Division Policies 5.15 and 5.17 (see G-2-b-i) specify the requirements for using and documenting use of any type of restraint (mechanical or pharmacological). Only the least restrictive intervention needed to adequately protect the client, others, or property may be used, and terminated as soon as the need for protection is over. Approved restraint use must be fully documented and reviewed at least monthly by the residential provider and at least quarterly by the client's interdisciplinary team. Any emergency use of a restraint requires an incident report to division headquarters where it is reviewed by the Incident Management Program Manager.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The Department of Social and Health Services, Aging and Disability Services Administration:
- Division of Developmental Disabilities
- Residential Care Services Division
- Adult Protective Services (APS)
- Child Protective Services (CPS)

Under state authority RCW 74.34, the Aging and Disability Services Administration (ADSA) receives reports and conducts investigations of abuse, neglect, exploitation and abandonment for clients enrolled with the Division of Developmental Disabilities. ADSA Residential Care Services (RCS) investigates abuse and neglect occurring in nursing homes, assisted living facilities, adult family homes, & supported living programs. ADSA Adult Protective Services (APS) investigates abuse and neglect involving adults residing in their own homes.

The DDD detects use of unauthorized restrictive intervention through:
- Reports submitted to Adult Protective Services,
- Reports submitted to Residential Care Services,
- Reports submitted to Child Protective Services,
- Reports received in the DDD Incident Reporting system,
- The face to face DDD Assessment process conducted yearly and at times of significant change,
- The DDD complaint/grievance process, and
- DDD Quality Assurance activities that include face to face interviews of clients and review of complaints.

Residential Care Services Division has contracted evaluators who evaluate the residential agencies/programs at least once every two years. Their review always includes any use of restraints, restrictive procedures, or use of psychoactive medications.

Quality Control Compliance (QCC) staff yearly review the positive behavior support plans (PBSPs) of a sample of waiver clients. One focus is on instances when the PBSP includes retraint that requires approval through an exception to rule (ETR). When the QCC team identifies PBSPs requiring an ETR that did not have an ETR, the QCC team verifies that individual corrective action was completed within 90 days and reports to management on systems issues.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The Department of Social and Health Services:
- *Developmental Disabilities Administration (DDA)
- *Aging and Long-Term Support Administration/Residential Care Services (RCS)
- *Aging and Long-Term Support Administration/Adult Protective Services (APS)

Under state authority RCW 74.34, the Aging and Long-Term Support Administration (ALTSA) receives reports and conducts investigations of abuse, neglect, exploitation and abandonment for clients enrolled with the Developmental Disabilities Administration. ALTSA's Residential Care Services (RCS) investigates the role of provider systemic issues in abuse and neglect occurring in nursing homes, adult residential care facilities, adult family homes, & supported living programs. ALTSA's Adult Protective Services (APS) investigates the perpetrators of abuse and neglect involving adults.

The DDA detects use of unauthorized restrictive intervention through:
- *Reports submitted to APS,
- *Reports submitted to RCS,
- *Reports received in the DDA Incident Reporting

system,
- *The face to face DDA Assessment process conducted yearly and at times of significant change,
- *The DDA complaint/grievance process, and
- *DDA Quality Assurance activities that include face to face interviews of clients and review of complaints.

Residential Care Services Division has contracted evaluators who evaluate the residential agencies/programs at least once every two years. Their review always includes any use of restraints, restrictive procedures, or use of psychoactive medications.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c -i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

When an individual is not receiving services from a DDD residential program the individual, their representatives, their healthcare provider and DDD work together to monitor medication management. Medication management is a component of the DDD assessment. The DDD assessment will trigger a referral requirement if medication risk factors are identified. Once this requirement is triggered the CRM or SSS must address the risk identified in the ISP. How the risks addressed depends on the concern identified. It could result in a medication evaluation referral, additional provider training, nurse oversight visits, consultation with the healthcare provider or any of a number of measures.

Psychoactive medications have proven to be a very effective treatment for many forms of mental illness. As with other prescription medications, psychoactive medications have the potential for unwanted side effects. Regular monitoring for side effects and evaluation of medication effectiveness is especially important for individuals who have a reduced capacity to communicate symptoms of potential side effects. Psychoactive medications are not necessarily the first or only treatment of choice, particularly for challenging

behaviors. Positive behavior support approaches may be equally or more effective and treatment decisions should always be made on an individual basis.
DDD policy 5.16 establishes guidelines for assisting a client with mental health issues or persistent challenging behavior to access accurate information about psychoactive medications and treatment, to make fully informed choices, and to be monitored for potential side effects of psychoactive medications.

Protections against the use of chemical restraints are included in DDD Policies 5.14 (Positive Behavior Support), Policy 5.15 (Use of Restrictive Procedures), Policy 5.16 (Use of Psychoactive Medications), and Policy 6.19 (Residential Medicaid Management) with respect to the use of psychoactive medications. If psychoactive medications are used, informed consent must be obtained, a functional assessment must be completed, a positive behavior support plan must be developed and implemented, and a Psychoactive Medication Treatment Plan must be in place. Psychoactive medications can only be used as prescribed.

Additionally, Policy 6.19 Residential Medication Management applies to individuals who receive services from a DDD certified residential program.

Policy 6.19 Residential Medication Management:

When providing instruction and support services to persons with developmental disabilities, the provider must ensure that individuals who use medications are supported in a manner that safeguards the person's health and safety.

PROCEDURES

A. Self-Administration of Medications

1. Residential service providers must have a written policy, approved by DDD, regarding supervision of self-medication.
2. The provider, unless he or she is a licensed health professional or has been authorized and trained to perform a specifically delegated nursing task, may only assist the person to take medications.
3. The provider may administer the person's medication if he/she is a licensed health care professional. Medications may only be administered under the order of a physician or a health care professional with prescriptive authority.
4. If a person requires assistance with the use of medication beyond that described in A.2. above, the assistance must be provided either by a licensed health care professional or a registered nurse (RN) who delegates the administration of the medication according to Chapters 388-101 and 246-840 WAC.

Per WAC 246-840 before delegating a nursing task, the registered nurse delegator decides the task is appropriate to delegate based on the elements of the nursing process: ASSESS, PLAN, IMPLEMENT, EVALUATE. (Please see WAC 246-840-910 through 990 for specific details)

Per WAC 246-841 Standards of practice and competencies for Nursing assistance. Competencies and standards of practice are statements of skills and knowledge, and are written as descriptions of observable, measurable behaviors. All competencies are performed under the direction and supervision of a licensed registered nurse or licensed practical nurse as required by RCW 18.88A.030.
Per WAC 246-841-405 Nursing assistant delegation identifies the certifiction requirements as stated below.

DDD Policy 6.15 ("Nurse Delegation Services") details eligibility requirements for services (including a stable and predictable client condition), which tasks can and cannot be delegated, training and certification requirements for delegated providers, the referral process, case manager responsibilities and Registered Nurse Delegator responsibilities, and authorization of services.

Training Requirements for Providers Who Perform Delegated Nursing Tasks

Before performing a delegated task, the provider must have completed:
1. Registration or certification as a Nursing Assistant and renew annually;
2. The Nurse Delegation for Nursing Assistants class (nine hours), either the classroom or self-study version;
3. For NAR only:
   a. For providers working in Supported Living: DDD Core Training (32 hours).
   b. For providers working in all other settings: Fundamentals of Caregiving (28 hours).
   c. An NAR may not perform a delegated task before DDD Core Training or Fundamentals of Caregiving is completed.
   d. DDD Core Training or Fundamentals of Caregiving is not required for an NAC to perform a delegated task.

Responsibilities of the Registered Nurse Delegator (RND)
The RND must:
1. Verify that the caregiver:
   a. Has met training and registration requirements;
   b. The registration is current and without restriction; and
   c. The caregiver is competent to perform the delegated task.
2. Assess the nursing needs of the client, determine the appropriateness of delegation in the specific situation and, if appropriate, teach the caregiver to perform the nursing task.
3. Monitor the caregiver's performance and continued appropriateness of the delegated task.
4. Communicate the results of the nurse delegation assessment to the CRM.
5. Establish a communication plan with the CRM as follows:
   a. Specify in the plan how often and when the RND will communicate with the CRM; and
   b. Document the plan and all ongoing related communication in the client's nurse delegation file.
6. Document and perform all delegation activities as required by law, rule and policy.
7. Work with the CRM, providers, and interested parties when rescinding RND to develop an alternative plan that ensures continuity for the provision of the delegated task.

Nurse delegation is an intermittent service. The nurse is required to visit at least once every ninety days, and may not need to see a client more frequently. However, the delegating nurse may determine that some clients need to be seen more often. The ADSA/DDD Central Office Nurse Delegation Program Manager will monitor the nurse's performance, including frequency of visits and SSPS payments.
In residential settings, providers are required to document all medication administration and client refusals.

WAC 388-101-3720 ("Medications--Documentation") indicates the service provider must maintain a written record of all medications administered to, assisted with, monitored, or refused by the client.

WAC 388-101-3690 ("Medication Refusal") indicates
(1) When a client who is receiving medication support from the service provider chooses to not take his or her medications, the service provider must:

(a) Respect the client's right to choose not to take the medication(s) including psychoactive medication(s); and

(b) Document the time, date and medication the client did not take.

(2) The service provider must take the appropriate action,

including notifying the prescriber or primary care practitioner, when the client chooses to not take his or her medications and the client refusal could cause harm to the client or others.
Any person may call the Nurse Delegation Hotline at (800) 422-3263 to file a complaint.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

The Department of Social and Health Services, Aging and Disability Services Administration:
- Division of Developmental Disabilities
- Residential Care Services Division

Division Policy 6.19 (see G-3-b-i) specifies the requirements for residential medication management. Residential Care Services Division has contracted evaluators who evaluate the residential agencies/programs at least once every two years.

Issues with medication management will also be identified if errors result in allegations of abuse, neglect, exploitation. Under authority provided via RCW 74.34 (public assistance Washington state law concerning abuse of vulnerable adults), the Aging and Disability Services Administration (ADSA) receives reports and conducts investigations of abuse, neglect, and exploitation for clients enrolled with the Division of Developmental Disabilities. ADSA Residential Care Services (RCS) investigates abuse and neglect occurring supported living programs.

RCS is using FamLink to document investigation activites including intake of complaints and outcome reports. There is an electronic connection between the FamLink and the CARE system to notify case managers of a) complaints that are referred for investigations and b) investigation outcomes. This is an electronic notification that will be identified in the client's CARE record.

ADSA will receive nightly data feeds from FamLink that will be used in this ADSA reporting system. FamLink information will be reviewed to determine if client information matches DDD waiver clients who are identified in CARE. DDD will use the ADSA reporting system to address specific programmatic and provider issues from the outcomes of the waiver clients who were involved in investigations by Residential Care Services (RCS). The data are broken out by type of incident and provider type.

