

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 (DOH administrative code concerning 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: Skilled Nursing****Provider Category:**

Agency

Provider Type:

LPN Skilled Nursing

Provider Qualifications**License (specify):**

Chapter 246-840 WAC (DOH administrative code concerning practical and registered nursing)

Certificate (specify):**Other Standard (specify):**

Verification of Provider Qualifications**Entity Responsible for Verification:****Frequency of Verification:****Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Skilled Nursing****Provider Category:****Provider Type:****Provider Qualifications****License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):**Verification of Provider Qualifications****Entity Responsible for Verification:****Frequency of Verification:****Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Skilled Nursing****Provider Category:****Provider Type:**

RN Skilled Nursing

Provider Qualifications

License (specify):

Chapter 246-840 WAC (DOH administrative code concerning 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: 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 Equipment and Supplies

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14031 equipment and technology

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):**Category 4:****Sub-Category 4:**

Specialized equipment and supplies are durable or non-durable medical and non-medical equipment or supplies necessary to prevent institutionalization, not available under the Medicaid state plan, or in excess of what is available, that enables individuals to:

- (a) Increase their abilities to perform their activities of daily living; or
- (b) Perceive, control, or communicate with the environment in which they live; or
- (c) Improve daily functioning through sensory integration.

This service also includes items necessary for life support; ancillary supplies and equipment necessary to the proper functioning of such items. Specialized equipment and supplies may include mobility devices, sensory regulation items, bathroom equipment, peri-care wipes, safety supplies, and other medical supplies not otherwise available on the Medicaid state plan, home health benefit or EPSDT.

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

- (1) Specialized equipment and supplies are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.
- (2) Habilitative support needs for specialized equipment and supplies are identified during the waiver participant's DDA person-centered assessment and documented in his/her person-centered service plan.
- (3) Specialized equipment and supplies require prior approval by the DDA Regional Administrator or designee when \$550 or more.
- (4) DDA reserves the right to require a second opinion by a department-selected provider.
- (5) Items paid for with waiver funds shall be in addition to any medical equipment and supplies furnished under the Medicaid state plan, private insurance, or other available programs.
- (6) Items must be of direct medical or remedial benefit to the individual and necessary as a result of the individual's disability.
- (7) Medications, vitamins, and supplements, prescribed or non-prescribed, are excluded.
- (8) Since this service is one of the services covered under the aggregate services package in the Basic Plus waiver, an expenditure limitation applies to these waivers as indicated in Appendix C-4.a.

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 | Specialized Equipment and Supplies Provider |
| Agency | Specialized Equipment and Supplies Provider |
| Individual | Shopper |
| Agency | Shopper |

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service**

Service Name: Specialized Equipment and Supplies

Provider Category:**Provider Type:****Provider Qualifications****License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):**Verification of Provider Qualifications****Entity Responsible for Verification:****Frequency of Verification:**

Appendix C: Participant Services

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

Service Type: Other Service**Service Name: Specialized Equipment and Supplies**

Provider Category:**Provider Type:****Provider Qualifications****License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):**Verification of Provider Qualifications**

Entity Responsible for Verification:**Frequency of Verification:****Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Specialized Equipment and Supplies****Provider Category:****Provider Type:****Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:****Frequency of Verification:****Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Specialized Equipment and Supplies****Provider Category:****Provider Type:**

Shopper

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Contract Standards. The State clarifies that this service provider and its employees must hold a current Washington State Business License, maintain all additional and necessary licenses required by the State, and utilize a financial business account to make the approved purchases.

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:

Specialized Habilitation

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17990 other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

Individualized and community-based supports to assist a waiver participant to reach identified habilitative goals to promote inclusion in their homes and communities as documented in their person-centered service plan. Specialized Habilitation offers teaching and training to a waiver participant to learn or maintain skills in:

- self-empowerment (such as becoming more aware of strengths and weakness and therefore become better equipped to deal with problems)
- safety awareness and self-advocacy (such as learning skills to for safety awareness or how to recognize and report abuse, neglect or exploitation)
- interpersonal skills and effective communication (such as avoiding or mitigating inappropriate peer pressure)
- coping strategies regarding typical life challenges (such as acclimating to a new family member or roommate)
- managing daily tasks and acquiring adaptive skills (such as selecting appropriate outfits for various work and social occasions)

Remote service delivery is an available service delivery option if chosen by the participant or their guardian (if appropriate), appropriately meets the participant's assessed needs as documented in their PCSP and is provided within the scope of the service being delivered. Service may be received in person or via telehealth as identified in the person-centered service plan. The waiver participant selects whether they want to receive service in person, via telehealth, or a combination of both. Remote service delivery means that the service is delivered by the provider to the participant via phone, video, computer, or other technology and that the technology and data storage is HIPAA compliant.

Assurances:

The well-developed person-centered service plan will document the participant's specific health and welfare needs and how each service selected by the participant contributes to meeting the participant's needs and does not duplicate supports.

Remote Supports does not provide any of the specific services or supports that are provided by services that are delivered via telehealth remotely.

The well-developed person-centered service plan will document which services are selected by the participant to meet their unique health and welfare needs and whether a participant selects a particular service to be provided via telehealth remotely. The service authorization system (ProviderOne) has distinct and separate service codes for each waiver service and has built-in system logic that prevents duplication of services. DDA policies and procedures provide guidance to Case Resource Managers on developing effective person-centered service plans that meet the unique needs of participants without any duplication of services.

Telehealth will be the delivery method for a particular service at the direction of the participant not by the preference of the service provider. A teleservice (telehealth) request form will be required prior to authorization of teleservice delivery. This request form will document the client's desired level of in person to teleservice delivery and will remind client's that they can change their mind about frequency of teleservice delivery at any time. This agreement is intended to assist in clear and documented communication between the client, DDA, and the provider (in addition to the person-centered service plan) to ensure the client is the driver of the method of service delivery they receive. Case/Resource Managers will consult with their participants and family members, if appropriate, to develop the person-centered service plan that includes the specific services and service delivery methods that best meets the participant's unique health and welfare needs. Participants will document in their PCSPs what approximate percentage of service delivery they desire to receive via telehealth. The State is not mandating what percentage of time telehealth will be the delivery method for the service to ensure person-centered service planning and promote client choice. Case/Resource Managers will be guided by DDA policy to assist participants to select services and service delivery methods that best meet their health and welfare needs employing a robust balance of in-person and if desired, telehealth delivery methods.

State will permit recording of live interactions with the participant via audio or video technology only at the request of the participant. Policy will include specific language around bathrooms and bedrooms. Video cameras are not permissible in bathrooms. If a client requests a video camera in their bedroom, there must be an approved exception to policy in place and the device must be situated in a way that does not compromise client privacy. Live 2-way interactions are always initiated by the participant. The participant can initiate the service when needed and turn off the equipment when not needed.

The State believes remote service delivery (telehealth) will be an important component in a well-developed and balanced person-centered service plan that focuses on the specific wants and health and welfare needs of the participant. Experience during the COVID-19 pandemic has shown that remote service delivery can facilitate community integration in a person-centered way. Washingtonians in the broader community utilize both technology-supported remote and in-person community service environments, and the proposed change in waiver services give waiver clients the same opportunity to participate in their community as everyone else. Case/Resource Managers will be guided by DDA policy to assist participants to select services and service delivery methods that best meet

their health and welfare needs employing a robust balance of in-person and if desired, telehealth delivery methods. Participants who need hands on assistance/physical assistance will require careful person-centered planning coordinated by their Case/Resource Manager to determine if remote service delivery is a practical or feasible option for the successful delivery of services. Voice-activated communication devices may be an option that some participants select to ensure that remote service delivery will work for them. Other clients may require in person service delivery only to ensure safety and successful service delivery.

The person-centered service plan is the first resource that will ensure the health and safety of that participant. The PCSP identifies supervision and physical assistance support needs that inform the decision making of whether remote service delivery (telehealth) is appropriate for the client. Providers employing remote service delivery will continue to follow all service protocols and will report any concerns they have to the Case/Resource Manager and make any appropriate incident reports.

The provider delivering services remotely will be responsible for using an approved delivery platform that the client is able and willing to use and will provide basic technical assistance as necessary during the course of their service delivery (device on and off, volume control, etc.). If a client is unable to use technology for remote service delivery, then in person service delivery would be the appropriate service delivery mechanism for the client and this would be discussed during the person-centered planning meeting.

The participant utilizing the services remote support and each person who shares a residence with that participant will be fully informed of what remote service delivery entails including, but not limited to: (A) that remote staff may observe their activities if they are within the view of the participant's video communication device; (B) that the participant decides where in the residence the remote support will occur; (C) whether or not recordings of sessions will be made (the participant's Case/Resource Manager will document in the PCSP); (D) that the participant will control the operation of the communication device, when it is turned on and when it is turned off. Please note that this service is not approved for clients receiving residential habilitation services.

The state will use the CARE assessment to determine client need for technology and remote support through the person-centered planning process. If a client requests that a video camera be placed in their home to use in the provision of remote support, there must be an exception to policy (ETP) in place with justification as to why the camera is needed instead of a simple sensor. The ETP must be approved and documented in the client's file before the device is installed and prior to the service being authorized.

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

- Specialized habilitation is limited to the waiver participant's annual aggregate budget (\$6,192) in the Basic Plus waiver.
- The need for this service is identified during the person-centered planning process and documented in the waiver participant's person-centered service plan.
- Specialized habilitation services are not included in the benefits available through special education, vocational, community first choice, behavioral health, skilled nursing, occupational therapy, physical therapy, or speech, language, and hearing services that are otherwise available through the Medicaid state plan, including early and periodic screening, diagnosis, and treatment, but are consistent with waiver objectives of avoiding institutionalization
- Specialized habilitation services, not provided as a stabilization service, require prior approval by the DDA regional administrator or designee.
- Stabilization Services – Specialized Habilitation is a distinct and separate service from specialized habilitation, appears in PCSPs separately, is authorized separately, and has a unique and separate billing code.
- Since this service is one of the services covered under the aggregate service package, an expenditure limitation applies as indicated in Appendix C-4.a.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

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

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

Provider Specifications:

| Provider Category | Provider Type Title |
|-------------------|-----------------------------------|
| Individual | Certified Life Skills Coach |
| Agency | Specialized Habilitation Provider |
| Agency | Certified Life Skills Coach |
| Individual | Specialized Habilitation Provider |

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Habilitation

Provider Category:

Individual

Provider Type:

Certified Life Skills Coach

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

The contractor must be a Life Skills Coach with current and valid certification. The State clarifies that this service provider must be a Life Skills Coach with current and valid certification and a minimum of one (1) year experience working with individuals who experience a developmental or intellectual disability.

Other Standard *(specify)*:

The contractor must be a Life Skills Coach with current and valid certification.
Contract Standards

When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy 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: Provider Specifications for Service

Service Type: Other Service

Service Name: Specialized Habilitation

Provider Category:

Provider Type:**Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

a. The contractor must be a Life Skills Coach with current and valid certification, or have a Bachelor's, Master's, or Doctoral degree in the field of psychology, sociology, social work, education, child development, gerontology, recreation therapy, nursing, or other related field approved in advance by DDA, or be in a University internship program for psychology, sociology, social work, education, child development, gerontology, recreation therapy, or nursing and be supervised by the University's internship program.

b. The Contractor must have a minimum of one year experience working with individuals who experience a developmental or intellectual disability.

Contract Standards

When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications**Entity Responsible for Verification:****Frequency of Verification:****Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Specialized Habilitation****Provider Category:****Provider Type:****Provider Qualifications****License (specify):**

Certificate (specify):

The contractor must be a Life Skills Coach with current and valid certification. The State clarifies that this service provider must be a Life Skills Coach with current and valid certification and a minimum of one (1) year experience working with individuals who experience a developmental or intellectual disability.

Other Standard (specify):

The contractor must be a Life Skills Coach with current and valid certification.
Contract Standards

When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy 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: Provider Specifications for Service****Service Type: Other Service****Service Name: Specialized Habilitation****Provider Category:**

Individual

Provider Type:

Specialized Habilitation Provider

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

a. The contractor must be a Life Skills Coach with current and valid certification, or have a Bachelor's, Master's, or Doctoral degree in the field of psychology, sociology, social work, education, child development, gerontology, recreation therapy, nursing, or other related field approved in advance by DDA, or be in a University internship program for psychology, sociology, social work, education, child development, gerontology, recreation therapy, or nursing and be supervised by the University's internship program.

b. The Contractor must have a minimum of one year experience working with individuals who experience a developmental or intellectual disability.

Contract Standards

When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy 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:

Stabilization Services- Staff/Family Consultation Services

HCBS Taxonomy:

Category 1:

10 Other Mental Health and Behavioral Services

Sub-Category 1:

10030 crisis intervention

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Continued)

Stabilization Services – Staff/Family Consultation Services are therapeutic services that assist family members, unpaid caregivers and/or paid support staff in carrying out individual treatment/support plans, and that are not covered by the Medicaid state plan, and are necessary to improve the individual's independence and inclusion in their community. This service is not intended to instruct paid staff on the competencies relative to their field they are required to have or to provide training required to meet provider qualifications, but rather to support staff in meeting the individualized and specific needs of the waiver participant. The person-centered service plan, developed by the case/resource manager in collaboration with the waiver participant and the waiver participant's family, provides the high-level summary of services and goals for each specified waiver service. The plan developed by the consultant provides step-by-step details necessary to reach a goal by implementing a specific course of supports by the participant's family or paid providers.

Consultation, such as assessment, the development, training and technical assistance to a home or community support plan, and monitoring of the provider and individual in the implementation of the plan, is provided to families or direct staff to meet the specific needs of the waiver participant as outlined in the individual's person-centered service plan, including:

- (a) Health and medication monitoring to report to health care provider;
- (b) Positioning and transfer;
- (c) Basic and advanced instructional techniques;
- (d) Residential Habilitation Positive Behavior Support Implementation;
- (e) Augmentative communication systems;
- (f) Consultation with potential referral resources (mental health crisis line or end-harm line);
- (g) Diet and nutritional guidance;
- (h) Disability information and education;
- (i) Strategies for effectively and therapeutically interacting with the participant;
- (j) Environmental consultation;
- (k) Assistive Technology;
- (l) Individual and family counseling; and
- (l) Parenting skills.

Stabilization Services – Staff/Family Consultation Services are distinct and separate services from Staff/Family Consultation Services, appear in PCSPs separately, are authorized separately and have an unique and separate billing code.

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

Stabilization services – Staff/Family Consultation Services are intermittent and temporary. The need for this service is identified during the person-centered planning process and documented in the waiver participant's person-centered service plan with consultation by a behavioral health specialist when appropriate. Service is provided to the waiver participant who is experiencing a crisis and is at risk of hospitalization. Once the crisis situation is resolved and the individual is stabilized, stabilization services will be terminated. Any ongoing need for Staff/Family Consultation Services will be met under the stand-alone Staff/Family Consultation Services category. The services under the waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Stabilization Services – Staff/Family Consultation Services is a distinct and separate services from Staff/Family Consultation Services, appears in PCSPs separately, is authorized separately and has an unique and separate billing code.

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 | Staff/Family Consultation Services |
| Individual | Staff/Family Consultation Services |
| Individual | Specialized Habilitation Provider |
| Agency | Specialized Habilitation Provider |

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Stabilization Services- Staff/Family Consultation Services

Provider Category:

Agency

Provider Type:

Staff/Family Consultation Services

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

Staff/Family Consultation providers shall be licensed, registered or certified in Washington State according to the standards of their profession as listed below:

- 1) Audiologist licensed in accordance with RCW 18.35;
 - 2) Licensed practical nurse licensed in accordance with RCW 18.79;
 - 3) Marriage and family therapist licensed in accordance with RCW 18.225;
 - 4) Mental health counselor licensed in accordance with RCW 18.225;
 - 5) Occupational therapist licensed in accordance with RCW 18.59;
 - 6) Physical therapist licensed in accordance with RCW 18.74;
 - 7) Registered nurse licensed in accordance with RCW 18.79;
 - 8) Sex offender treatment provider licensed in accordance with RCW 18.155;
 - 9) Speech/language pathologist licensed in accordance with RCW 18.35;
 - 10) Social worker licensed in accordance with RCW 18.225;
 - 11) Psychologist licensed in accordance with RCW 18.225;
 - 12) Certified American Sign Language instructor;
 - 13) Nutritionist licensed in accordance with RCW 18.138;
 - 14) Counselors certified in accordance with RCW 18.19;
 - 15) Certified dietician licensed in accordance with RCW 18.138;
 - 16) Professional advocacy organization;
 - 17) Recreation therapist registered certified in Washington in accordance with RCW 18.230 and certified by the national council for therapeutic recreation;
 - 18) Educator or teacher certified in accordance with RCW 18.79A;
 - 19) Providers listed in WAC 388-845-0506 and with a current contract with DDA to provide CIIBS intensive services; or
 - 20) Or other provider identified in WAC chapter 388-845 for Staff/Family Consultation.
- 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: Provider Specifications for Service

Service Type: Other Service

Service Name: Stabilization Services- Staff/Family Consultation Services

Provider Category:

Individual

Provider Type:

Staff/Family Consultation Services

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (*specify*):

Staff/Family Consultation providers shall be licensed, registered or certified in Washington State according to the standards of their profession as listed below:

- 1) Audiologist licensed in accordance with RCW 18.35;
- 2) Licensed practical nurse licensed in accordance with RCW 18.79;
- 3) Marriage and family therapist licensed in accordance with RCW 18.225;
- 4) Mental health counselor licensed in accordance with RCW 18.225;
- 5) Occupational therapist licensed in accordance with RCW 18.59;
- 6) Physical therapist licensed in accordance with RCW 18.74;
- 7) Registered nurse licensed in accordance with RCW 18.79;
- 8) Sex offender treatment provider licensed in accordance with RCW 18.155;
- 9) Speech/language pathologist licensed in accordance with RCW 18.35;
- 10) Social worker licensed in accordance with RCW 18.225;
- 11) Psychologist licensed in accordance with RCW 18.225;
- 12) Certified American Sign Language instructor;
- 13) Nutritionist licensed in accordance with RCW 18.138;
- 14) Counselors certified in accordance with RCW 18.19;
- 15) Certified dietitian licensed in accordance with RCW 18.138;
- 16) Professional advocacy organization;
- 17) Recreation therapist registered certified in Washington in accordance with RCW 18.230 and certified by the national council for therapeutic recreation;
- 18) Educator or teacher certified in accordance with RCW 18.79A;
- 19) Providers listed in WAC 388-845-0506 and with a current contract with DDA to provide CIIBS intensive services; or
- 20) Or other provider identified in WAC chapter 388-845 for Staff/Family Consultation.

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: Provider Specifications for Service**

Service Type: Other Service

Service Name: Stabilization Services- Staff/Family Consultation Services

Provider Category:

Individual

Provider Type:

Specialized Habilitation Provider

Provider Qualifications**License** (*specify*):
Certificate (*specify*):

Other Standard (*specify*):

- a. The contractor must be a Life Skills Coach with current and valid certification, or have a Bachelor's, Master's, or Doctoral degree in the field of psychology, sociology, social work, education, child development, gerontology, recreation therapy, nursing, or other related field approved in advance by DDA, or be in a University internship program for psychology, sociology, social work, education, child development, gerontology, recreation therapy, or nursing and be supervised by the University's internship program.

b. The Contractor must have a minimum of one year experience working with individuals who experience a developmental or intellectual disability.

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: Stabilization Services- Staff/Family Consultation Services

Provider Category:

Agency

Provider Type:

Specialized Habilitation Provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

- a. The contractor must be a Life Skills Coach with current and valid certification, or have a Bachelor's, Master's, or Doctoral degree in the field of psychology, sociology, social work, education, child development, gerontology, recreation therapy, nursing, or other related field approved in advance by DDA, or be in a University internship program for psychology, sociology, social work, education, child development, gerontology, recreation therapy, or nursing and be supervised by the University's internship program.

b. The Contractor must have a minimum of one year experience working with individuals who experience a developmental or intellectual disability.

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:

Stabilization Services-Crisis Diversion Bed

HCBS Taxonomy:

| | |
|---|--------------------------------------|
| Category 1: | Sub-Category 1: |
| <div>10 Other Mental Health and Behavioral Services</div> | <div>10030 crisis intervention</div> |
| Category 2: | Sub-Category 2: |
| <div></div> | <div></div> |
| Category 3: | Sub-Category 3: |
| <div></div> | <div></div> |
| Service Definition (Scope): | |
| Category 4: | Sub-Category 4: |
| <div></div> | <div></div> |

Crisis diversion beds are available to individuals determined by DDA to be at risk of institutionalization. Crisis diversion beds may be provided in a client's home, licensed, or certified setting. Crisis diversion beds are short-term residential habilitation supports provided by trained specialists and include direct care, supervision, or monitoring, habilitative supports, referrals, and consultation. This service is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Short-term is designed to reflect a temporary, multiple day or multiple week time frame. Individualized person-centered planning identifies the minimally necessary time for a participant to be stabilized and returned to their own home, if an out of home setting is required, without a specific time limit. The need for this service is identified during the person-centered planning process and is documented in the waiver participant's person-centered service plan. Individualized person-centered planning identifies the minimally necessary time for a participant to be stabilized and returned to their own home, if an out of home setting is required, without a specific time limit. 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 in waiver services. DDA works closely with the Behavioral Health Administration (BHA) and the Health Care Authority to prevent duplication of BHO/State Plan MH Services. DSHS's expectation is that any DDA eligible client who meets the BHA, MCO, or HCA access to care or medical necessity standards will receive behavioral health services through their health plans. Community mental health services are provided through Behavioral Health Organizations, FFS Medicaid or Managed care Organizations, which carry out the contracting for local mental health care. Individuals with primary diagnoses and functional impairments that are only a result of developmental or intellectual disability are not eligible for behavioral health waiver services. As a result, individuals with these support needs must display an additional covered diagnosis and a medically necessary support need in order to be served through the behavioral health system. Individuals that do not meet access to care or medical necessity standards for the service type may be served under stabilization services.