Information and findings are communicated to the Medicaid agency at least quarterly via the Medicaid Agency Waiver Management Committee.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Division Policy 6.19 (see G-3-b-i) specifies the requirements for residential medication management. Residential Care Services Division has contracted evaluators who evaluate the residential agencies/programs at least once every two years.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

Division of Developmental Disabilities (DDD)

(b) Specify the types of medication errors that providers are required to *record:*

Providers are required to record all medication errors.

(c) Specify the types of medication errors that providers must *report* to the State:

Providers are rquired to report medication errors causing injury/harm, or a pattern of errors.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Deparment of Social and Health Services, Aging and Disability Services Administration:
* Division of Developmental Disabilities
* Residential Care Services Division

Division Policy 6.19 (see G-3-b-i) specifies the requirements for residential medication management. Residential Care Services Divisoin has contracted evaluators who evaluate the residential agencies/programs at least once every two years.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.1: The % of incidents alleging abuse, neglect, abandonment and/or financial exploitation of wvr clnts that were reported by DDD, per policy, to Adult Protective Services (APS), Child Protective Services (CPS), or Residential Care Services (RCS). N= # of incidents where CRMs reported allegations to APS, CPS or RCS. D= Total # of incidents requiring notification by DDD to APS, CPS or RCS.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
Data are compiled from a database that documents incidents, including incident type and who was notified.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.2: The number of allegations of abuse, neglect, abandonment, or financial exploitation substantiated by APS, by type of incident. Numerator= The number of substantiated allegations of abuse, neglect, abandonment, or financial exploitation by APS, by incident type. Denominator= The total number of allegations substantiated by APS.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
FAMLINK will be used after July 2013. Prior to this time, DDD will use APS data.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.3: The percentage of waiver clients for whom a report of abuse, neglect, abandonment, or financial exploitation was substantiated by Residential Care Services (RCS) by type of incident. Numerator= The number of substantiated allegations of abuse, neglect, abandonment, or financial exploitation by RCS, by type of incident. Denominator= Total number of allegations substantiated by RCS.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Match of a list of clients on the waiver with a list of DDD clients whose reports were substantiated by RCS.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.4 The total number of investigations involving waiver recipients completed by RCS by provider and type of enforcement activities. Numerator=The number of

providers with findings by type of enforcement activities. Denominator=The total number of investigation involving waiver recipients.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
FAMLINK

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.5: The percentage of families responding to the NCI Survey who report that they know how to report a concern or make a complaint about services. Numerator= All families of waiver participants who respond to the NCI Survey and report they know how to report a concern or make a complaint about services. Denominator= All families of waiver participants who respond to the NCI Survey.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Quality Assurance Team within DDD.	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 95%=/- Random sample across all HCBS Waivers
	☐ **Other**	

	Specify:

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.6: The percentage of waiver participants whose death was subject to review that were reviewed by the DDD Mortality Review Team (MRT). Numerator= The number of waiver participants whose death was reviewed. Denominator= The number of waiver participants whose death was subject to review.

Data Source (Select one):
Mortality reviews
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify:	☐ **Annually**	☐ **Stratified**

DDD Mortality Review Team (MRT)		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.7: The number of waiver recipient deaths reviewed by the Mortality Review Team (MRT) by cause of death. Numerator= The number of waiver recipient deaths reviewed by the MRT by cause of death. Denominator= The total number of waiver recipient deaths reviewed by the MRT.

Data Source (Select one):
Mortality reviews
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	

		☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: DDD Mortality Review Team (MRT)	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.8: The percentage of wvr recipients with four or more incident reports during the calendar ternary that was reviewed by QA Managers to verify appropriate actions were taken. Numerator= Number of wvr recipients with four or more

incident reports during the ternary with appropriate action taken. Denominator= Total number of wvr recipients with four or more incidents during the ternary.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.9: The percentage of waiver recipients with a critical incident report whose ISP was amended when it should have been amended. Numerator= Number of waiver recipients with a critical incident report whose ISP was amended when it should have been amended. Denominator= Total number of waiver recipients with a critical incident whose ISP should have been amended.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Incident Review Team (IRT)	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 40 individuals (across all waivers) per year.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.10: The percentage of waiver recipient ISPs in which all identified health and welfare needs were addressed. Numerator= the number of ISPs in which identified health and welfare needs were addressed. Denominator= The total number of waiver recipient ISPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
This requirement is system-enforced by CARE.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified**

		Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.11: The percentage of waiver recipients' ISPs with critical indicators triggered in the assessment that were addressed in the ISP. Numerator= The number of ISPs in which all identified critical indicators were addressed. Denom= The total number of waiver recipient ISPs

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	

		☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Control and Compliance (QCC) Team within DDD.	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.12.The number and percentage of complaints by type reported. Numerator=Number of complaints document in the CARE Service Episode Record and DDD complaints database. Denominator=The Total number of Waiver clients.

Data Source (Select one):

Other
If 'Other' is selected, specify:
DDD CARE system and Complaints Database.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
a.i.13. The Percentage of Positive Behavior Support Plans requiring an Exception to Policy (ETP) with an ETP in the CARE system. The Numerator=the number of waiver client files reviewed with a PBSP which had the required ETP. The Denominator=the number of waiver client files reviewed with a PBSP requiring an ETP.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

a.i.1: Alleged incidents of abuse, neglect, abandonment and exploitation are recorded in the DDD Incident Reporting (IR) Database. The database also documents contacts and follow-up referrals. A report is compiled based on incident type and other agencies contacted to document whether or not APS, CPS, or RCS was notified.

a.i.2: Quarterly staff from Adult Protective Services (APS) provide a report that lists clients for whom a report of abuse, neglect, abandonment, or financial explolitation was substantiated. The data are broken out by type of incident.

a.i.3: Quarterly staff from Residential Care Services (RCS) provide information on clients served by residential programs for whom a report of abuse, neglect, abandonment, or financial exploitation was substantiated. DDD compares that list to a list of waiver clients. The data are broken out by type of incident.

a.i.5: DDD compares data on response rates to NCI questions and responses from waiver year to waiver year. DDD constructs pie charts for questions and analyzes the outcome of the survey with the Waiver Oversight Committee and Stakeholders. DDD uses this information to assist with the development of the Waiver training curriculum as well as to develop needed policy changes.

a.i.6 and a.i.7: The Mortality Review Team (MRT) reviews waiver recipients whose death occurred while receiving medically intensive program services or whose death was unusual or unexplained to identify factors that may have contributed to the deaths and to recommend measures to improve client supports and services.

a.i.8: Each of the DDD Regions has a designated Quality Assurance (QA) Manager. Every four months those individuals review individuals with four or more reports in the DDD Incident Reporting database. A report is provided by each regional QA Manager to the Waiver Program Manager listing all waiver recipients with four or more incident reports that were reviewed during that four-momth period.

a.i.9: Every month members of the Central Office Incident Review Team (IRT) review a sample of individuals for which a critical incident was reported during the waiver year. Each member reviews the information contained in CARE/CMIS to verify that the response to the incident was appropriate, including whether there should have been (and was or was not) an amendment to the ISP.

a.i.11, and a.i.13:
The QCC Team completes an audit of randomly selected files on a waiver-specific basis across a two-year period. The list for the QCC Team audit is based on a random sample representative of each waiver with a 95% confidence level and a confidence interval of +/-5%. The findings from these reviews are collected in a database. All findings are expected to be corrected within 90 days. Corrections are monitored by QCC Team members.

The audit protocol addresssed (among other things) the following areas with a target of 100% compliance.
-For each identified [critical] indicator in the ISP DDD Referral Panel, the information in the "Reasons" box is consistent with other information in the assessment and there is evidence of follow-up for referrals (SER, documentation in the file such as e-mail print-outs, reports from provider, etc.).
-If the Positive Behavior Support Plan requires an Exception to Policy (ETP), was there an appropriate ETP in the CARE system?

a.i.12: The Division maintains a Complaint Tracking Database which documents all complaints received by Regional or Central Office Administration. Reports that categorize this information by topic of the complaint

and verify that the complaints were resolved or had appropriate action taken within Policy 5.03 (Client Complaints) timeframes are compiled twice a year and reviewed annually for trends and patterns.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
a.i.1: If the review determines specific allegations of abuse, neglect, abandonment and exploitation were not referred to APS, CPS, or RCS, an immediate referral to the appropriate entity is made.

a.i.2; a.i.3; and a.i.4: If a pattern of critical incidents is identified with respect to a specific individual or a specific provider, the quality Assurance Office Chief works with the appropriate HQ and/or regional staff to take appropriate steps to prevent future occurences of such incidents. For example, client ISPs or positive behavior support plans might be updated, provider reviews and/or certification might be adjusted to target the underlying factors resulting in the incidents, provider alerts might be developed if a pattern across provicers is detected. In addition, case manager training might focus on prevention, detection, and remediation of critical incidents.

a.i.6 and a.i.7: Changes implemented as a result of information gained from MRT reviews include caregiver alerts, curriculum for providers and case managers, and changes in DSHS administrative rules (WAC). For example, topics of caregiver alerts include "How hot is your water?", "Aspiration", "Seizures and Bathing", and "Type 2 Diabetes".

a.i.8: QA Managers review any client with four or more incidents in each four-month period and report findings to central office. The Incident Review Team (Central Office) reviews QA reports and makes recommendations for corrective actions if needed.

a.i.9: In the review of the IR information, if amendments to the ISP or PBSP are determined necessary but were not made or were insufficient, the case manager and/or regional management are notified to ensure that the participant's needs are being addressed and that necessary changes are included in the ISP or PBSP.

a.i.10: When the QCC team identifies health and welfare needs that were not adequately addressed in the ISP, the QCC team verifies each individual corrective action was completed within 90 days and reports to management on systems issues.

a.i.11: When the QCC team identifies critical indicators in the assessment that were not addressed appropriately, the QCC team verifies each individual corrective action was completed within 90 days and reports to management on systems issues.

a.i.12: Complaints that are not resolved or acted upon appropriately are reviewed semi-annually to determine what action is necessary. Protection and Advocacy reviews complaints semi-annually and recommends action when necessary. Remediation may include revisions in training curriculum, policy clarification, personnel action, revisions in form format and instructions, revisions in Waiver WAC, and revisions in regional processes.

Any trends and patterns are addressed through training where indicated.

a.i.13: When the QCC team identifies Positive Behavior Support Plans requiring an ETP that did not have an ETP, the QCC team verifies each individual corrective action was completed within 90 days and reports to management on systems issues.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other**	☑ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Two times per year.

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Division of Developmental Disabilities (DDD) has managed at least one HCBS waiver since 1983. The last several years have seen great improvement in quality assurance processes. In 2003 a statewide effort was launched to coordinate the implementation of Quality Improvement in all agencies. DDD continually works to improve the way we do business. We have developed multiple processes for trending, prioritizing, and implementing system improvements that have been prompted as a result of data analysis.

Internal ADSA Systems
DDD uses several data systems that are vital to the implementation of the Community Protection (CP) Waiver.