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

The duration and amount of services needed to stabilize the individual in crisis is determined by DDA with consultation from a behavioral health professional. Stabilization Services - Crisis Diversion Bed is limited to additional services not otherwise covered under the state plan, but consistent with the waiver objectives of avoiding institutionalization. "Short-term" reflects the fact that these services are not provided on an on-going basis. They are provided to individuals who are experiencing a crisis and are at risk of hospitalization. Once the crisis situation is resolved and the individual is stabilized, Stabilization services will be terminated.

The State confirms that the crisis diversion bed service is never provided in an institutional setting. The State will specify that room and board is excluded from payment.

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 | Crisis Diversion Bed Provider (Supported Living Agency) |
| Agency | Crisis Diversion Bed Provider (State-operated) |
| Agency | Crisis Diversion Bed Provider (Other department-licensed or certified agencies) |
| Agency | Crisis Diversion Bed Provider (licensed and contracted) |

Appendix C: Participant Services

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

Service Type: Other Service**Service Name: Stabilization Services-Crisis Diversion Bed**

Provider Category:**Provider Type:****Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:****Frequency of Verification:****Appendix C: Participant Services**

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

Service Type: Other Service**Service Name: Stabilization Services-Crisis Diversion Bed**

Provider Category:**Provider Type:****Provider Qualifications****License (specify):****Certificate (specify):**

Chapter 388-101 & 388-101D WAC (ALTSA & DDA administrative code concerning requirements for certified community residential services and support)

Other Standard *(specify)*:

Contract Standards

Verification of Provider Qualifications
Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Stabilization Services-Crisis Diversion Bed

Provider Category:

Agency

Provider Type:

Crisis Diversion Bed Provider (Other department-licensed or certified agencies)

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Chapter 388-101 WAC (ALTSA administrative code concerning requirements for Certified Community residential services and support)

Other Standard *(specify)*:

Contract Standards

Verification of Provider Qualifications
Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every year

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Stabilization Services-Crisis Diversion Bed

Provider Category:**Provider Type:****Provider Qualifications****License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):**Verification of Provider Qualifications****Entity Responsible for Verification:****Frequency of Verification:**

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:

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:**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:**

Category 3:**Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Stabilization Services-Specialized Habilitation is short term individualized and community-based support when a client is experiencing crisis to assist the waiver participant to reach an identified habilitative goal to promote inclusion in their homes and communities to avoid immediate institutionalization.

Specialized Habilitation offers teaching and training to a waiver participant to learn or maintain skills in:

- Self-empowerment (such as becoming more aware of strengths and weaknesses and therefore becoming better equipped to deal with problems)
- Safety awareness and self-advocacy (such as learning skills for safety awareness or how to recognize and report abuse, neglect or exploitation)
- Interpersonal skills and effective communication (such as avoiding or mitigating inappropriate peer pressure)
- Coping strategies regarding typical life challenges (such as acclimating to a new family member or roommate)
- Managing daily tasks and acquiring adaptive skills (such as selecting appropriate outfits for various work and social occasions)

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

- Stabilization services – Specialized Habilitation are intermittent and temporary.
- The need for this service is identified during the person-centered planning process and documented in the waiver participant's person-centered service plan.
- Once the crisis situation is resolved and the individual is stabilized, stabilization services will be terminated.
- Any ongoing need for Specialized Habilitation services will be met under the stand-alone Specialized Habilitation services category for eligible clients.
- The services under the waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.
- Stabilization Services – Specialized Habilitation is a distinct and separate service from Specialized Habilitation, appears in PCSPs separately, is authorized separately and has an unique and separate billing code.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

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

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

Provider Specifications:

| Provider Category | Provider Type Title |
|-------------------|-----------------------------------|
| Agency | Specialized Habilitation Provider |
| Individual | Specialized Habilitation Provider |

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Stabilization Services-Specialized Habilitation

Provider Category:**Provider Type:****Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

a. The contractor must be a Life Skills Coach with current and valid certification, or have a Bachelor's, Master's, or Doctoral degree in the field of psychology, sociology, social work, education, child development, gerontology, recreation therapy, nursing, or other related field approved in advance by DDA, or be in a University internship program for psychology, sociology, social work, education, child development, gerontology, recreation therapy, or nursing and be supervised by the University's internship program.

b. The Contractor must have a minimum of one year experience working with individuals who experience a developmental or intellectual disability.

Contract Standards

Verification of Provider Qualifications**Entity Responsible for Verification:****Frequency of Verification:**

Appendix C: Participant Services

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

Service Type: Other Service**Service Name: Stabilization Services-Specialized Habilitation**

Provider Category:**Provider Type:****Provider Qualifications****License (specify):****Certificate (specify):**

Other Standard (specify):

- a. The contractor must be a Life Skills Coach with current and valid certification, or have a Bachelor’s, Master’s, or Doctoral degree in the field of psychology, sociology, social work, education, child development, gerontology, recreation therapy, nursing, or other related field approved in advance by DDA, or be in a University internship program for psychology, sociology, social work, education, child development, gerontology, recreation therapy, or nursing and be supervised by the University’s internship program.

b. The Contractor must have a minimum of one year experience working with individuals who experience a developmental or intellectual disability.
- 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:
Staff/Family Consultation Services

HCBS Taxonomy:

| | |
|-------------------|-----------------|
| Category 1: | Sub-Category 1: |
| 17 Other Services | 17990 other |
| Category 2: | Sub-Category 2: |
| | |
| Category 3: | Sub-Category 3: |
| | |

Service Definition (Scope):

Category 4:

Sub-Category 4:

- Clinical and professional services that assist formal (paid) and informal (unpaid) caregivers, support staff, or family members of a waiver participant in carrying out individual treatment/support plans.
 - Professional services are those that are not covered by the Medicaid state plan and are necessary to improve the individual's independence and inclusion in their community.
 - This service is not intended to instruct paid staff/family on the competencies relative to their field they are required to have or to provide training required to meet provider qualifications, but rather to support staff/family in meeting the individualized and specific needs of the waiver participant.
 - The person-centered service plan, developed by the case resource manager in collaboration with the waiver participant and the waiver participant's staff/family, provides the high-level summary of services and goals for each specified waiver service.
 - The plan developed by the consultant provides step-by-step details necessary to reach a goal by implementing a specific course of supports by the participant's staff/family or other paid providers.
 - Consultation, such as assessment, development, training, and technical assistance to a home or community support plan, and monitoring of the provider and individual in the implementation of the plan, is provided to families or direct staff to meet the specific needs of the waiver participant as outlined in the waiver participant's person-centered service plan, including:
 - (a) Health and medication monitoring to report to the healthcare provider;
 - (b) Positioning and transfer;
 - (c) Basic and advanced instructional techniques;
 - (d) Residential Habilitation Positive Behavior Support implementation;
 - (e) Augmentative communication systems;
 - (f) Consultation with potential referral resources (mental health crisis line or end-harm line);
 - (g) Diet and Nutritional Guidance;
 - (h) Disability Information and Education;
 - (i) Strategies for effectively and therapeutically Interacting with the Participant;
 - (j) Environmental consultation;
 - (k) Assistive technology;
 - (l) Individual and Family Counseling; and
 - (m) parenting skills.

All Staff/Family consultation providers shall be licensed, registered, or certified in Washington State according to the standards of their approved profession in Title 18 RCW or other standard of profession.

Remote service delivery is an available service delivery option if chosen by the participant or their guardian (if appropriate), appropriately meets the participant's assessed needs as documented in their PCSP and is provided within the scope of the service being delivered. Service may be received in person or via telehealth as identified in the person-centered service plan. The waiver participant selects whether they want to receive service in person, via telehealth, or a combination of both. Remote service delivery means that the service is delivered by the provider to the participant via phone, video, computer, or other technology and that the technology and data storage is HIPAA compliant.

Assurances:

The well-developed person-centered service plan will document the participant's specific health and welfare needs and how each service selected by the participant contributes to meeting the participant's needs and does not duplicate supports.

Remote Supports does not provide any of the specific services or supports that are provided by services that are delivered via telehealth remotely.

The well-developed person-centered service plan will document which services are selected by the participant to meet their unique health and welfare needs and whether a participant selects a particular service to be provided via telehealth remotely. The service authorization system (ProviderOne) has distinct and separate service codes for each waiver service and has built-in system logic that prevents duplication of services. DDA policies and procedures provide guidance to Case Resource Managers on developing effective person-centered service plans that meet the unique needs of participants without any duplication of services.

Telehealth will be the delivery method for a particular service at the direction of the participant not by the preference of the service provider. A teleservice (telehealth) request form will be required prior to authorization of teleservice delivery. This request form will document the client's desired level of in person to teleservice delivery and will remind client's that they can change their mind about frequency of teleservice delivery at any time. This agreement is intended to assist in clear and documented communication between the client, DDA, and the provider (in addition

to the person-centered service plan) to ensure the client is the driver of the method of service delivery they receive. Case/Resource Managers will consult with their participants and family members, if appropriate, to develop the person-centered service plan that includes the specific services and service delivery methods that best meets the participant's unique health and welfare needs. Participants will document in their PCSPs what approximate percentage of service delivery they desire to receive via telehealth. The State is not mandating what percentage of time telehealth will be the delivery method for the service to ensure person-centered service planning and promote client choice. Case/Resource Managers will be guided by DDA policy to assist participants to select services and service delivery methods that best meet their health and welfare needs employing a robust balance of in-person and if desired, telehealth delivery methods.

State will permit recording of live interactions with the participant via audio or video technology only at the request of the participant. Policy will include specific language around bathrooms and bedrooms. Video cameras are not permissible in bathrooms. If a client requests a video camera in their bedroom, there must be an approved exception to policy in place and the device must be situated in a way that does not compromise client privacy. Live 2-way interactions are always initiated by the participant. The participant can initiate the service when needed and turn off the equipment when not needed.