DDD Assessment:
- o The DDD Assessment is designed to discover the individual support needs of each individual who is assessed. It is a tool to help case managers plan for services and supports to meet the needs of individuals with developmental disabilities.
- o All CP Waiver participants will be assessed using this tool, which includes an assessment of caregiver stress, behavior issues, critical medical issues, and protective supervision needs.
  - • Reports are pulled as needed by program managers, the waiver manager, quality assurance staff and management.
  - • Reports are analyzed by the appropriate entity who is using the information for system improvement activities.

Case Management Information System (CMIS):
- o Assists case managers to provide effective monitoring of case status and service plans.
- o Provides a system of “ticklers” or alerts to cue case resource manager action at specific intervals based upon client need.
- o Replaced current paper processes with an automated process for Exception to Rule (ETR), Prior Approvals and Waiver Requests.
- o Developed a consistent, reliable and automated process.
- o Provides client demographic and waiver status at a moment’s notice.
- o Provides management reports to look for trends and patterns in the CP Waiver caseload.
  - • Reports are pulled as needed by program managers, regional staff, quality assurance staff and management.
  - • Reports are analyzed by the appropriate entity who is using the information for

system improvement activities.

Quality Control and Compliance (QCC) Audit database:
- o Is used to collect audit data to insure that the processes and procedures required in delivering waiver services are followed according to requirements.
- o Is used to develop regional and statewide corrective action plans.
  - • Reports are developed by the Office of Compliance and Monitoring.
  - • Reports are created at least annually.
  - • Reports are analyzed by Regional Management, the Program Manager, Waiver Oversight Committee and as requested by management.

DDD Incident Reporting system (IR):
- o The IR system provides management information concerning significant incidents occurring in the client's lives.
- o Individual incidents come first to the CRM for input into the IR system.
- o DDD has developed protocols and procedures to respond to incidents that have been reported.
- o Analysis processes are in place to review and monitor the health and welfare of DDD clients.
  - • Reports are pulled by the Incident Program Manager.
  - • Reports are pulled three times a year.
  - • Reports are analyzed by the Incident Reporting Team and as requested by management.

Individual Support Plan Meeting Survey:
- o A ISP Meeting survey is mailed to waiver participants within one month of the ISP planning meeting. This survey gives participants an opportunity to respond to a series of questions about the ISP process. The survey is mailed from Central Office based on a random sample representative of each waiver with a 95% confidence level and a confidence interval of +/-5%. Information collected is analyzed annually at the Waiver Oversight Committee.
- o Any information regarding trends or patterns that is gathered from that data is acted upon, through additional training for case managers, clarification of information for participants, etc.
  - • Reports are pulled by the Research Specialist.
  - • Reports are pulled at least annually.
  - • Reports are analyzed by the Waiver Oversight Committee and as requested by management.

Complaint Data Base:
- o DDD maintains a Complaint data base that is the repository for complaints that rise above the standard issues that case managers or supervisors handle each day as a normal business practice.
  - • Reports are pulled by the Research Specialist.
  - • Reports are pulled at least annually.
  - • Reports are analyzed by the Waiver Oversight Committee and as requested by management.

DSHS systems external to ADSA:

Social Service Payment System:
- o DDD audits information from this system to verify services identified in the Individual Support Plan as necessary to meet health and welfare needs have been authorized.
- o DDD also audits information from this system to ensure that services are only authorized after first being identified in the Individual Support Plan.
  - • Reports are pulled by the SSPS Program Manager.
  - • Reports are pulled at least annually.
  - • Reports are analyzed by the Program Manager, Waiver Oversight Committee and as requested by management.

Adult Protective Services (APS):
- o APS is the entity responsible for investigating and making official findings on any accusations of abuse, neglect or exploitation of a vulnerable adult, who does not live in either a licensed setting or is served by a certified residential service.
- o DDD refers all such incidents to them for investigation and works cooperatively with them to provide information about the incident and to protect the adult during the investigation.
  - • Reports are pulled by the Research Specialist.
  - • Reports are pulled at least annually.
  - • Reports are analyzed by the Regional Quality Assurance Managers and as requested by management.

Residential Care Services (RCS):
- o RCS is the entity responsible for investigating and making official findings on any accusations of abuse, neglect or exploitation of a vulnerable adult, who receives services from either a licensed setting or is served by a certified residential agency.
- o DDD refers all such incidents to them for investigation and works cooperatively with them to provide information about the incident and to protect the adult during the investigation.
  - • Reports are pulled by the DDD Incident Program Manager.
  - • Reports are pulled at least annually.
  - • Reports are analyzed by the Waiver Oversight Committee and as requested by management.

FAMLINK is a electronic system that maintains notifications, investigative and outcome information for CPS, APS and RCS. Data from FAMLINK will be used to track and trend inforamtion related to allegations of abuse, neglect, abandonment and financial exploitation.

Administrative Hearing Data Base:
- o The Administrative Hearings data base tracks requests for administrative hearings requested by waiver clients who disagree with decisions made by DDD.
- o DDD uses data from this data base to review the concerns of persons on the waivers and determine if there are system issues that need to be addressed.
  - • Reports are pulled by the Research Specialist.
  - • Reports are pulled at least annually.
  - • Reports are analyzed by the Program Manager, Waiver Oversight Committee and as requested by management.

All Contracts Data base (ACD):
- o The ACD is an important tool in assuring that waiver service providers have contracts in place that meet requirements.
- o The tool is used by DSHS to monitor all state contracts.
- o The system monitors compliance with background check requirements, training requirements, evidence of any required licensure, and timeliness of contracts.
  - • Reports are pulled by the Contracts Program Manager.
  - • Reports are pulled at least annually.
  - • Reports are analyzed by the Program Manager, Waiver Oversight Committee and as requested by management.

External Non Governmental Systems:

National Core Indicators (NCI) Survey:
- o DDD has been participating in the National Core Indicators Survey since 2000.
- o Additional questions have been added about waiver services.
- o This data is reviewed with stakeholders and state staff.
  - • Reports are pulled by the Research Specialist.
  - • Reports are pulled at least annually.
  - • Reports are analyzed by the Program Manager, Waiver Oversight Committee and as

requested by management.
o Recommendations for needed changes are drawn from this process and then acted upon.

Developmental Disabilities Council (DDC):
o The DDC partners with the state to conduct focus groups that look at the NCI data and make recommendations to the state.
o Reports are developed by the DDC and submitted to the state for action.
• Reports are pulled at least annually.
• Reports are analyzed by program managers, Waiver Oversight Committee and as requested by management.

Information from the above data systems is gathered and analyzed in order to continually monitor and make changes to our delivery system when the need is demonstrated. DDD utilizes a variety of methods to analyze data. Some examples include identifying "trigger" points that require more in-depth analysis using control charts and other types of analysis; or the occurrence of an egregious incident that requires immediate in-depth work.

Once the need for change has been determined through the analysis of data, DDD prioritizes quality improvement steps based on a risk management strategy that considers health and safety, best practices, legislative requirements, and CMS recommendations.

DDD then implements needed system improvements through a variety of methods, such as training and re-training; resource allocation; studies; policy or rule changes; and funding requests. DDD identifies who is responsible for implementation of the needed change, how that will be accomplished and timelines for accomplishing the needed change.

Strategies for improvement are specific to the type of improvement that is indicated by the data that has been reviewed. However the process is generally the same:
1. We review and analyze data;
2. We strategize to find solutions to any problems identified from the data;
3. Action plans are developed; and
4. Progress is reviewed until goals are accomplished.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **State Medicaid Agency**	☑ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☑ **Other** Specify: 2 times per year. 3 times per year. 6 times per year. During the first year of the biennium.

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

DDD uses a discovery and monitoring process to analyze the effectiveness of our current systems. All collected data is identified by waiver type in order to evaluate and monitor each individualized waiver program. Performance is measured in terms of outcomes. DDD uses both internal and external groups to analyze this data. DDD reviews data from multiple data sources to discover whether trends and patterns meet

expected outcomes. DDD begins an improvement process if they do not. DDD's Quality Improvement (QI) process has been part of the Division's activities for decades.

The goal of Quality Improvement in DDD is to promote, encourage, empower and support continuous quality improvement. Major areas of focus:

Surveys
- ISP-related surveys give individuals/guardians an opportunity to provide anonymous feedback on the planning process. Information collected from these surveys is used to analyze the effectiveness of the planning process.

Audits
- Audits ensure processes and procedures required in delivering waiver services are according to requirements.
- Waiver audit findings are analyzed and shared with regional and statewide management teams for corrective action and system improvement.

Ternary evaluations of performance measures
- Ternary Regional management reports on waiver performance.
- The report contains data such as the number of waiver assessments due against the number that were completed, the regional progress on correction related to QCC audit findings, and many other key indicators of operational performance.

Training
- Training is a significant focus to ensure that divisional employees are equipped with the skills and knowledge to carry out their waiver responsibilities.
- Annual Waiver training is provided for ongoing improvement.

There are many entities that play a critical role and are essential to DDD's Quality Management Strategy:

Internal (within DSHS)

Waiver Oversight Committee (WOC):
- This committee meets three times per year and is comprised of representatives from across ADSA.
- The committee reviews and makes recommendations from the following data and reports:
  - QCC audits
  - National Core Indicators
  - ISP satisfactions surveys
  - Fiscal reports
  - CRM face to face meeting data
  - Incident Reports

County Oversight Committee (COC);
- This committee meets yearly to develop and review county quality assurance measures. In addition it reviews corrective actions developed from biennial survey of county quality assurance activities and makes recommendations to the Program Manager for County Programs to implement in working with counties.
- Team members are:
  - Office Chief, Quality Programs and Services
  - Office Chief, Field Services Supports
  - Program Manager for County Programs
  - Performance and Quality Improvement Program Manager

Incident Review Team (IRT):
- This team meets monthly to review aggregate data from the Electronic Incident Reporting System and make recommendations to prevent incidents.
- Team members are:
  - Waiver Program Managers (PM), Waiver Requirements PM, RHC PM, Incident PM, Mental Health PM, Vocational PM, Quality Assurance PM, Compliance and Monitoring Unit

Office Chief, Quality Programs and Services Office
Chief, Special Investigation Unit PM and Data Analyst
for RHC investigation unit.

Mortality Review Team (MRT):
- Meets monthly to review deaths of participants and monitor and make recommendations on trends and patterns.
- Team members are:
  - RHC PM, Mental Health PM, Residential PMs, Compliance and Monitoring Unit Office Chief, Quality Programs and Services Office Chief, Waiver PM, Special Investigation Unit PM and Nursing Services PM.

Nursing Care Consultants (NCC):
- Assigned to Regions to review and monitor health and safety concerns.
- Nurses consult with case managers on health and welfare concerns.

State Waiver Program Manager and Regional Waiver Coordinators:
- The primary responsibility for the implementation of this waiver resides with the Waiver Program Manager
- Regional Waiver Coordinators work collaboratively with the Waiver Program Manager to ensure proper implementation at the regional level.
- The Waiver Program Manager and Waiver Coordinators meet monthly to monitor waiver implementation and recommend necessary waiver changes.

Regional Quality Assurance (QA) Staff:
- Regional QA staff work in partnership with volunteers who are self-advocates or family members trained by the DDC to complete face-to-face surveys of waiver clients to ensure satisfaction with waiver services.
- Regional QA staff provide quarterly reports which contain quality assurance information on incidents and other QA activities in the region.