The State believes remote service delivery (telehealth) will be an important component in a well-developed and balanced person-centered service plan that focuses on the specific wants and health and welfare needs of the participant. Experience during the COVID-19 pandemic has shown that remote service delivery can facilitate community integration in a person-centered way. Washingtonians in the broader community utilize both technology-supported remote and in-person community service environments, and the proposed change in waiver services give waiver clients the same opportunity to participate in their community as everyone else. Case/Resource Managers will be guided by DDA policy to assist participants to select services and service delivery methods that best meet their health and welfare needs employing a robust balance of in-person and if desired, telehealth delivery methods. Participants who need hands on assistance/physical assistance will require careful person-centered planning coordinated by their Case/Resource Manager to determine if remote service delivery is a practical or feasible option for the successful delivery of services. Voice-activated communication devices may be an option that some participants select to ensure that remote service delivery will work for them. Other clients may require in person service delivery only to ensure safety and successful service delivery.

The person-centered service plan is the first resource that will ensure the health and safety of that participant. The PCSP identifies supervision and physical assistance support needs that inform the decision making of whether remote service delivery (telehealth) is appropriate for the client. Providers employing remote service delivery will continue to follow all service protocols and will report any concerns they have to the Case/Resource Manager and make any appropriate incident reports.

The provider delivering services remotely will be responsible for using an approved delivery platform that the client is able and willing to use and will provide basic technical assistance as necessary during the course of their service delivery (device on and off, volume control, etc.). If a client is unable to use technology for remote service delivery, then in person service delivery would be the appropriate service delivery mechanism for the client and this would be discussed during the person-centered planning meeting.

The participant utilizing the services remote support and each person who shares a residence with that participant will be fully informed of what remote service delivery entails including, but not limited to: (A) that remote staff may observe their activities if they are within the view of the participant's video communication device; (B) that the participant decides where in the residence the remote support will occur; (C) whether or not recordings of sessions will be made (the participant's Case/Resource Manager will document in the PCSP); (D) that the participant will control the operation of the communication device, when it is turned on and when it is turned off. Please note that this service is not approved for clients receiving residential habilitation services.

The state will use the CARE assessment to determine client need for technology and remote support through the person-centered planning process. If a client requests that a video camera be placed in their home to use in the provision of remote support, there must be an exception to policy (ETP) in place with justification as to why the camera is needed instead of a simple sensor. The ETP must be approved and documented in the client's file before the device is installed and prior to the service being authorized.

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

- (1) Clinical and support needs for staff/family consultation services are identified in the waiver participant's DDA person-centered assessment and documented in their person-centered service plan.
- (2) 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 services.
- (3) Staff/Family Consultation services will not duplicate services available through third party payers, social service organizations, or schools.
- (4) Since this service is one of the services covered under the aggregate services package in the Basic Plus waiver, an expenditure limitation applies to these waivers as indicated in Appendix C-4.a.
- (5) Individual and Family Counseling is available when the waiver participant has documentation in the person-centered service plan that they engage in assaults toward family members and are receiving positive behavior support to address those assaultive behaviors.
- (6) Stabilization Services –Staff/Family consultation are distinct and separate services from Staff/Family Consultation services, appear in PCSPs separately, are authorized separately, and have unique and separate billing codes.

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 | Speech/Language Pathologist |
| Individual | Social Worker |
| Individual | Marriage and Family Therapist |
| Agency | Staff/Family Consultation Agency Provider |
| Agency | Specialized Habilitation Provider |
| Individual | Psychologist |
| Individual | Certified Life Skills Coach |
| Individual | Physical Therapist |
| Individual | Sex Offender Treatment Provider |
| Individual | Educator |
| Individual | Mental Health Counselor |
| Individual | Registered or Certified Counselor |
| Individual | Nutritionist |
| Individual | Certified American Sign Language Instructor |
| Individual | Occupational Therapist |
| Individual | Registered Nurse |
| Individual | Audiologist |
| Individual | Specialized Habilitation Provider |
| Individual | Certified Dietician |
| Individual | Teacher |
| Individual | Certified Recreation Therapist |
| Individual | Licensed Practical Nurse |
| Agency | Certified Life Skills Coach |

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Staff/Family Consultation Services

Provider Category:

Individual

Provider Type:

Speech/Language Pathologist

Provider Qualifications

License (*specify*):

Certificate (*specify*):

WAC 246-828-105 (DOH administrative code concerning speech-language pathology-minimum standards of practice.)

Other Standard (*specify*):

Contract Standards

When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy 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: Staff/Family Consultation Services

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

When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Staff/Family Consultation Services

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

When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

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 Services

Provider Category:

Agency

Provider Type:

Staff/Family Consultation Agency Provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

An agency could employ any of the individual provider types listed under this service and the employees must meet the qualifications listed.

When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy 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: Staff/Family Consultation Services

Provider Category:

Agency

Provider Type:

Specialized Habilitation Provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Contract Standards

When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Staff/Family Consultation Services

Provider Category:

Individual

Provider Type:

Psychologist

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Contract Standards

When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

Appendix C: Participant Services

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

Service Type: Other Service**Service Name: Staff/Family Consultation Services****Provider Category:****Provider Type:****Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications**Entity Responsible for Verification:****Frequency of Verification:**

Appendix C: Participant Services

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

Service Type: Other Service**Service Name: Staff/Family Consultation Services****Provider Category:****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.

When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy 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: Staff/Family Consultation Services

Provider Category:

Individual

Provider Type:

Sex Offender Treatment Provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Chapter 246-930 WAC (concerning requirements for Sex Offender Treatment Provider)

Other Standard (*specify*):

Contract Standards

When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

Appendix C: Participant Services

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

Service Type: Other Service**Service Name: Staff/Family Consultation Services****Provider Category:****Provider Type:****Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:****Frequency of Verification:**

Appendix C: Participant Services

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

Service Type: Other Service**Service Name: Staff/Family Consultation Services****Provider Category:****Provider Type:****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

When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy 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: Staff/Family Consultation Services

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

When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy 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: Staff/Family Consultation Services

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

When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy 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: Staff/Family Consultation Services

Provider Category:

Individual

Provider Type:

Certified American Sign Language Instructor

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Contract Standards

When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy 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: Staff/Family Consultation Services

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.

When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy 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: Staff/Family Consultation Services****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

When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy 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: Staff/Family Consultation Services**

Provider Category:**Provider Type:****Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications**Entity Responsible for Verification:****Frequency of Verification:****Appendix C: Participant Services**

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

Service Type: Other Service**Service Name: Staff/Family Consultation Services**

Provider Category:**Provider Type:****Provider Qualifications****License (specify):****Certificate (specify):**

Other Standard (*specify*):

Contract Standards

When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy 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: Staff/Family Consultation Services

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

When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy 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: Staff/Family Consultation Services

Provider Category:

Individual

Provider Type:

Teacher

Provider Qualifications

License (*specify*):

Certificate (*specify*):

WAC 181-79A

Other Standard (*specify*):

contract standards

When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy 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: Provider Specifications for Service

Service Type: Other Service

Service Name: Staff/Family Consultation Services

Provider Category:

Individual

Provider Type:

Certified Recreation Therapist

Provider Qualifications

License (*specify*):

Certificate (*specify*):**Other Standard** (*specify*):

Contract Standards

When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications**Entity Responsible for Verification:****Frequency of Verification:****Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Staff/Family Consultation Services****Provider Category:****Provider Type:****Provider Qualifications****License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):

Contract Standards

When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Frequency of Verification:

Appendix C: Participant Services

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

Service Type: Other Service**Service Name: Staff/Family Consultation Services****Provider Category:****Provider Type:****Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications**Entity Responsible for Verification:****Frequency of Verification:**

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:

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

Service Title:

Therapeutic Adaptations

HCBS Taxonomy:**Category 1:**

14 Equipment, Technology, and Modifications

Sub-Category 1:

14031 equipment and technology

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Therapeutic adaptations are modifications to the environment necessary to reduce or eliminate environmental stressors, enable social support, or give a sense of control to the waiver participant in order for a therapeutic plan to be implemented. Adaptations include modifications such as:

- Noise reduction or enhancement
- Lighting Adjustment
- Wall Softening
- Tactile Accents
- Visual Accents

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

One time adaptation every five years limited to funds available in the aggregate budget and emergency assistance when eligible. Modifications may not add square footage to the home or convert nonliving space into living space. Requires a recommendation by a behavioral health provider, OT or PT within the waiver participant's current therapeutic plan. Therapeutic adaptations are not items covered under the Medicaid state plan including those benefits under EPSDT.

These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Since this service is one of the services covered under the aggregate service package, an expenditure limitation applies as indicated in Appendix C-4.a.

The State notes that Therapeutic Adaptations is an unique and specific service that does not overlap with either Specialized Equipment and Supplies or Environmental Adaptations. Each service is authorized separately and has an unique billing code.

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 | Environmental adaptation provider |
| Individual | Shopper |
| Individual | Specialized Equipment and Supplies Provider |
| Agency | Specialized Equipment and Supplies Provider |
| Agency | Shopper |
| Individual | Environmental adaptation provider |

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Therapeutic Adaptations

Provider Category:

Agency

Provider Type:

Environmental adaptation provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Contract Standards and
 Chapter 18.27 RCW (State law concerning the registration of contractors)
 Chapter 19.27 RCW (State law concerning the state building code)

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: Provider Specifications for Service****Service Type: Other Service****Service Name: Therapeutic Adaptations****Provider Category:**

Individual

Provider Type:

Shopper

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):

Contract Standards. The State clarifies that this service provider and its employees must hold a current Washington State Business License, maintain all additional and necessary licenses required by the State, and utilize a financial business account to make the approved purchases.

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: Therapeutic Adaptations****Provider Category:**

Individual

Provider Type:

Specialized Equipment and Supplies Provider

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Therapeutic Adaptations

Provider Category:

Agency

Provider Type:

Specialized Equipment and Supplies Provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Therapeutic Adaptations

Provider Category:**Provider Type:****Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

Contract Standards. The State clarifies that this service provider and its employees must hold a current Washington State Business License, maintain all additional and necessary licenses required by the State, and utilize a financial business account to make the approved purchases.

Verification of Provider Qualifications**Entity Responsible for Verification:****Frequency of Verification:****Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Therapeutic Adaptations****Provider Category:****Provider Type:****Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

Contract Standards and
Chapter 18.27 RCW (State law concerning the registration of contractors)

Chapter 19.27 RCW (State law concerning the state building code)

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:

Transportation

HCBS Taxonomy:

| | |
|-------------------------------|----------------------------------|
| Category 1: | Sub-Category 1: |
| 15 Non-Medical Transportation | 15010 non-medical transportation |
| Category 2: | Sub-Category 2: |
| | |
| Category 3: | Sub-Category 3: |
| | |
| Service Definition (Scope): | |
| Category 4: | Sub-Category 4: |
| | |

- Reimbursement for transporting a waiver participant to and from waiver funded services, when the transportation is required and specified in the participant's Person-Centered Service Plan.
 - Waiver transportation is available if the cost and responsibility for transportation is not already included in the provider's contract and payment.
 - 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:

- (1) Transportation to/from medical or medically related appointments is a Medicaid State Plan transportation service and is to be considered and used first. This includes benefits under EPSDT.
- (2) Transportation is offered in addition to medical transportation but cannot replace Medicaid State Plan transportation services.
- (3) Transportation is limited to travel to and from a waiver service.
- (4) Transportation does not include the purchase of a bus pass.
- (5) Reimbursement for provider mileage is paid according to contract.
- (6) This service does not cover the purchase or lease of vehicles.
- (7) Reimbursement for provider travel time is not included in this service.
- (8) Reimbursement to the provider is limited to transportation that occurs when the waiver participant is with the provider.
- (9) The waiver participant is not eligible for transportation services if the cost and responsibility for transportation is already included in the provider's contract and payment.
- (10) Since this service is one of the services covered under the aggregate services package, an expenditure limitation applies as indicated in Appendix C-4.a.

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 | Non-Emergency Medical Transportation Companies |
| Individual | Transportation |
| Agency | HCA Contracted Non-Emergency Medical Transportation Brokers |
| Agency | Transportation |

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Provider Type:**Provider Qualifications****License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):**Verification of Provider Qualifications****Entity Responsible for Verification:****Frequency of Verification:**

Appendix C: Participant Services

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

Service Type: Other Service**Service Name:** Transportation**Provider Category:****Provider Type:****Provider Qualifications****License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):**Verification of Provider Qualifications****Entity Responsible for Verification:**

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Transportation

Provider Category:

Agency

Provider Type:

HCA Contracted Non-Emergency Medical Transportation Brokers

Provider Qualifications

License (specify):

WAC 182-546-5000-6200 (State administrative code concerning non-emergency medical transportation); Chapter 308-104 WAC (State administrative code concerning driver's licenses)

Certificate (specify):

Other Standard (specify):

Contract Standards; Chapter 308-106 WAC (State administrative code concerning mandatory insurance to operate a vehicle)

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: Transportation

Provider Category:

Agency

Provider Type:

Transportation

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:

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:

Wellness Education

HCBS Taxonomy:

Category 1:

13 Participant Training

Sub-Category 1:

13010 participant training

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Continued)

Wellness education provides waiver participants with monthly informational and educational materials designed to assist them in managing health related issues, achieving goals identified in their person centered service plans and addressing health and safety issues. This service will assist participants to achieve greater health, safety and success in community living.

- a. The individualized material is being developed by the state and by the contracted provider.
- b. The participants will receive printed material.
- c. The participants will receive a monthly mailing.
- d. The Wellness Education service is designed to assist participants to live in the community and avoid institutionalization by ensuring that they receive needed information and tools. For example, the service can provide information needed to:
 - Successfully manage chronic conditions in order to halt progression resulting in risk of nursing home placements;
 - Prevent and avoid health risks such as, pneumonia, influenza, infections, and other illnesses or conditions that can lead to nursing home placement for elderly or frail participants;
 - Work effectively with health providers in order to understand and follow recommendations for the correct course of treatment in order to prevent hospitalization or nursing home placement;
 - Develop support networks that can promote engagement and combat isolation that can lead to increased health and safety risks that can result in nursing home placement;
 - Develop an effective person centered service plan that utilizes an array of paid and informal supports to address the whole person needs of the person to live successfully in the community;
 - Achieve community goals identified in the person centered service plan.

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

Waiver participants who elect to receive this waiver service will receive the service monthly.
Since this service is one of the services covered under the annual allocation, an expenditure limitation applies as indicated in Appendix C-4.a.

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 | Wellness Education |

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Wellness Education

Provider Category:

Agency

Provider Type:

Wellness Education

Provider Qualifications**License** (*specify*):
Certificate (*specify*):
Other Standard (*specify*):
Verification of Provider Qualifications**Entity Responsible for Verification:**

Frequency of Verification:

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.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *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:

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):

DDA requires all individuals who may have unsupervised access to persons with developmental disabilities to complete a DSHS background check. This includes all contracted providers, individual providers, employees of contracted providers, county contracted providers that are funded by DDA, and any other individual who needs to be qualified by DDA to have unsupervised access to individuals with developmental disabilities. Staff may work in an unsupervised capacity through a provisional hire, only after they have completed an initial non-disqualifying Washington state background check and the national fingerprint-based background check results are pending. If staff are working with individuals with developmental disabilities prior to their background check being completed, they must be supervised.

All applicants identified as all long-term care workers (as defined below) are required to have a fingerprint-based check through the FBI. Individuals being hired by DDA who have lived in Washington less than three years or who live out of state and work in Washington are also required to have a fingerprint-based check through the FBI.

The DSHS Background Check Central Unit is assigned to complete all background checks required. Background check searches include multiple information sources including state and federal law enforcement records, state court records, and agency databases. Specifically, the following data sources are searched: Washington State patrol (WSP) WATCH criminal history records, Administrative Office of the Courts Public Data Mart – criminal history records, Washington State Adult Protective Services findings, Washington State Residential Client Protection Program findings, Washington State Child Protective Services findings, Washington State Department of Health findings, applicant self-disclosures, and stored Washington State Patrol and Federal Bureau of Investigations fingerprint record Records of Arrests and Prosecution (RAP) sheets and state RAP sheets, Washington State Department of Corrections Felony Offender Reporting System, Washington State Patrol Fingerprint-based search, FBI fingerprint-based search, Western Identification Network State Search for certain states.

"Long-term care workers"(as defined in RCW 74.39A.009(17)(a) includes all persons who provide paid, hands-on personal care services for the elderly or persons with disabilities, including but not limited to individual providers of home care services, direct care workers employed by home care agencies, providers of home care services to persons with developmental disabilities under Title 71A RCW, all direct care workers in state-licensed assisted living facilities, and adult family homes, respite care providers, direct care workers employed by community residential service businesses, and any other direct care worker providing home or community-based services to the elderly or persons with functional disabilities or developmental disabilities.

(d) Relevant state laws, regulations and policies are: RCW 43.20A.710 (Investigation of conviction records or pending charges of state employees and individual providers), RCW 43.43.830 (Background checks – Access to children or vulnerable persons-Definitions),RCW 43.43.832 (Background checks – Disclosure of information), RCW 43.43.837 (fingerprint-based background checks), RCW 43.43.842 (Vulnerable adults – Additional licensing requirements for agencies, facilities, and individuals providing services), RCW 74.15.030 (care of children, expectant mothers, persons with developmental disabilities), Chapter 74.39A RCW (Long-term care services), Chapter WAC 388-06 (background checks)Chapter 388-101 WAC (Certified Community Residential Services and Supports), Chapter 388-101D WAC (Requirements for Providers of Residential Services and Supports), Chapter 388-113 WAC (Disqualifying Crimes and Negative Actions), Chapter 388-825 WAC (Developmental Disabilities Administration Services Rules), DDA Policy 5.01 (Background Check Authorizations)and DSHS Administrative Policy 18.63 (employee background check requirements).

The Administration is audited periodically by a number of entities, including the Washington State Auditor's Office, and DSHS Operations Review. The requirement to conduct criminal history background investigations is monitored by these entities due to its importance in reducing risk to clients of the Administration.

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) Under state authority, RCW 26.44 (state law concerning abuse of children), Child Protective Services (CPS) within the Department of Children, Youth and Families is responsible for receiving and investigating reports of suspected child abuse and neglect.

Under state authority, RCW 74.34 (state law concerning abuse of vulnerable adults), the Aging and Long Term Support Administration (AL TSA) receives reports and conducts investigations of abuse, neglect, exploitation and abandonment for individuals enrolled with the Developmental Disabilities Administration. AL TSA Residential Care Services (RCS) investigates provider practice issues with respect to abuse and neglect occurring in nursing homes, assisted living facilities, adult family homes, & supported living programs. AL TSA Adult Protective Services (APS) investigates abuse and neglect involving adults residing in residential facilities and in their own homes. The BCCU checks APS, RCS, and CPS registries for final findings of abuse and neglect.

(b) All background checks conducted require screening through the APS, RCS, and CPS registries. 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 background checks), all DDA direct hires and direct contracts which may involve unsupervised access to children or people with developmental disabilities require a background check through the BCCU which includes abuse registry screening.

Prior to providing contracted waiver services, the DSHS requires screening of individuals through the BCCU which includes the abuse registry findings. Per RCW 74.39A.050(8)(state law concerning quality improvement of long-term care services), no provider or staff, or prospective provider or staff, entered into a state registry finding him or her guilty of abuse, neglect, exploitation, or abandonment of a minor or a vulnerable adult as defined in Chapter 74.34 RCW (state law concerning abuse of vulnerable adults) shall be employed in the care of and have unsupervised access to vulnerable adults.

(c) DDA requires all individuals who may have unsupervised access to persons with developmental disabilities to complete a DSHS background check. As part of the background check process, the DSHS Background Check Central Unit (BCCU) cross-checks all potential and current employees against state registries that contain information on all individuals with a founded or substantiated finding of abandonment, abuse, neglect, and/or exploitation against a child or vulnerable adult. The BCCU provides the results of their screenings to DDA and DDA providers for action. (c) 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 providers 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 unsupervised access to children or vulnerable adults). These background checks must be renewed at least every three years or more often as required by program rule or contract. In addition to Washington state name/date of birth background checks, national fingerprint checks are conducted on all new long term care workers and individuals who have resided less than three continuous years in Washington state or live out of state and work in Washington. DSHS Enterprise Risk Management Office (ERMO) conducts regular internal audits of DDA residential program background checks. The State Auditor's Office (SAO) also conducts regular background check audits. DDA works with providers regarding these audits and determines training needs. DDA provides ongoing background check training and consultation to providers and staff.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page is contained in response to C-5.

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.*

- ☐ **Self-directed**
- ☐ **Agency-operated**

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.*

State regulations stipulate the following limitations apply to providers for waiver services:

- (1) The client's spouse cannot be their paid provider for any waiver service.
- (2) If the client is under age eighteen, their natural, step, or adoptive parent cannot be their paid provider for any waiver service.
- (3) If the client is age eighteen or older, their natural, step, or adoptive parent cannot be their paid provider for any waiver service with the exception of:
 - (a) Personal care;
 - (b) Transportation to a waiver service;
 - (c) Residential Habilitation services per WAC 388-845-1510 if their parent is certified as a residential agency per Chapter 388-101 WAC; or
 - (c) Respite care for the individual if they and their parent live in separate households.

The following controls are in place to ensure payments are made only for services rendered:

- Annual Person-Centered Service Plans
- CRM monitoring of plan
- Annual PCSP audits
- Supervisory file reviews
- National Core Indicator interviews
- Person-Centered Service Plan surveys

To ensure the safety of waiver participants, the state instructs Case Resource Managers to locate a third party to supervise providers when the client is unable to do so.