External

Stakeholder input and review of waiver programs:
- A listserv and dedicated web site offers stakeholders an opportunity to:
  - Review annual waiver reports.
  - Review quality assurance activities.
  - Provide input on needed changes.
  - Provide suggestions for ways to better serve waiver clients.
  - Participate in an on-going dialogue about the quality of services for individuals on HCBS waivers.

Developmental Disabilities Council (DDC):
- The DDC is comprised of self advocates, family members and department representatives.
  - Analyzes and provides recommendations for improvement using the National Core Indicators Survey as it's tool.
  - Regional Quality Assurance Staff work in partnership with volunteers who are self- advocates or family members trained by the DDC to do face-to-face surveys of waiver clients to ensure satisfaction with waiver services.

The HCBS (DDD) Waivers Quality Assurance Committee:
- Sponsored by the DDC and comprised of self advocates, family members, providers and Department representatives.
  - Meets twice a year, with provision for more frequent sub-committee meetings on select topics as needed.
  - Provides a forum for active, open and continuous diaglogue between stakeholders and the DDD for implementing, mornitoring and improving the

delivery of waiver services to best meet the needs of people with intellectual and developmental disabilities.

The Medicaid Agency Waiver Management Committee:

- Includes representatives from the Health Care Authority (the single State Medicaid Agency) and Divisions within the operating agency: DDD, HCS, RCS, and DBHR. The committee meets quarterly to review all functions delegated to the operating agency, current quality assurance activity, pending waiver activity (e.g., amendments, renewals), potential waiver policy and rule changes and quality improvement activities.

Various reports are disseminated to both external and internal groups. These groups are involved in evaluating the performance and progress of the Waiver program. Through this review process these groups also provide feedback on opportunities for improvement.

Included in the distribution cycle are:

Internal:

- Division Director, HQ Management Team and Regional Management Team reviews:
  - Ternary Regional management reports on the waiver performance.
  - The report contains data such as the number of waiver assessments due against the number that were completed, the regional progress on correction related to QCC audit findings, and many other key indicators of operational performance.

- Division Director, HQ Management Team and all Regional Management Teams reviews:
  - The Ternary Regional Quality Assurance Managers' reports are compiled into one final report.
  - Each regional QA report, also in a PowerPoint format contains 8 control charts from the "key" incident types, a detailed analysis of any client with 3 or more incidents, analysis of deaths, and information/data on many other QA activities in the region.
  - When the final report is compiled best practices and concerns are reviewed.

Waiver Oversight Committee reviews:

- Monthly fiscal reports provided by Management Services Division (MSD).
  - These reports provide detailed analysis of the waiver expenditures and clients served.
- Quality Compliance and Control (QCC) audit reports. The QCC team report quarterly on the outcome of regional audits. This is a review of the questions in the QCC audit and the percent conformance to the requirements.

QCC reviews:

- Statewide analysis of audit findings. The report includes data and recommendations from the annual audit cycle. This report is then shared with the Waiver Oversight Committee and the Statewide Management Team.
- Regional audit findings. The regional reports are specific to the regional audit. Each report provides an analysis of the audit data from the most current review and compares historical data (when available).

ADSA Assistant Secretary Reviews:

- Monthly fiscal reports provided by Management Services Division (MSD).
  - These reports provide detailed analysis of the waiver expenditures and clients served.

External

A listserv and dedicated web site offers stakeholders an opportunity to review:

- Annual waiver progress/performance reports.
- The reports are often PowerPoint presentations with control charts or Pareto charts constructed from data related to performance measures. For example, one report is

structured around the “key” incident types from the Incident Reporting data base. Another example is a report that contains data indicating the number of National Core Indicator NCI) survey visits against the regional goals established and NCI survey data containing the % responding to particular questions. These data are displayed graphically usually in a bar chart, along with narrative.

Washington State Developmental Disabilities Council (DDC):

- Annual NCI Core Indicator reports are provided to the DDC for their recommendation and feedback.
- The NCI reports focus on participant satisfaction or areas of concern.
- The DDC invites families and self-advocates to review the data from the National Core Indicator survey report. Their feedback and recommendations are then shared with management after every evaluation.

The HCBS (DDD) Waivers Quality Assurance Committee:

- Sponsored by the DDC and comprised of self advocates, family members, providers and Department representatives.
- Meets twice a year, to discuss/review selected topics of focus, which may include
  - Current quality assurance activities
  - Pending waiver activities (e.g., amendments, renewals)
  - Potential waiver policy and rule changes
  - Quality improvement activities

The Medicaid Agency Waiver Management Committee:

- Includes representatives from the Health Care Authority (the Single State Medicaid Agency) and divisions within the operating agency: DDD, HCS, RCS, and DBHR.
- Meets at least quarterly to review:
  - All functions delegated to the operating agency
  - Current quality assurance activity
  - Pending waiver activity (e.g., amendments, renewals)
  - Potential waiver policy and rule changes
  - Quality improvement activities

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Division of Developmental Disabilities (DDD) believes that the quality of programs and services delivered to people with developmental disabilities in Washington State is everyone’s business. The evaluation and improvement of processes and systems are ongoing. All collected data is identified by each waiver type in order to evaluate and monitor individualized waiver program effectiveness.

Each year DDD improves services to waiver clients by using the numerous data collection points, appropriate analysis and prioritization techniques, evaluation and feedback from differing groups.

ADSA also seeks the assistance of CMS and other entities through grants, conferences, or “Best Practices” information, to continue to refine benchmarks for improvement and evaluate the system against those benchmarks.

The Quality Improvement Strategy will be re-evaluated at least once during the three year approval period. The following process will be followed in reviewing and updating the Quality Improvement Strategy:

- All processes and strategies will be continuously improved through the various methods of evaluation, monitoring, analysis and actions taken.
- DDD will work with participants, families, advocates, and providers to identify opportunities for performance improvement and report the progress being made back to stakeholders.
- State staff, providers and stakeholders will provide ongoing monitoring of the system. Changes may be recommended by any of the above entities.
- The Waiver Oversight Committee reviews suggested changes and improvements and recommends actions that should be taken.
- The Waiver Oversight Committee reviews suggested changes and

improvements and recommends actions that should be taken.
- The HCBS (DDD) Waivers Quality Assurance Committee will also review and provide input on the Quality Improvement Strategy.

Explanation and Examples of Types of Data Analysis Used:

Charting Data : Using charts and graphs, often provides greater insight and interpretation of data. Data charts provide a powerful tool to help observe and analyze the behavior of processes and the effects of trial solutions. They are the best way to present data to others helping them to quickly grasp the information.

Chart Selection Guide : The information below summarizes several chart types that are useful in Quality Improvement and suggests possible applications:

A pie chart presents data as a percentage of a total. Examples of application include sources of errors and make up of a budget.

A bar chart presents comparisons of data categories. These can be categories at a point in time or changes in categories over a period of time. Examples of application include the number of errors over time,process output by month or by department, comparison of results using different methods.

Pareto charts present data relative to the size of categories in order. Examples of application include customer quality characteristics in order of importance, and types of customer complaints.

Histo-grams present a distribution of a set of data (how frequently the given values occur) and shows the stability of a process. One example of application is variation of complaint resolution times.

Line charts represent behavior over time, same data collection frequency, and X charts. Examples of application include time to complete inspections over time, and the number of customer complaints over time.

Control charts present the common cause and special cause variation based on 3 sigma of the average, X bar and R, X and mr charts. Examples of application include time to fulfill customer requests, and the number of IRs per month.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

a) Providers are not required to have an independent financial audit of their financial statements. Agency providers are required to submit a cost report. If the department has reason to be concerned, the department will request an audit by Operations Review and Consultation or the State Auditors Office. Operations Review and Consultation is within DSHS. The State Auditors Office is a state agency outside the Department of Social and Health Services.

b) The Office of Rates Management conducts desk audits on all annual cost reports submitted by providers. The revenues reported by providers are reconciled to the payments made through SSPS (later, ProviderOne) for services and the provider's contract(s) in place during the period. The Office of Rates Management may require additional information from the provider (payroll records, other financial records, etc.) if there are concerns about the integrity of the cost report information. The Office of Rates Management may also conduct on-site reviews of provider financial records to ensure that the cost report is accurate and completed in accordance with contract requirements.

c) The state agencies responsible for conducting the financial audit program are the DSHS Operations Review and Consultation Services and/or the State Auditors Office.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.1a: The percentage of waiver participants who initially met financial eligibility for waiver enrollment. Numerator= All waiver participants who initially met financial eligibility for waiver enrollment. Demoninator= All waiver participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

Quality Control and Compliance (QCC) Team within DDD.		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.1.b: The percentage of waiver participants who continued to meet financial eligibility for waiver enrollment. Numerator= All waiver participants who continued to meet financial eligibility for waiver enrollment. Denominator= All waiver participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Control and Compliance (QCC) Team within DDD.	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.2: The percentage of waiver participants whose authorized service amounts are equal to or less than the amount identified in the ISP. Numerator= All waiver participants whose authorized service amounts are equal to or less than the amount identified in the ISP. Denominator= All waiver participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Control and Compliance (QCC) Team within DDD.	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.3.a: The percentage of waiver participants who initially met disability criteria as established in the Social Security Act. Numerator= All waiver participants who initially met disability criteria as established in the Social Security Act. Denominator= All waiver participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Control and Compliance (QCC) Team within DDD.	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.3.b: The percentage of waiver participants who continued to meet disability criteria as established in the Social Security Act. Numerator= All waiver participants who continued to meet disability criteria as established in the Social Security Act. Denominator= All waiver participants reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Control and Compliance (QCC) Team within DDD.	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.4: The percentage of case files reviewed whose providers have valid contracts, which initially met and continue to meet DDD contract standards. Numerator= All case files reviewed that met contract standards. Denominator= All case files reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Quality Control and Compliance (QCC) Team within DDD.	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other**

		Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.i.5: The percentage of all payments claimed under the Community Protection Wiaver that are made for Community Protection Waiver recipients. Numerator= All payments appropriately claimed under the Community Protection Waiver for Community Protection Waiver participants. Denominator= All payments claimed under the Community Protection Waiver.

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
a.i.1.a; a.i.i.b; a.i.2; a.i.3.a; a.i.3.b; a.i.4:
The QCC Team completes an audit of randomly selected files on a waiver-specific basis across a two-year period. The list for the QCC Team audit is generated to produce a random sample representative of each waiver with a 95% confidence level and a confidence interval of +/-5%. The findings from these reviews are collected in a database. All findings are expected to be corrected within 90 days. Corrections are monitored by QCC Team members.