The State has established that the provision of services by the guardian can be in the best interests of the participant through a system of participant and service oversight that ensures participant safety and welfare. Annual person-centered service plans, Case Resource Manager monitoring of the PCSP, annual PCSP audits, supervisory file reviews, National Core Indicator surveys, and Person-Centered Service Plan surveys are all designed to ensure high quality, accountable services and supports are delivered to participants, whether by guardians or other contracted providers.

- ☐ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- ☐ **Other policy.**

Specify:

- f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The State of Washington allows for continuous open enrollment of all qualified providers. Provider qualifications are available to the public on-line per Washington Administrative Code (WAC)388-825-072 Where do I find information on DDA's home and community based services (HCBS) waiver services, eligibility rules and definitions? Waiver enrollees may select qualified providers at any time during the waiver year. Providers may enroll at any time during the year.

DDA has revised counties contracts with DDA to clarify the requirement for continuous open enrollment of all qualified providers. DDA monitors for compliance with this requirement as part of the biennial contract review.

State has posted contract information on the DDA internet site to connect potential waiver service providers with DDA contracts staff at: <https://www.dshs.wa.gov/dda/developmental-disabilities-administration-contracts>

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

C.a.1: # & % of wvr serv providers requiring licensure or certification, which initially met and continued to meet all DDA contract standards, including lic or cert, prior to furnishing services
N = # of wvr serv prvdrs requiring lic or cert, which initially met & continued to meet all DDA cntrt stds, including lic or cert, prior to furnishing svcs
D= All wvr svcs prvdrs that require lic or cert

Data Source (Select one):

Other

If 'Other' is selected, specify:

Agency 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): |
|--|---|---|
| <input type="checkbox"/> State Medicaid | <input type="checkbox"/> Weekly | <input checked="" type="checkbox"/> 100% Review |

| | | |
|--|--|---|
| Agency | | |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly | <input type="checkbox"/> Less than 100% Review |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly | <input type="checkbox"/> Representative Sample Confidence Interval = <div></div> |
| <input type="checkbox"/> Other Specify: <div></div> | <input checked="" type="checkbox"/> Annually | <input type="checkbox"/> Stratified Describe Group: <div></div> |
| | <input type="checkbox"/> Continuously and Ongoing | <input type="checkbox"/> Other Specify: <div></div> |
| | <input type="checkbox"/> Other Specify: <div></div> | |

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): |
| <input type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly |
| <input type="checkbox"/> Other Specify: <div></div> | <input checked="" type="checkbox"/> Annually |
| | <input type="checkbox"/> Continuously and Ongoing |
| | <input type="checkbox"/> Other |

| | |
|---|---|
| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis (check each that applies): |
| | Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div> |

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

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

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

Performance Measure:

C.b.1: Number & percent of waiver participant files with all authorized non-licensed/non-certified providers that met DDA contract standards and waiver requirements. N = # of waiver participant files with all authorized non-licensed/non-certified providers that met DDA contract standards and waiver requirements. D = All waiver participant 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): |
| <input type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly | <input type="checkbox"/> 100% Review |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly | <input checked="" type="checkbox"/> Less than 100% Review |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly | <input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence level with a +/- 5% margin of error. </div> |

| | | |
|--|--|--|
| <input checked="" type="checkbox"/> Other Specify: <div>Quality Compliance Coordinator (QCC) Team within DDA.</div> | <input checked="" type="checkbox"/> Annually | <input type="checkbox"/> Stratified Describe Group: <div></div> |
| | <input type="checkbox"/> Continuously and Ongoing | <input type="checkbox"/> Other Specify: <div></div> |
| | <input type="checkbox"/> Other Specify: <div></div> | |

Data Aggregation and Analysis:

| Responsible Party for data aggregation and analysis (<i>check each that applies</i>): | Frequency of data aggregation and analysis (<i>check each that applies</i>): |
|--|---|
| <input type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly |
| <input type="checkbox"/> Other Specify: <div></div> | <input checked="" type="checkbox"/> Annually |
| | <input type="checkbox"/> Continuously and Ongoing |
| | <input type="checkbox"/> Other Specify: <div></div> |

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

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

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

Performance Measure:

C.c.2: # & % of licensed/certified waiver service providers who met state & waiver training requirements as verified by state policies & procedures. N = # of licensed/certified wvr svcs providers who met state & waiver training requirements as verified by state policies & procedures. D = All licensed/certified wvr svcs providers requiring licensure/certification & state & waiver training.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Agency 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): |
|--|---|---|
| <input type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly | <input checked="" type="checkbox"/> 100% Review |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly | <input type="checkbox"/> Less than 100% Review |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly | <input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/> |
| <input type="checkbox"/> Other Specify: <input type="text"/> | <input checked="" type="checkbox"/> Annually | <input type="checkbox"/> Stratified Describe Group: <input type="text"/> |
| | <input type="checkbox"/> Continuously and Ongoing | <input type="checkbox"/> Other Specify: <input type="text"/> |
| | <input type="checkbox"/> Other Specify: <input type="text"/> | |

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): |
|--|--|
| <input type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly |
| <input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div> | <input checked="" type="checkbox"/> Annually |
| | <input type="checkbox"/> Continuously and Ongoing |
| | <input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div> |

Performance Measure:

C.c.3 The number and percent of non-licensed/non-certified waiver providers who met state and waiver training requirements as verified by state policies and procedures. **N** = Number of non-licensed/non-certified waiver providers who met state and waiver training requirements as verified by state policies and procedures. **D** = All non-licensed/non-certified waiver providers.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Agency 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): |
|---|--|---|
| <input type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly | <input checked="" type="checkbox"/> 100% Review |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly | <input type="checkbox"/> Less than 100% Review |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly | <input type="checkbox"/> Representative Sample Confidence Interval = |

| | | |
|---|---|---|
| | | |
| <input type="checkbox"/> Other Specify: | <input checked="" type="checkbox"/> Annually | <input type="checkbox"/> Stratified Describe Group: |
| | <input type="checkbox"/> Continuously and Ongoing | <input type="checkbox"/> Other Specify: |
| | <input type="checkbox"/> Other Specify: | |

Data Aggregation and Analysis:

| Responsible Party for data aggregation and analysis <i>(check each that applies):</i> | Frequency of data aggregation and analysis <i>(check each that applies):</i> |
|--|---|
| <input type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly |
| <input type="checkbox"/> Other Specify: | <input checked="" type="checkbox"/> Annually |
| | <input type="checkbox"/> Continuously and Ongoing |
| | <input type="checkbox"/> Other Specify: |

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

C.a.1 and C.c.3: The Contracts Program Manager produces an annual report comparing claims data against the Agency Contracts Database (ACD) to verify that providers of service to all waiver participants meet contract standards, including licensure and other requirements, as verified by a valid contract.

C.c.2 and C.c.3: DDA maintains provider contract records in the Agency Contracts Database (ACD) that verifies providers have met ongoing training requirements prior to contract renewal. ACD reports are run annually to verify completion of training requirements.

C.b.1.: The Quality Compliance Coordinator (QCC) Team completes a review of randomly selected files across all waivers on an annual basis. The list for the QCC Team review is generated to produce a random sample with a 95% confidence level and a confidence interval of +/-5%. The findings from these reviews are collected in a database. All findings are expected to be corrected within 90 days. Corrections are monitored by QCC Team members.

As a part of the QCC review, the team checks to see that providers of service to waiver participants continue to meet contract standards, which include appropriate licensure, certification and other standards including training requirements, as verified by a valid contract in the Agency Contracts Database.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Contract Reports:

C.a.1; C.c.2; and C.c.3:

The results of the annual report comparing claims data against the ACD are shared with the regions for immediate follow up. Providers without a valid contract or the necessary training requirements are reviewed to determine the appropriate course of contract action. Services are terminated for those without valid contracts.

QCC Waiver File Reviews:

C.b.1. and C.c.1:

Individual findings are expected to be corrected within 90 days. Regional management and QCC are available to provide individualized support and assistance with these corrections. QCC staff monitors to ensure corrections occur.

Next, findings are analyzed by DDA management. Based on the analyses, additional necessary steps are taken. For example:

- Annual staff Waiver Training curriculum is developed and/or modified.
- Policies are clarified.
- Personnel issues are identified and addressed.
- Form format and instructions are modified.
- Waiver administrative code (WAC) is revised.
- Regional processes are revised.

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): |
|--|---|
| <input type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly |
| <input type="checkbox"/> Other Specify: | <input checked="" type="checkbox"/> Annually |

| Responsible Party <i>(check each that applies):</i> | Frequency of data aggregation and analysis <i>(check each that applies):</i> |
|---|---|
| <div></div> | |
| | <input type="checkbox"/> Continuously and Ongoing |
| | <input type="checkbox"/> Other Specify: <div></div> |

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.

Current compliance is 92% and trending up

Root cause: Field Staff compliance, hard file

Remediation Plan:

• *CARE change request plan review screen to include verbiage “client had a choice of providers” and “client had a choice of services”. This would then populate onto the PCSP summary and the client signature would indicate client*

satisfaction with planned providers and services.

• *Reminder of Waiver wrap up forms and the opportunity to have a conversation with clients about their services*

Remediation Goal: CRMs understand the value of the form and there is a support system in place for filing

Implementation Plan:

HQ Responsibilities

Field Implementation Expectations

CARE Change Request

• *Add verbiage to the CARE plan review screen to allow client opportunity*

• *At 6 month plan review,*

CRMs document on plan review screen that the client was satisfied OR made changes to services or

to discuss choice of providers and services and make any changes

service providers.

Develop MB and Policy on Remediation Expectations

• *HQ will outline clear expectations related to waiver wrap up forms*

• *Field staff will begin, at*

effective date of the MB, to implement the remediation strategies

and plan review, and all of the above mentioned strategies.

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) Requirements concerning the independent audit of provider agencies:

The CDE is required to have an annual independent financial audit and provide the results to the state.

Home Care Agencies are required to have an independent financial audit without findings covering the two- year period prior to contracting. The audit must be conducted by a licensed CPA or a recognized financial firm.

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 annually conducts desk audits on all annual cost reports submitted by providers. The revenues reported by providers are reconciled to the payments made through ProviderOne and Individual 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.

The Office of Rates Management audits cost reports submitted by residential providers in accordance with the processes and procedures outlined in DDA Policy 6.04 Cost Reports for Supported Living, Group Training Homes, and Group Homes and DDA Policy 6.02 Rates, Billing, and Payment for Supported Living, Group Training Homes and Group Homes to ensure provider costs do not include unallowable expenses, such as the cost for room and board. State utilizes a tiered rate methodology where the rate varies by identified characteristics of the individual client, county of residence and composition of the household. Nine tiers are formed by matching individuals, stratified by the DDA assessment, with associated payment brackets, which are based on average cost of service. Cost reports are submitted by residential providers to the State on a State-designed form and include the following rate components: instruction and support services (ISS), administrative, transportation, residential professional services and other non-ISS supports. Additional allowable costs may include cost of care adjustments, staff add-on for client-specific need, client transition and summer program for supported living clients. Detail in the cost reports and supporting documents provided by residential providers help rates management auditors ensure accurate cost reports by verifying: all sections of the cost report are complete; all information matches the ProviderOne payment report; the report conforms with generally accepted accounting principles; and the reports meet the requirements of the providers contract.