A valid sample is produced for the QCC audit. The audit protocol includes (among others) the following questions with a target of 100% compliance.
"Was the client financially eligible per program requirements at the time of the initial or annual assessment?"
"Is the client currently financially eligible per program requirements at the time of the audit or review?"
"Are the authorized service amounts equal or less than the amounts identified in the ISP?"
"Did the client meet disability eligiblity criteria as established in the Social Security Act as the time of the Initial or annual assessment?"
"Does the client currently meet disability criteria as established in the Social Security Act at the time of the audit or review?"
"Do all providers have valid contracts for the services they were authorized to provide during the time the service was provided?"

a.i.5:
A claims data report is run annually to verify that all claims made for FFP are for waiver participants.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Waiver File Reviews (Annual QCC audit):
a.i.1.a; a.i.i.b; a.i.2; a.i.3.a; a.i.3.b; a.i.4:
Findings from QCC Team and Supervisor file reviews are analyzed by management, and based on the analysis necessary steps are taken to increase compliance. For example:.
- Annual Waiver Training curriculum is developed in part to address audit findings
- Annual Automated Client Eligibility System (ACES) training addresses financial and disability eligibility determination issues reflected in annual audits
- Policy clarifications occur as a result of audit findings.
- Analyses of findings assist regions to recognize personnel issues.
- Analysis of audit finding may impact format and instructions on forms.
- Analysis of findings has led to revision in Waiver WAC to clarify rule.
- Analysis of findings has led regions to revise regional processes.

Providers whose service authorization included a rate higher than the contracted rate are reviewed to determine the appropriate course of action. Overpayments are processed as necessary.

a.i.5: Claims that are made for nonwaiver participants are removed from the claim for FFP.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

○ **No**

◉ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
The DDD will develop standardized reports to verify client financial eligibility (Performance Measure a.i.1), client disability (Performance Measure a.i.2), and the presence of all authorized services in the ISP (Performance Measure a.i.3) across all waiver enrollees.

The Department is also implementing a new MMIS (known as "ProviderOne") which (as of December 2011) will reimburse providers of social services to DDD clients (as well as reimbursing medical care providers, which will occur earlier). ProviderOne will verify financial eligibility status (as contained in the ACES), ensuring that waiver clients are financially eligible prior to authorization or payment for waiver services (Performance Measure a.i.1). ProviderOne will also verify waiver status prior to authorization or payment.

Phase 1 of ProviderOne (which covers most medical care reimbursement) was implemented May 9, 2010. Federal Certification for the ProviderOne MMIS was obtained on July 20, 2011.

Phase 2 of ProviderOne implemention will include payments for social services. The exact timing is still being determined, but the current target is to have ADSA providers reimbursed by ProviderOne no later than June 30, 2013.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

• Residential Habilitation:
o Contracted Supported Living: Rates are determined for each individual client based on the number of direct care staff hours
needed as determined by the case manager and other regional staff. Staff hours are paid at a pre-determined

benchmark rate
specific to county categories (MSA, Non-MSA and King County). In addition to the direct staff rate, an administrative
rate is determined using the Administrative Rate Standard schedule (Attachment C to Policy 6.04), and a client transportation rate using the Client Transportation Assessment.

Individual rates are negotiated regionally utilizing policy and standards developed by the central office cost reimbursement
section and the residential program manager. This group works closely with regional personnel and with the residential
provider group to formulate policy and standards used in setting reimbursement rates. Final rates are based on residential
support levels (assigned by the DDD assessment), specific support needs listed in the assessment, support provided by others
(e.g., family members), and the number of people living in the household who can share the support hours. All negotiated
rates are reviewed by the cost reimbursement analyst and approved by the Residential Program Manager and the Division Director.

Annual cost reports are required from each service provider itemizing the cost of providing the contracted service for the
calendar year. The cost reports are desk audited by the Cost Reimbursement Analyst to determine accuracy and reasonableness
of reported costs. Reported revenue receive is reconciled to DSHS/SSPS payment information to determine over/under
payments for services.

Settlements are calculated by the Cost Reimbursement Analyst to determine pay back amounts in cases where providers
contracted for more direct service hours than they provided, or received more reimbursement for direct care costs than they
paid for direct care costs. There is no settlement provision for the non-direct care staff components of the payment rate.

o State-Operated Supported Living: A prospective (daily) rate based on staffing and overhead costs is established each year
for each location (region) based on the projected costs and number of resident days for the ensuing fiscal year. The
established rates are transmitted to the Office of Financial Recovery (OFR). The OFR uses the daily reimbursement rates and
the number of Medicaid eligible days at each location to recalculate the federal share of cost for each program. The OFR
calculation report goes to the Office of Accounting Services and to ADSA. The fiscal unit at ADSA prepares a journal
voucher to record the federal share under the federal funds appropriation in the FRS. Reported resident days and FFP claims
are reconciled with OFR each month. At the close of each year, a settlement calculation is prepared to recover additional
federal funds, or to pay back funds previously received.

• Expanded Habilitation: Variations in rates are due to differences among providers related to overhead, staff wage, and the
local demand for services.
o Prevocational: Unit rates are negotiated between the counties and their providers with the parameteres established by the
County Service Guidelines and the county allocations.
o Supported Employment:
• Group Supported Employment: Unit rates are negotiated between the counties and their providers with the parameters
established by the County Service Guidelines and the county allocations.
• Individual Supported Employment: Unit rates are negotiated between the counties and their providers with the

parameters
established by the County Service Guidelines and the county allocations.

• Behavior Support and Consultation: Regional DDD staff negotiate rates on a provider-specific basis. Variations in rates are
due to differences among providers related to overhead, staff wages, and the local demand for services.

• Staff/Family Consultation and Training: Regional DDD staff negotiate rates on a provider-specific basis. Variations in
rates are due to differences among providers related to overhead, staff wages, and the local
demand for services.

• Environment Accessibility Adaptations: Rates are based upon bids received from potential contractors. Variations in rates are
due to differences among providers related to overhead and the local demand for services.

• Transportation: The rate per mile is based on the Collective Bargaining Agreement (CBA) with the State Employees
International Union (SEIU).

• Specialized Medical Equipment and Supplies: All rates are based upon the usual and customary charges for the specialized
medical equipment/supplies. Variations in rates are due to differences among providers related to overhead and staff wages.

• Community Transition: Based upon local housing (e.g., rent deposit) and utility costs and the specific needs of the individual (e.g., for furnishings).

• Skilled Nursing: The rate for skilled nursing services is the Medicaid unit rate with no vacation or overtime.

• Sexual Deviancy Evaluation: The rate per evaluation is provider-specific and is negotiated by DDD regional staff. Variations
in rates are due to differences among providers related to overhead and the local demand for services.

• Specialized Psychiatric Services: DDD regional staff negotiate with providers on a client-specific basis unit rates that are
at or below the DSHS standard rate. Variations in rates are impacted by provider overhead and the local demand for services.

• Behavioral Health Stabilization Services: Variations in rates for contracted services are due to differences among providers related to overhead, staff wages, and the local demand for services.
o Behavior Support and Consultation (privately-contracted): Rates are negotiated by DDD regional staff with the Regional
Support Networks and/or individual providers.
o Behavior Support and Consultation (state-operated): Rates are established on a prospective basis by the ADSA/DDD cost
reimbursement section based on labor and overhead costs.
o Specialized Psychiatric Services: Rates are negotiated by DDD regional staff with the Regional Support Networks and/or
individual providers.
o Behavioral Health Crisis Diversion Bed Services (privately-contracted: Rates are negotiated by DDD regional staff with
the Regional Support Networks and/or individual providers.
o Behavioral Health Crisis Diversion Bed Services (state-staffed): Rates are established on a prospective basis by the
ADSA/DDD cost reimbursement section based on labor and overhead costs.

• Extended State Plan Services: Variations in rates are due to differences among providers related to overhhead and the local
demand for services.
o Occupational Therapy: Rates are negotiated by DDD regional staff on a provider-specific basis.

- o Speech, Hearing and Language: Rates are negotiated by DDD regional staff on a provider-specific basis.
- o Physical Therapy: Rates are negotiated by DDD regional staff on a provider-specific basis.

• Individualized Techical Assistance: Unit rates are negotiated between the counties and their providers within the parameters
established by the County Service Guidelines and county allocations. Variations in rates are due to differences among
providers related to overhead, staff wages, and the local demand for services.

The State Medicaid Agency is required to follow the Administrative Procedure Act (Chapter 34.05 RCW) when soliciting public comments on rate determination methods. Changes to rates made by the legislature in the budget process are part of public hearings on budget and policy legislation. Rates are posted on public web sites.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The Department of Social and Health Services (DSHS), which is the State Operating Agency, receives funding appropriated by the Legislature in the biennial budget. Funding (both state dollars and federal dollars) is provided to DSHS and allotted to the Developmental Disabilities Administration (DDA). DDA receives the appropriation and allots funds to its operating regions via Regional Budgets for most service (e.g., residential, personal care, professional) categories.

Direct Service Payments (Current)
DSHS/DDA contracts directly with providers of service for all services except state-staffed services, which are state-operated living alternatives (SOLA) services, state-staffed behavior support and consultation services and state-staffed behavioral health crisis diversion bed services as components of behavioral health stabilization services. For direct payment, DDA authorizes services via the social services authorization system, and providers bill the agency directly for services using service vouchers. Payments are made directly from DSHS/DDA via SSPS/ProviderOne to the providers of service.

Direct Service Payments (January, 2015)
Washington State's Health Care Authority (the single state Medicaid Agency) has a new MMIS titled "ProviderOne". Payments for Medicaid State Plan services (except personal care and state-operated ICFs/ID and NFs) are made via ProviderOne.

Effective January 2015, payment to service providers categorized as "1099 providers" will be made via ProviderOne (i.e., will no longer be made via the SSPS payment system) directly to service providers. Included will be social service providers such as community residential providers, home care agencies, and medical providers that did not transition to the ProviderOne system in the first phase of the project.
1099 Providers
• Adult Family Homes
• Assisted Living Facilities
• Counseling
• Durable Medical Equipment
• Group Homes/Group Training Homes
• Home Care Agencies
• Licensed Staff Residential
• Mental and Physical Incapacity Evaluations
• Nurse Delegation
• Physical, Occupational, Speech Therapy
• Private Duty Nursing
• Skilled Nursing
• Supported Living
Funding for Medicaid services covered under the Community Protection waiver will continue to be appropriated to the State Operating Agency, and the cost of payments for Community Protection waiver services will be charged directly to the State Operating Agency.

Payments to State Employees
The State-Operated Living Alternatives (SOLA) programs are supported living program staffed with state employees. Employee salaries are included in the appropriation provided to the Division by the Legislature. Salaries

for State-staffed behavior support and consultation and behavioral health crisis diversion bed services as components of behavioral health stabilization services are also included in the appropriation provided to the Division by the Legislature. State employees that provide these services are paid twice a month like other state employee, with the payment amount determined by their job classification and experience.

Claim for FFP for Services Provided by State Employees
A prospective (daily) rate for SOLA services is established each year for each location (region) based on the projected costs and number of resident days for the ensuing fiscal year. The established rates are transmitted to the Office of Financial Recovery (OFR). OFR uses the daily reimbursement rates and the number of Medicaid eligible days at each location to calculate the federal share of cost for each facility. The OFR calculation report goes to the Office of Accounting Services and to the Management Services Division (MSD). MSD fiscal staff prepare a journal voucher to record the federal share under the federal funds appropriation in the Financial Reporting System (FRS). Reported resident days and FFP claims are reconciled with OFR each month. The DSHS includes the daily cost multiplied by the number of days in the HCFA-64 Report to collect FFP for SOLA services provided to waiver clients. At the close of each year, a settlement calculation is prepared to recover additional federal funds, or to pay back funds previously received.
The same processes as described for SOLA services directly above are applied to determine the claim amount for state-staffed behavior support and consultation and state-staffed behavioral health crisis diversion bed services as components of behavioral health stabilization services.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the

individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

a.) Individual was eligible for Medicaid waiver payment on the date of service.
1) ProviderOne has a waiver identifier based on waiver status that indicates an individual is on a home and community-based services waiver.
2) Waiver Status in CARE Waiver Screen
The Developmental Disabilities Administration's 'CARE includes a "Waiver Screen" that contains the type of waiver an individual is on, the waiver begin date, and waiver end date (if any). A waiver effective date for the individual is entered into the Waiver Screen by CARE once the necessary waiver eligibility confirmation steps have been completed. These include verification of the need for ICF/IID Level of Care (LOC) and financial eligibility (as established by financial workers in the Long Term Care Specialty Unit within Home and Community Services), documentation of Voluntary Participation statement (Form #10-424), verification of disability per criteria established in the SSA, and completion of an Individual Support Plan (ISP). CARE enters a waiver effective date based on the effective date of the individual service plan (ISP), which is the last step in the waiver eligibility verification process. The waiver effective date serves as the beginning date for claiming of federal financial participation for waiver services.
3) SSPS: The Client Authorization Services Input System (CASIS) is used by case managers to create social service payment system (SSPS) authorizations for client services using an automated electronic form. CASIS validates provider data via SSPS provider tables, and all service code data through SSPS account and service codes tables before submitting the authorization to the SSPS.
The SSPS contains service codes unique to the Community Protection waiver. The waiver status (in the CARE Waiver Screen) of the individual must be consistent with the code being authorized. Waiver expenditures are annually compared with waiver status to ensure that payments are consistent with the waiver status of the individual.
4) ProviderOne
Washington State's Health Care Authority (the single state Medicaid Agency) has a new MMIS named "ProviderOne". Payments for Medicaid State Plan services (except personal care and state-operated ICFs/IID and NFs) are made via ProviderOne.
Effective January 2015, payment to service providers categorized as "1099 providers" will be made via ProviderOne (i.e., will no longer be made via the SSPS payment system) directly to service providers. Included will be social service providers such as community residential providers, home care agencies, and medical providers that did not transition to the ProviderOne system in the first phase of the project. Virtually all Community Protection waiver providers except individual respite care providers will be reimbursed using ProviderOne.
The usual MMIS edits will be applied to billings under the Community Protection waiver. I.e., the following will be verified: the individual is on the Community Protection waiver, the service is covered under the Community Protection waiver, the provider is a valid provider of the service, the provider is a qualified provider with a current contract, and the specifics of the claim are consistent with the service authorization completed by the DDA case manager.
b.) Service was included in the participant's approved service plan to ensure that ISPs reflect the current needs of the individual, ISPs are updated as needed and at least annually (please see Appendix H-1-b-3 for a description of the steps taken to ensure ISPs are updated).
DDA Quality Compliance Coordinators (QCCs) annually review a statewide sample of clients. Their review includes a comparison of service payments with the services contained in approved ISPs to ensure that services claimed against the Community Protection waiver are contained in the approved ISP.
c.) The services were provided.
Monitoring of the provision of services is outlined in Appendix H-1-b-4. Steps taken include:
•*QCC file reviews verify the authorization matches the ISP including the type, scope, amount, duration and frequency of the service. When findings occur, regions have 30 days to correct problems. QCCs monitor the corrective action plans.
•*CRMs or Social Service Specialists complete a review of last year's plan with the waiver recipient prior to beginning the planning process for the upcoming year. A portion of the review is to confirm that services were received in accordance with the ISP. •*The State participates in the National Community Protection Indicators Survey, which includes waiver related questions. This annual face-to-face sampling of waiver participants enables DDA management to evaluate ISP outcomes from the recipient's perspective.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

- **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

  Payment to providers is made by counties for day program/individualized technical assistance/prevocational/ supported employment.

  a.) and b) Most waiver svcs are paid and tracked through the State's automated Social Services Payment System (SSPS). The State's A-19 invoice review and payment system pays for svcs funded through the counties and the County Human Resource Information System (CHRIS) tracks services funded through the counties. The A-19 invoice voucher is also used to reimburse for most mental health stabilization services (not including those provided by state employees).

  Overview of the SSPS: The SSPS authorizes the delivery and/or purchase of svcs, collects required state and federal statistical and management data, and initiates the payment process for purchased svcs. On the basis of Community Protection (CP) Waiver service codes, SSPS expenditure information interfaces with the department's accounting system (Financial Reporting System/Agency Financial Reporting System-FASTRACK/AFRS). Aging and Disability Services Administration (ADSA) Headquarters staff maintain an account crosswalk that links CP Waiver SSPS service codes with the FASTRACK/AFRS system.

  Overview of the CHRIS: Billings for svcs (e.g., individualized technical assistance, prevocational, supported employment) contracted through the counties are submitted monthly to the department using the CHRIS. Each billing includes a list of clients that were in each service that month, identification of clients on each waiver, the total units of svc provided, the unit rate, and the total amount billed the division for each client. Data from the CHRIS is carried forward to the A-19.

  Overview of the A-19 Invoice Voucher: The A-19 invoice voucher is a state payment form that requests reimbursement for svc provision. The A-19 contains and/or is accompanied by support documentation (e.g., CHRIS forms) that identifies all CP Waiver svcs for CP Waiver clients, units of svc, and rates per unit of svc. The A-19 invoice vouchers are manually coded and processed through the state's vendor payment system.

  c.) All payments are backed by an audit trail. Key steps in the audit trail include:
  - Verification of client and provider eligibility for Medicaid;
  - Service authorization;
  - Verification of service delivery;
  - Invoicing and payment; and
  - Calculation of FFP.

  Client Eligibility: Individual client case records document the recipient's eligibility for the waiver. Persons placed on the waiver are also identified in the CARE, which is a computer-based and contains client characteristic/status information. Client eligibility status is maintained in client case records for a minimum of

five (5) years.

Provider Eligibility: All providers of waiver svcs must hold current contracts/provider agreements that define the svcs to be provided and the payment for those svcs. Contracts require providers to document and retain records of all svcs and charges for at least three (3) years after svc delivery.

Service Authorization: Waiver services are authorized prior to svc delivery by the DDD case manager, who ensures that the svcs authorized are included in the approved individual support plan. Svc authorizations reflect service-specific information contained in the individual support plan and indicate if the svc is to be claimed under the waiver.

Records of SSPS electronic authorizations are retained for a minimum of 3 years. Paper authorization forms for services paid under the manual A-19 system are retained in the client record for a minimum of 5 years.

Service Delivery and Records Maintained by Providers: Contract agreements with providers of waiver svcs require providers to document and retain records of all svcs delivered for at least three (3) years after svc delivery.

Service Invoicing and Payment: Completion of the SSPS service authorization triggers issuance of an invoice to the provider that identifies the individuals authorized to receive each svc. The provider includes on the invoice the unit type and number of units delivered to each client, signs a certification statement, and returns it to the state. State staff cross-check the invoice to verify consistency with the service authorization, after which a warrant is issued.

Records Maintained by the ADSA/Division of Developmental Disabilities: Information on client eligibility is maintained in client case records for a minimum of five (5) years. Copies of provider contracts are maintained for a minimum of five years in ADSA/DDD regional offices.

Records of electronic service authorizations for payment are retained for a minimum of three years. Paper authorization forms for services paid under the A-19 system are retained in the client record for a minimum of five years. Back-up documentation for CMS-64 reports are maintained for a minimum of three years.

d) Federal financial participation (FFP) for CP Waiver services is calculated through the state's approved and automated cost allocation plan. The FFP is collected through two payment systems: one automated (SSPS) and one manual (Invoice voucher A-19). Both payment systems' accounting information is processed through the State of Washington Agency Financial Reporting System (AFRS) and the Department of Social and Health Services FASTRACK System which includes the Federal Cost Allocation Plan. The basis for the dollars claimed under the CP Waiver in the CMS 64 is waiver-specific account coding contained in the Departments FASTRACK/AFRS financial reporting system. All expenditures for services claimable under the CP Waiver are coded using the CP Waiver account coding. Those expenditures are included in the CMS-64 under the CP Waiver.

○ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

☐ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

☑ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Payments to providers for most services are made directly by the State Operating Agency.

Funding for Individualized Technical Assistance/Prevocational Services/Supported Employment is provided by the State Operating Agency to Counties. Some Counties are direct service providers. Most contract with and reimburse direct service providers.

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

○ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

◉ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Payments for Individualized Technical Assistance/Prevocational Services/Supported Employment are made to Counties.

Payments for state-staffed Supported Living services as provided by State Operated Living Alternatives (SOLA) and for state-staffed behavior support and consultation and state-staffed behavioral health crisis diversion bed services as components of behavioral health stabilization services are made to state employees.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

Counties

ii. Organized Health Care Delivery System. *Select one:*

No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

Appropriation of State Tax Revenues to the State Medicaid agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I -2-c:

The Department of Social and Health Services/Developmental Disabilities Administration (the State Operating Agency), receives funding for all waiver services. Payment for most waiver services will be made directly to service providers via ProviderOne, an approved MMIS which is operated by the Health Care Authority, the Single State Agency. (Initially respite services provided by individual providers will be paid directly to providers by the State Operating Agency.)

No funds to cover the portion of the rates that are non-match are transferred to the Medicaid agency. All nonmatch
funding is appropriated to the State Medicaid Agency or the State Operating Agency by the Legislature.