On-site reviews conducted by the Office of Rates Management are at their sole discretion and may occur if the Office of Rates Management deems it necessary to validate the information contained in the cost report by reviewing provider financial records.

The Office of Rates Management sends a letter to the provider describing the results for both the desk and on-site audits. If the state requires correction action plans from providers, the Office of Rates Management will follow-up with the providers to verify that the corrective action plans have been completed evidenced by corrected cost reports and audited financial records.

c) The State Auditor's Office conducts the periodic independent audit of the waiver program as required by the single audit act.d)Federal rules are followed for agencies that have non-profit status per the Single Audit Act and OMB Circular A-133. A single or program specific audit is required for the AAA and other subcontractors who expend more than \$750,000 in federal assistance in a year.

Federal rules are followed for agencies that have non-profit status per the Single Audit Act and OMB CIRCULAR A-133. A single or program specific audit is required for the Area Agencies on Aging (AAAs) and other subcontractors who expend more than \$750,000 in federal assistance in a year. Per 45 CFR 75, an annual audit is required for AAAs and other subrecipients who expend \$750,000 or more in a year in federal awards. A 45 CFR 75 Single Audit will be conducted unless the entity makes an election to have a program-specific audit conducted. The Washington State Auditor's Office conducts annual audits of county or governmental AAAs. For all other entities, including tribal governments, a certified public accounting firm must be used to conduct annual audits.

If the subcontractor is a for-profit organization, it may be a subrecipient, but it will not fall under the OMB CIRCULAR A-133 requirements for a federal single or program-specific audit. In this unique case, the for-profit is monitored annually as

follows:

1. By performing a desk review of the vendor's annual audit,
2. By on-site monitoring and completion of the monitoring worksheet.

The agency responsible for the desk review of a vendor's annual audit, on-site monitoring, and completion of monitoring worksheet, and review of subcontractor's relevant cost information when contract is renewed is the Area Agency on Aging. There are no for-profit Area Agencies on Aging in Washington State.

AAAs are required to use the following risk factors to help determine if on-site monitoring should be done:

- a. frequency of outside audits,
- b. prior audit findings,
- c. type of Contract,
- d. dollar amount of contract,
- e. internal control structure of subcontractor,
- f. abnormal frequency of personnel turnover,
- g. length of time as a subcontractor,
- h. history of marginal performance,
- i. has not conformed to conditions of previous contracts.

3. Review of subcontractor's relevant cost information when contract is renewed.

(a) The State Auditor's Office conducts the periodic independent audit of the waiver program as required by the single audit act.

(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:

AAAs are responsible for monitoring Home Care Agency service contractors with whom they have executed contracts. Full on-site monitoring occurs every two years. A new subcontractor must receive a full monitoring for each of the first two years they are under contract. Abbreviated monitoring occurs in each year when full on-site monitoring does not occur. Desk monitoring occurs semi-annually. Review tools and policies are available through ALTSA. In addition to administrative review, client record and plan of care review, full on-site monitoring includes a fiscal review.

Fiscal Review: Comparison of a sample of contractor billings/ProviderOne reports to contractor-maintained documentation of work performed. A review of individual employee time records is part of this responsibility. The minimum sample size is 5% of current authorizations. The monitoring activity verifies that work billed for was performed, that the contractor is maintaining documentation of work performed, and that employees are paid for work performed. The five percent sample size has been the standard for decades and represents a statistically valid sample size. HCS is in the process of updating their policy chapter on contracts and changing the sample size methodology to give AAAs more latitude in applying their resources to the highest risk programs and providers based on their risk assessment. A five percent sample is still the recommended floor for sample sizes.

An abbreviated review consists of a review of complaints and review of any items where compliance was not met during the full review. The abbreviated review must be expanded to a full review when a subcontractor exhibits significant problems that are not corrected as required by corrective action.

Desk monitoring consists of a review of program and financial reports to compare level of service provided to the level of service authorized. AAA verification of a sample of time keeping records is required for home care agencies that exceed a ratio of provided versus authorized hours of 92% or above for the quarter reviewed. AAAs must require a written response from home care agencies that have a quarterly ratio of provided versus authorized hours that are equal to or less than 75%. If the reason for the underserved hours is primarily due to an agency's inability to appropriately respond to referrals or provide adequate staffing levels, a corrective action must be submitted by the agency.

Payment Review Program:

DSHS launched the Payment Review Program in 1999 to employ new technology to assist with the regular DSHS review of Medicaid billings for accuracy. The focus of the Payment Review Program is to identify and prevent billing and payment errors. Originally, PRP only looked at claims through the MMIS. Social Service Payment System (SSPS) billings were added to PRP in 2002. The Health Care Authority continues to run the PRP after moving out of DSHS and still includes DSHS billings from ProviderOne and individual ProviderOne.. PRP employs algorithms to detect patterns and occurrences that may indicate problem billings. The PRP uses an extensive internal algorithm development and review process. To keep providers informed about finalized algorithms, the Payment Review Program has posted the algorithm descriptions on the

HCA Internet site.

Teams of HCA, ALTSA, and DDA clinical, program and policy experts rigorously review all data analysis results from PRP reports to ensure accuracy.

Monitoring for other waiver service contractors is conducted at a minimum every two years. AAAs may conduct either a full or abbreviated monitoring based on a usage/risk threshold. Triggers for a full monitoring are within a two-year period and include:

1. five or more authorizations, or
2. one complaint concerning quality of care or client safety, or
3. \$5000 or more in payments, or
4. any other reason the AAA thinks a contractor needs to be monitored

Full monitoring of other waiver service contractors includes a comparison of contractor billings to contractors' maintained documentation of work performed. Verification that the work was performed should also be obtained from the client if possible. The minimum sample size for short term or one time services such as environmental modifications or specialized medical equipment is 5% of the total clients the contractor served in the previous two years. The minimum sample size for services that are generally ongoing such as skilled nursing or PERS is 5% of current authorizations. Monitoring includes review of individual files where they exist for services such as skilled nursing, client training, adult day care, home delivered meals and home health aide services.

(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).

The Aging and Long-Term Support Administration is responsible for conducting the financial review program of AAAs. AAAs are responsible for conducting financial review activities of subcontracted providers. The State Auditor's Office conducts the periodic independent audit of the waiver program as required by the single audit act.

Continued at Main B. Optional:

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

I.a.1: # & % of claims coded & paid in accordance with reimbursement methodology in approved waiver for waiver services rendered per waiver participant's PCSP with documented service delivery. N = # of claims coded & paid in accordance with reimbursement methodology in approved wvr for wvr services rendered per wvr part's PCSP with documented service delivery. D = # of wvr claims reviewed.

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

providerOne

| 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): |
|--|--|---|
| <input type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly | <input type="checkbox"/> 100% Review |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly | <input checked="" type="checkbox"/> Less than 100% Review |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly | <input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence interval with a +/- 5% margin of error </div> |
| <input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <input checked="" type="checkbox"/> Annually | <input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> |
| | <input type="checkbox"/> Continuously and Ongoing | <input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> |
| | <input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | |

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): |
|--|--|
| <input type="checkbox"/> <i>State Medicaid Agency</i> | <input type="checkbox"/> <i>Weekly</i> |
| <input checked="" type="checkbox"/> <i>Operating Agency</i> | <input type="checkbox"/> <i>Monthly</i> |
| <input type="checkbox"/> <i>Sub-State Entity</i> | <input type="checkbox"/> <i>Quarterly</i> |
| <input type="checkbox"/> <i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> | <input checked="" type="checkbox"/> <i>Annually</i> |
| | <input type="checkbox"/> <i>Continuously and Ongoing</i> |
| | <input type="checkbox"/> <i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> |

- b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

Performance Measures

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

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

Performance Measure:

I.b.1: # & % of waiver provider rate methodologies utilized by contract specialists that are consistent with rate methodology in approved waiver application. N = # of wvr provider rate methodologies utilized by contract specialists that are consistent with rate methodology in approved wvr application. D = # of wvr provider rate methodologies utilized by contract specialists that were reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Agency 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): |
|--|---|---|
| | | |

| | | |
|--|--|---|
| <input type="checkbox"/> <i>State Medicaid Agency</i> | <input type="checkbox"/> <i>Weekly</i> | <input type="checkbox"/> <i>100% Review</i> |
| <input checked="" type="checkbox"/> <i>Operating Agency</i> | <input type="checkbox"/> <i>Monthly</i> | <input checked="" type="checkbox"/> <i>Less than 100% Review</i> |
| <input type="checkbox"/> <i>Sub-State Entity</i> | <input type="checkbox"/> <i>Quarterly</i> | <input checked="" type="checkbox"/> <i>Representative Sample</i> <i>Confidence Interval =</i> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> 95% confidence level with a +/- 5% margin of error. </div> |
| <input checked="" type="checkbox"/> <i>Other Specify:</i> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> Waiver Service Unit Manager </div> | <input checked="" type="checkbox"/> <i>Annually</i> | <input type="checkbox"/> <i>Stratified Describe Group:</i> <div style="border: 1px solid black; height: 30px; margin-top: 10px;"></div> |
| | <input type="checkbox"/> <i>Continuously and Ongoing</i> | <input type="checkbox"/> <i>Other Specify:</i> <div style="border: 1px solid black; height: 30px; margin-top: 10px;"></div> |
| | <input type="checkbox"/> <i>Other Specify:</i> <div style="border: 1px solid black; height: 30px; margin-top: 10px;"></div> | |

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): |
|--|--|
| <input type="checkbox"/> <i>State Medicaid Agency</i> | <input type="checkbox"/> <i>Weekly</i> |
| <input checked="" type="checkbox"/> <i>Operating Agency</i> | <input type="checkbox"/> <i>Monthly</i> |
| <input type="checkbox"/> <i>Sub-State Entity</i> | <input type="checkbox"/> <i>Quarterly</i> |
| <input type="checkbox"/> <i>Other Specify:</i> <div style="border: 1px solid black; height: 30px; margin-top: 10px;"></div> | <input checked="" type="checkbox"/> <i>Annually</i> |
| | <input type="checkbox"/> <i>Continuously and Ongoing</i> |

| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis (check each that applies): |
|---|---|
| | <input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> |

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

I.a.1: The Waiver Team completes a review of all paid claims files across all waivers annually using the ProviderOne MMIS. Findings that require corrections are referred to Payment Specialists who will work with case resource managers to make necessary corrections within 90 days.