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

  Check each that applies:
  - [ ] **Health care-related taxes or fees**
  - [ ] **Provider-related donations**
  - [ ] **Federal funds**

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ( ) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- (●) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The rates claimed for behavioral health crisis stabilization services do not include room and board costs, which are reimbursed separately.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C -3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	114087.36	4970.00	119057.36	183128.00	1958.23	185086.23	66028.87
2	114083.31	4970.00	119053.31	183128.00	1958.23	185086.23	66032.92
3	114088.06	4970.00	119058.06	183128.00	1958.23	185086.23	66028.17
4	114408.86	4970.00	119378.86	183648.00	1958.23	185606.23	66227.37
5	114099.76	4970.00	119069.76	183128.00	1958.23	185086.23	66016.47

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	463	463

Waiver Year	Total Unduplicated Number of Participants (from Item B -3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 2	460	460
Year 3	458	458
Year 4	456	456
Year 5	454	454

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The 352-day projected average length of stay for Waiver Renewal Years 1,2,3 and 5 and the 353-day average length of stay for Waiver Renewal Year 4 are based upon the number of individuals that will be on the waiver for the entire waiver renewal year and the projected number of days on the waiver of those added to the waiver and those leaving the waiver during the waiver year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Projections for the following services for the Waiver Renewal are based on the Initial 372 Report prepared for Waiver Renewal Year 3 (4/1/2009 - 3/31/2010):

• Contracted Supported Living
• State-Staffed Supported Living
• Prevocational Services
• Supported Employment Services
• Behavior Management and Consultation
• Staff/Family Consultation and Training
• Environmental Accessibility Adaptations
• Community Transition
• Skilled Nursing
• Sexual Deviancy Evaluation
• Behavioral Health Stabilization Services: Behavior Support and Consultation (privately-contracted)
• Behavioral Health Stabilization Services: Behavioral Health Crisis Diversion Bed Svcs (privately-contracted)
• Behavioral Health Stabilization Services: Specialized Psychiatric Services

Projections for the following services are based on utilization under the Core Waiver (#0410):
• Specialized Medical Equipment and Supplies
• Transportation
• Physical Therapy
• Oocupational Therapy
• Speech, Hearing and Language Services

Projections for the following services are based on provider capacity and professional judgment:
• Behavioral Health Stabilization Services: Behavior Support and Consultation (state-operated)

• Behavioral Health Stabilization Services: Behavioral Health Crisis Diversion Bed Svcs (state-operated)

Projections of the use of specialized psychiatric services are based on historical use of the use of this services as a Mental Health Stabilization Service and professional judgment.

Projections of the use of individualized technical assistance are based on transition to the new service during the Waiver Renewal Year 5 and professional judgment.

Projections of the use of adult dental services are based on the use of those services by Community Protection Waiver recipients during the 4/1/2010 - 3/31/2011 waiver year. As of January 1, 2014, adult dental services are no longer a service provided through the waiver, but rather through the State Plan.

Projections of the number of users of privately-contracted crisis diversion beds have been reduced to reflect the removal of crisis diversion beds that are in an IMD.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor D' estimate for the Waiver Renewal is based on expenditures compiled for an Initial CMS-372 Report for Waiver Renewal Year 3 (4/1/2009 - 3/31/2010. No trend factors were applied, due to reduced state revenue and a corresponding lack of vendor rate increases.

The base data for projections of Factor D' are from a time period that is after implementation of Medicare Part D coverage. Consequently, the base data do not include expenditures for drugs covered under Part D, as those costs are not reflected in Washington State's expenditure data for dual-eligible Medicaid clients.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Estimates of Factor G values are based upon the aggregate average daily cost for state-operated and privately -operated ICF/ID beds in Washington State for State Fiscal Year (SFY) 2012 (7/1/2011 – 6/30/2012) times the number of days clients on the waiver would be in an ICF/ID if the waiver did not exist. In the absence of the waiver, waiver clients would be on an ICF/ID for the same number of days that they are projected to be on the waiver. The average number of days on the waiver is contained in the projections of Factor D.

No trend factors were applied for the Waiver Renewal period, due to reduced state revenue and a corresponding lack of pay increases for state employees and privately-contracted service providers.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' projections are based on the actual per person cost ($1,958.23) of State Plan services by ICF/ID residents during the 4/1/2009 - 3/31/2010 waiver renewal year. No trend factors were applied, due to reduced state revenue and a corresponding lack of vendor rate increases.

The base data for projections of Factor G' are from a time period that is after implementation of Medicare Part D coverage. Consequently, the base data do not include expenditures for drugs covered under Part D, as those costs are not reflected in Washington State's expenditure data for dual-eligible Medicaid clients.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Individual Supported Employment/Group Supported Employment	
Prevocational Services	
Residential Habilitation	
Occupational Therapy	
Physical Therapy	

Waiver Services	
Speech, Hearing, and Language Services	
Behavior Support and Consultation	
Behavioral Health Stabilization Services - Behavior Support and Consultation	
Behavioral Health Stabilization Services - Behavioral Health Crisis Diversion Beds	
Behavioral Health Stabilization Services - Specialized Psychiatric Services	
Community Transition	
Environmental Accessibility Adaptations	
Individualized Techical Assistance	
Sexual Deviancy Evaluation	
Skilled Nursing	
Specialized Medical Equipment and Supplies	
Specialized Psychiatric Services	
Staff/Family Consultation and Training	
Transportation	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Supported Employment/Group Supported Employment Total:						**1911586.38**
Individual Supported Employment/Group Supported Employment	Month	278	11.00	625.11	**1911586.38**	
Prevocational Services Total:						**198669.60**
Prevocational Services	Month	41	10.00	484.56	**198669.60**	
Residential Habilitation Total:						**48633131.44**
Contracted Supported Living	Day	460	346.00	303.13	**48246170.80**	
State Staffed Supported Livining (SOLA)	Day	3	352.00	366.44	**386960.64**	
Occupational Therapy Total:						**1092.48**
Occupational Therapy	Hour	1	64.00	17.07	**1092.48**	

GRAND TOTAL:	**52822449.60**
Total Estimated Unduplicated Participants:	**463**
Factor D (Divide total by number of participants):	**114087.36**
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Physical Therapy Total:						**983.40**
Physical Therapy	Hour	2	6.00	81.95	**983.40**	
Speech, Hearing, and Language Services Total:						**1197.00**
Speech, Hearing, and Language Services	Hour	1	76.00	15.75	**1197.00**	
Behavior Support and Consultation Total:						**1602692.56**
Behavior Support and Consultation	Hour	452	43.00	82.46	**1602692.56**	
Behavioral Health Stabilization Services - Behavior Support and Consultation Total:						**90744.00**
Behavior Support and Consultation-Privately Contracted	Hour	66	10.00	134.00	**88440.00**	
Behavior Support and Consultation-State-Operated	Hour	1	12.00	192.00	**2304.00**	
Behavioral Health Stabilization Services - Behavioral Health Crisis Diversion Beds Total:						**240486.84**
Behavioral Health Crisis Diversion Bed Services-Privately Contracted	Day	1	5.50	332.88	**1830.84**	
Behavioral Health Crisis Diversion Bed Services-State-Operated	Day	1	176.00	1356.00	**238656.00**	
Behavioral Health Stabilization Services - Specialized Psychiatric Services Total:						**22345.12**
Behavioral Health Stabilization Services - Specialized Psychiatric Services	Hour	28	4.00	199.51	**22345.12**	
Community Transition Total:						**3776.13**
Community Transition	Each	3	1.00	1258.71	**3776.13**	
Environmental Accessibility Adaptations Total:						**8412.32**
Environmental Accessibility Adaptations	Each	8	1.88	559.33	**8412.32**	
Individualized Techical Assistance Total:						**31200.00**
Individualized Techical Assistance	Month	13	6.00	400.00	**31200.00**	
Sexual Deviancy Evaluation Total:						**27160.20**
Sexual Deviancy Evaluation					**27160.20**	

GRAND TOTAL:	**52822449.60**
Total Estimated Unduplicated Participants:	**463**
Factor D (Divide total by number of participants):	**114087.36**
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Each	30	1.00	905.34		
Skilled Nursing Total:						**13777.28**
Skilled Nursing	Hour	22	19.00	32.96	**13777.28**	
Specialized Medical Equipment and Supplies Total:						**218.58**
Specialized Medical Equipment and Supplies	Each	1	1.00	218.58	**218.58**	
Specialized Psychiatric Services Total:						**1596.08**
Specialized Psychiatric Services	Hour	2	4.00	199.51	**1596.08**	
Staff/Family Consultation and Training Total:						**32435.16**
Staff/Family Consultation and Training	Hour	267	2.00	60.74	**32435.16**	
Transportation Total:						**945.03**
Transportation	Mile	1	1853.00	0.51	**945.03**	
				GRAND TOTAL:		**52822449.60**
				Total Estimated Unduplicated Participants:		**463**
				Factor D (Divide total by number of participants):		**114087.36**
				Average Length of Stay on the Waiver:		352

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Supported Employment/Group Supported Employment Total:						**1897833.96**
Individual Supported Employment/Group Supported Employment	Month	276	11.00	625.11	**1897833.96**	
Prevocational Services Total:						**193824.00**
Prevocational Services	Month	40	10.00	484.56	**193824.00**	
				GRAND TOTAL:		**52478323.87**
				Total Estimated Unduplicated Participants:		**460**
				Factor D (Divide total by number of participants):		**114083.31**
				Average Length of Stay on the Waiver:		352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						**48318482.50**
Contracted Supported Living	Day	457	346.00	303.13	**47931521.86**	
State Staffed Supported Livining (SOLA)	Day	3	352.00	366.44	**386960.64**	
Occupational Therapy Total:						**1092.48**
Occupational Therapy	Hour	1	64.00	17.07	**1092.48**	
Physical Therapy Total:						**983.40**
Physical Therapy	Hour	2	6.00	81.95	**983.40**	
Speech, Hearing, and Language Services Total:						**1197.00**
Speech, Hearing, and Language Services	Hour	1	76.00	15.75	**1197.00**	
Behavior Support and Consultation Total:						**1592055.22**
Behavior Support and Consultation	Hour	449	43.00	82.46	**1592055.22**	
Behavioral Health Stabilization Services - Behavior Support and Consultation Total:						**90744.00**
Behavior Support and Consultation-Privately Contracted	Hour	66	10.00	134.00	**88440.00**	
Behavior Support and Consultation-State-Operated	Hour	1	12.00	192.00	**2304.00**	
Behavioral Health Stabilization Services - Behavioral Health Crisis Diversion Beds Total:						**240486.84**
Behavioral Health Crisis Diversion Bed Services-Privately Contracted	Day	1	5.50	332.88	**1830.84**	
Behavioral Health Crisis Diversion Bed Services-State-Operated	Day	1	176.00	1356.00	**238656.00**	
Behavioral Health Stabilization Services - Specialized Psychiatric Services Total:						**22345.12**
Behavioral Health Stabilization Services - Specialized Psychiatric Services	Hour	28	4.00	199.51	**22345.12**	
Community Transition Total:						**3776.13**
Community Transition	Each	3	1.00	1258.71	**3776.13**	

GRAND TOTAL:	**52478323.87**
Total Estimated Unduplicated Participants:	**460**
Factor D (Divide total by number of participants):	**114083.31**
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations Total:						**8412.32**
Environmental Accessibility Adaptations	Each	8	1.88	559.33	**8412.32**	
Individualized Techical Assistance Total:						**31200.00**
Individualized Techical Assistance	Month	13	6.00	400.00	**31200.00**	
Sexual Deviancy Evaluation Total:						**27160.20**
Sexual Deviancy Evaluation	Each	30	1.00	905.34	**27160.20**	
Skilled Nursing Total:						**13777.28**
Skilled Nursing	Hour	22	19.00	32.96	**13777.28**	
Specialized Medical Equipment and Supplies Total:						**218.58**
Specialized Medical Equipment and Supplies	Each	1	1.00	218.58	**218.58**	
Specialized Psychiatric Services Total:						**1596.08**
Specialized Psychiatric Services	Hour	2	4.00	199.51	**1596.08**	
Staff/Family Consultation and Training Total:						**32192.20**
Staff/Family Consultation and Training	Hour	265	2.00	60.74	**32192.20**	
Transportation Total:						**946.56**
Transportation	Mile	1	1856.00	0.51	**946.56**	
				GRAND TOTAL:		**52478323.87**
				Total Estimated Unduplicated Participants:		**460**
				Factor D (Divide total by number of participants):		**114083.31**
				Average Length of Stay on the Waiver:		352

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Supported Employment/Group Supported Employment Total:						**1890957.75**
Individual Supported Employment/Group Supported Employment	Month	275	11.00	625.11	**1890957.75**	
Prevocational Services Total:						**193824.00**
Prevocational Services	Month	40	10.00	484.56	**193824.00**	
Residential Habilitation Total:						**48108716.54**
Contracted Supported Living	Day	455	346.00	303.13	**47721755.90**	
State Staffed Supported Livining (SOLA)	Day	3	352.00	366.44	**386960.64**	
Occupational Therapy Total:						**1092.48**
Occupational Therapy	Hour	1	64.00	17.07	**1092.48**	
Physical Therapy Total:						**983.40**
Physical Therapy	Hour	2	6.00	81.95	**983.40**	
Speech, Hearing, and Language Services Total:						**1197.00**
Speech, Hearing, and Language Services	Hour	1	76.00	15.75	**1197.00**	
Behavior Support and Consultation Total:						**1584963.66**
Behavior Support and Consultation	Hour	447	43.00	82.46	**1584963.66**	
Behavioral Health Stabilization Services - Behavior Support and Consultation Total:						**89404.00**
Behavior Support and Consultation-Privately Contracted	Hour	65	10.00	134.00	**87100.00**	
Behavior Support and Consultation-State-Operated	Hour	1	12.00	192.00	**2304.00**	
Behavioral Health Stabilization Services - Behavioral Health Crisis Diversion Beds Total:						**240486.84**
Behavioral Health Crisis Diversion Bed Services-Privately Contracted	Day	1	5.50	332.88	**1830.84**	
Behavioral Health Crisis Diversion Bed Services-State-Operated	Day	1	176.00	1356.00	**238656.00**	
Behavioral Health Stabilization Services -						**21547.08**

GRAND TOTAL:	**52252329.60**
Total Estimated Unduplicated Participants:	**458**
Factor D (Divide total by number of participants):	**114088.06**
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Psychiatric Services Total:						
Behavioral Health Stabilization Services - Specialized Psychiatric Services	Hour	27	4.00	199.51	**21547.08**	
Community Transition Total:						**3776.13**
Community Transition	Each	3	1.00	1258.71	**3776.13**	
Environmental Accessibility Adaptations Total:						**8412.32**
Environmental Accessibility Adaptations	Each	8	1.88	559.33	**8412.32**	
Individualized Techical Assistance Total:						**31200.00**
Individualized Techical Assistance	Month	13	6.00	400.00	**31200.00**	
Sexual Deviancy Evaluation Total:						**27160.20**
Sexual Deviancy Evaluation	Each	30	1.00	905.34	**27160.20**	
Skilled Nursing Total:						**13777.28**
Skilled Nursing	Hour	22	19.00	32.96	**13777.28**	
Specialized Medical Equipment and Supplies Total:						**218.58**
Specialized Medical Equipment and Supplies	Each	1	1.00	218.58	**218.58**	
Specialized Psychiatric Services Total:						**1596.08**
Specialized Psychiatric Services	Hour	2	4.00	199.51	**1596.08**	
Staff/Family Consultation and Training Total:						**32070.72**
Staff/Family Consultation and Training	Hour	264	2.00	60.74	**32070.72**	
Transportation Total:						**945.54**
Transportation	Mile	1	1854.00	0.51	**945.54**	

GRAND TOTAL:	**52252329.60**
Total Estimated Unduplicated Participants:	**458**
Factor D (Divide total by number of participants):	**114088.06**
Average Length of Stay on the Waiver:	352

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Supported Employment/Group Supported Employment Total:						**1884081.54**
Individual Supported Employment/Group Supported Employment	Month	274	11.00	625.11	**1884081.54**	
Prevocational Services Total:						**193824.00**
Prevocational Services	Month	40	10.00	484.56	**193824.00**	
Residential Habilitation Total:						**48037367.79**
Contracted Supported Living	Day	453	347.00	303.13	**47649307.83**	
State Staffed Supported Livining (SOLA)	Day	3	353.00	366.44	**388059.96**	
Occupational Therapy Total:						**1092.48**
Occupational Therapy	Hour	1	64.00	17.07	**1092.48**	
Physical Therapy Total:						**983.40**
Physical Therapy	Hour	2	6.00	81.95	**983.40**	
Speech, Hearing, and Language Services Total:						**1197.00**
Speech, Hearing, and Language Services	Hour	1	76.00	15.75	**1197.00**	
Behavior Support and Consultation Total:						**1581417.88**
Behavior Support and Consultation	Hour	446	43.00	82.46	**1581417.88**	
Behavioral Health Stabilization Services - Behavior Support and Consultation Total:						**89404.00**
Behavior Support and Consultation-Privately Contracted	Hour	65	10.00	134.00	**87100.00**	
Behavior Support and Consultation-State-Operated	Hour	1	12.00	192.00	**2304.00**	
Behavioral Health Stabilization Services - Behavioral Health Crisis Diversion Beds Total:						**240486.84**

GRAND TOTAL:	**52170439.42**
Total Estimated Unduplicated Participants:	**456**
Factor D (Divide total by number of participants):	**114408.86**
Average Length of Stay on the Waiver:	353

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavioral Health Crisis Diversion Bed Services-Privately Contracted	Day	1	5.50	332.88	**1830.84**	
Behavioral Health Crisis Diversion Bed Services-State-Operated	Day	1	176.00	1356.00	**238656.00**	
Behavioral Health Stabilization Services - Specialized Psychiatric Services Total:						**21547.08**
Behavioral Health Stabilization Services - Specialized Psychiatric Services	Hour	27	4.00	199.51	**21547.08**	
Community Transition Total:						**3776.13**
Community Transition	Each	3	1.00	1258.71	**3776.13**	
Environmental Accessibility Adaptations Total:						**8412.32**
Environmental Accessibility Adaptations	Each	8	1.88	559.33	**8412.32**	
Individualized Techical Assistance Total:						**31200.00**
Individualized Techical Assistance	Month	13	6.00	400.00	**31200.00**	
Sexual Deviancy Evaluation Total:						**27160.20**
Sexual Deviancy Evaluation	Each	30	1.00	905.34	**27160.20**	
Skilled Nursing Total:						**13777.28**
Skilled Nursing	Hour	22	19.00	32.96	**13777.28**	
Specialized Medical Equipment and Supplies Total:						**218.58**
Specialized Medical Equipment and Supplies	Each	1	1.00	218.58	**218.58**	
Specialized Psychiatric Services Total:						**1596.08**
Specialized Psychiatric Services	Hour	2	4.00	199.51	**1596.08**	
Staff/Family Consultation and Training Total:						**31949.24**
Staff/Family Consultation and Training	Hour	263	2.00	60.74	**31949.24**	
Transportation Total:						**947.58**
Transportation	Mile	1	1858.00	0.51	**947.58**	

GRAND TOTAL:	**52170439.42**
Total Estimated Unduplicated Participants:	**456**
Factor D (Divide total by number of participants):	**114408.86**
Average Length of Stay on the Waiver:	353

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Supported Employment/Group Supported Employment Total:						**1870329.12**
Individual Supported Employment/Group Supported Employment	Month	272	11.00	625.11	**1870329.12**	
Prevocational Services Total:						**193824.00**
Prevocational Services	Month	40	10.00	484.56	**193824.00**	
Residential Habilitation Total:						**47689184.62**
Contracted Supported Living	Day	451	346.00	303.13	**47302223.98**	
State Staffed Supported Livining (SOLA)	Day	3	352.00	366.44	**386960.64**	
Occupational Therapy Total:						**1092.48**
Occupational Therapy	Hour	1	64.00	17.07	**1092.48**	
Physical Therapy Total:						**983.40**
Physical Therapy	Hour	2	6.00	81.95	**983.40**	
Speech, Hearing, and Language Services Total:						**1197.00**
Speech, Hearing, and Language Services	Hour	1	76.00	15.75	**1197.00**	
Behavior Support and Consultation Total:						**1574326.32**
Behavior Support and Consultation	Hour	444	43.00	82.46	**1574326.32**	
Behavioral Health Stabilization Services - Behavior Support and Consultation Total:						**89404.00**
Behavior Support and Consultation-Privately Contracted	Hour	65	10.00	134.00	**87100.00**	

GRAND TOTAL:	**51801289.26**
Total Estimated Unduplicated Participants:	**454**
Factor D (Divide total by number of participants):	**114099.76**
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavior Support and Consultation-State-Operated	Hour	1	12.00	192.00	**2304.00**	
Behavioral Health Stabilization Services - Behavioral Health Crisis Diversion Beds Total:						**240486.84**
Behavioral Health Crisis Diversion Bed Services-Privately Contracted	Day	1	5.50	332.88	**1830.84**	
Behavioral Health Crisis Diversion Bed Services-State-Operated	Day	1	176.00	1356.00	**238656.00**	
Behavioral Health Stabilization Services - Specialized Psychiatric Services Total:						**21547.08**
Behavioral Health Stabilization Services - Specialized Psychiatric Services	Hour	27	4.00	199.51	**21547.08**	
Community Transition Total:						**3776.13**
Community Transition	Each	3	1.00	1258.71	**3776.13**	
Environmental Accessibility Adaptations Total:						**8412.32**
Environmental Accessibility Adaptations	Each	8	1.88	559.33	**8412.32**	
Individualized Techical Assistance Total:						**31200.00**
Individualized Techical Assistance	Month	13	6.00	400.00	**31200.00**	
Sexual Deviancy Evaluation Total:						**27160.20**
Sexual Deviancy Evaluation	Each	30	1.00	905.34	**27160.20**	
Skilled Nursing Total:						**13777.28**
Skilled Nursing	Hour	22	19.00	32.96	**13777.28**	
Specialized Medical Equipment and Supplies Total:						**218.58**
Specialized Medical Equipment and Supplies	Each	1	1.00	218.58	**218.58**	
Specialized Psychiatric Services Total:						**1596.08**
Specialized Psychiatric Services	Hour	2	4.00	199.51	**1596.08**	
Staff/Family Consultation and Training Total:						**31827.76**
Staff/Family Consultation and Training	Hour	262	2.00	60.74	**31827.76**	

GRAND TOTAL:	**51801289.26**
Total Estimated Unduplicated Participants:	**454**
Factor D (Divide total by number of participants):	**114099.76**
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation Total:						**946.05**
Transportation	Mile	1	1855.00	0.51	**946.05**	

GRAND TOTAL:	**51801289.26**
Total Estimated Unduplicated Participants:	**454**
Factor D (Divide total by number of participants):	**114099.76**
Average Length of Stay on the Waiver:	352