I.b.1: Waiver Team annually audits a stratified random sample of provider contracts across all waiver services to verify that provider rate methodologies utilized by contract specialists are consistent with the rate methodologies in the approved waiver. When unapproved rate methodologies are found, contract specialists are notified and contracts are modified or terminated. Waiver Team follows up with contract specialists to verify that contracts are modified or terminated.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States 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.

The state's intent is to consistently verify financial and disability eligibility of waiver participants during the evidentiary review process.

Waiver File Reviews:

I.a.1:

Findings from Waiver Team and Supervisor file reviews are analyzed by DDA 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.*
- *Overpayments are processed as necessary.*

I.b.1: Waiver Team annually audits a stratified random sample of provider contracts across all waiver services to verify that provider rate methodologies utilized by contract specialists are consistent with the rate methodologies in the approved waiver. When unapproved rate methodologies are found, contract specialists are notified and contracts are modified or terminated. Waiver Team follows up with contract specialists to verify that contracts are modified or terminated.

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): |
|--|--|
| <input type="checkbox"/> <i>State Medicaid Agency</i> | <input type="checkbox"/> <i>Weekly</i> |
| <input checked="" type="checkbox"/> <i>Operating Agency</i> | <input type="checkbox"/> <i>Monthly</i> |
| <input type="checkbox"/> <i>Sub-State Entity</i> | <input type="checkbox"/> <i>Quarterly</i> |
| <input type="checkbox"/> <i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> | <input checked="" type="checkbox"/> <i>Annually</i> |
| | <input type="checkbox"/> <i>Continuously and Ongoing</i> |
| | <input type="checkbox"/> <i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> |

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 DDA has developed standardized reports to verify the presence of all authorized services in the PCSP (Performance Measure I.a.1) across all waiver enrollees.

The Department has implemented a new MMIS (known as "ProviderOne") which reimburses providers of social services to DDA clients (as well as reimbursing medical care providers). ProviderOne verifies financial eligibility status (as contained in the ACES), ensuring that waiver clients are financially eligible prior to authorization or payment for waiver services. ProviderOne also verifies 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 implementation included payments for social services began in January 2015. Individual ProviderOne implemented payments for individual providers (i.e. Respite) in January 2016.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The State publishes its fee schedules at: <https://www.dshs.wa.gov/altsa/management-services-division/office-rates-management>.

The DDA and the Health Care Authority follow the federal guidelines found in 42 U.S.C. § 1396a(a)(30)(A) when establishing rates so that payments are consistent with efficiency, economy and quality of care and are sufficient to enlist providers for services to ensure adequate access to care for Medicaid recipients. Steps taken to ensure rates comply with federal requirements include: workgroups, stakeholder meetings, consultation with program managers, consultation with professional organizations, analysis of market rates, rates paid by other states for comparable services, and the budget impacts of rates. For example, for nursing services, comparable services in the private sector and in other states include private duty nursing/in-home nursing as provided by LPNs or RNs.

Payment cannot exceed 1) the prevailing charges in the locality for comparable services under comparable circumstances, or 2) the rates charged for comparable services funded by other sources. Methods for determining reasonable rates include periodic market surveys, cost analysis and price comparison. HCA conducts these activities every two to four years, per requests by the Legislature and/or indications that access to services is being impacted by current rates. For DDA rates, this information has been added below under each set of services.

Waiver service definitions and provider qualifications are standardized. This helps ensure that rates are comparable (not necessarily identical) across the state for those services that are negotiated on a regional basis by DDA staff, as rates are for identical services with providers meeting the same qualifications.

HCA rates are updated every January with any possible new codes, and rates are changed every July to align with the new relative value units (RVUs), State geographic price cost index (GPCI), and State specific conversion factor. For codes that do not have RVUs, rates are usually set at a flat rate. If analysis shows they need to be updated, that happens every July with the other codes. The most recent update was in July 2021, and will be updated again this coming July 2022.

With respect to rates established by DDA, the most recent rate comparison was conducted in the winter of 2021.

For HCA-based rates, an amendment to the rates is triggered by directive and/or funding by the Legislature, and/or a change to RVUs, and the Legislature is responsible for funding rate changes. The HCA identifies the need for a rate change using indicators listed below. Without additional funding, rate changes must be budget neutral. If a rate change is not budget neutral, it would be made only if funding was provided by the Legislature or the Legislature required service coverage changes to save the funding needed for the rate change.

For DDA, specifics regarding when rates are adjusted & the criteria used to evaluate the need for rate adjustments are at the end of the discussion of each set of services. When funding is available, the Legislature mandates rate increases for specific types of vendors (e.g., individual providers, residential providers, adult family homes) and/or services.

Regarding criteria for HCA to adjust rates, RVU driven rates are updated yearly per new RVUs. For flat rates, a significant (e.g., 25%) drop in the use of services by Medicaid participants, a significant (e.g., 25%) drop in the number of enrolled providers, an indication that payment rates are substantially (e.g., 40%) below third-party insurer rates, and/or a request by the Legislature for an analysis of rate adequacy are indicators of the need for rate adjustments. Rates are adjusted with approval from the Legislature.

Rates negotiated with employee unions are static during the life of the contract & are the rates identified within the contract. These rates are only adjusted as written within the contract.

Regarding the cost allocation plan, DSHS does not establish indirect rates for Title XIX administration. A Public Assistance Cost allocation plan allocates administrative costs through various allocation methodologies (see attachment for the most current submission). The Public Assistance Cost Allocation plans for DDA & ALSTA describe the cost allocation methodologies to the CFDA (Medicaid) grant level & does not list specific waivers.

OPPORTUNITY FOR PUBLIC COMMENT IN THE RATE DETERMINATION PROCESS:

The Administrative Procedure Act, Chapter 34.05 RCW, is followed when soliciting public comments on rate determination methods. Changes to rates that are made by the legislature in the biennial and supplemental budget process are part of public hearings on budget and policy legislation. Rates are posted on public web sites. The State

engages in significant public input processes outlined in Main Section 6-I.

Day Habilitation- Fee schedule

o Community Inclusion: The state uses a fee schedule model of rate setting with two rate ranges reflecting urban and rural settings. The operating budget is set by the State legislature. Unit rates are negotiated annually between the counties and their providers within the parameters established by the county Service Guidelines and the county allocations. Variations in rates are due to differences among providers related to overhead, staff wages, and the local demand for services. Rates are available to the public through the counties. Draft rate study conducted by DSHS Research and Data Analysis Division and DDA provides proposed rates for ISE/GSE and CI starting in WY2 and continuing through WY3-5. Units of service for both ISE/GSE and CI are changed from "each" to "hour."

o Individual Supported Employment/Group Supported Employment- Fee Schedule

The state uses a fee schedule model of rate setting with one rate for the single service of ISE/GSE. The operating budget is set by the State legislature. Unit rates are negotiated annually between the counties and their providers within the parameters established by the county Service Guidelines and the county allocations. Variations in rates are due to differences among providers related to overhead, staff wages, and the local demand for services. Rates are available to the public through the counties. For Individual and Group Employment, and Individualized Technical Assistance, State discusses rates with the Association of County Human Services. Participants are involved in the development of rates through their participation in the Waiver Quality Assurance Advisory Committee which meets quarterly to review all aspects of waiver services, including provider rates. Draft rate study conducted by DSHS Research and Data Analysis Division and DDA provides proposed rates for ISE/GSE and CI starting in WY2 and continuing through WY3-5. Units of service for both ISE/GSE and CI are changed from "each" to "hour."

Specialized Equipment & Supplies, and community-based settings for respite services: Rates are based on usual & customary charges for the products/services as paid by the general public. Charges are adjusted by the supplier based on overhead, staff wages & the local demand for the products/services. To maintain availability of these products/services for waiver participants, DDA adjusts rates if rate comparisons indicate prevailing market rates have increased significantly (e.g., 20%+).

Respite: The Washington State Legislature determines the rates for the following providers:

- CDE who employs Individual Providers of respite*
- Transportation provided by Individual Providers of respite*
- Home Care Agencies*

Respite rate methodology: Individual and Home Care Agency respite providers:

Respite rates are based on a per hour unit and is determined by a rate setting board and approved by the State legislature. The rate includes wages, L & I, vacation pay, mileage reimbursement, comprehensive medical, training, and seniority pay. For individual providers who have completed the home care aide certification, the hourly rate also includes a certification differential payment. Due to the agency parity law [RCW 74.39A.310(1)(a)(v)] the home care agency vendor rates are equivalent to that of the individual provider rate. Rates for Individual Providers of respite, transportation provided by Individual Providers of respite and Home Care Agencies will be reflected in the published fee schedule based upon the state fiscal year July 1 through June 30. The fee schedule is updated at least annually to reflect any rate changes resulting from legislative action or collective bargaining. Rate changes are determined through legislative action and appropriation. Rates may be reviewed annually during the 5-year period or sooner if rates are not sufficient to meet economy, efficiency, or quality of care to enlist enough providers.

Changes to rates for Individual Providers: The rate setting board reviews the rates every two years for Individual providers. Changes to rates for Agency Providers: Due to the agency parity law [RCW 74.39A.310(1)(a)(v)] the home care agency vendor rates are equivalent to that of the individual provider rate. • Enabling legislation set the starting rates in 2019 and due to the delayed implementation to 2021, the rates have been updated to July 2021.

Additional Rate Determination Methods content is found at: Main. B. Optional

- 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), 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

Washington State's Health Care Authority (the single state Medicaid Agency) has a MMIS titled "ProviderOne". The State makes most payments for client services through ProviderOne. Once a provider is authorized for a service that the provider must claim, the provider provides the service and submits the claim directly into the MMIS ProviderOne system. Payments are issued by EFT or Warrant.

Case managers pre-authorize services based on the assessed need for the services. After the goods or service are provided the provider then reports the amount of service provided by date of service and are paid based on their claim. ProviderOne is an integrated MMIS system that manages medical and social service claims. Independent contractors who receive a 1099 tax form are paid directly through ProviderOne. Individual providers who receive a W2 for reportable wages are paid through a payroll system operated by the CDE. All authorization and claim data regardless of provider type is integrated and reportable in ProviderOne and the ProviderOne data warehouse.

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 Administration by the Legislature. Salaries for State-staffed stabilization services - crisis diversion bed as components of stabilization services are also included in the appropriation provided to the Administration by the Legislature. State employees that provide these services are paid twice a month like other state employees, with the payment amount determined by their job classification and experience.

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 Case Management Information System (CMIS) 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 steps include:

- Verification of the need for ICF/IID Level of Care (LOC),
- Financial eligibility (as established by financial workers in the Long Term Care & Specialty Programs Unit within DDA),
- Documentation of Voluntary Participation statement,
- Verification of disability per criteria established in the SSA, and
- Completion of a Person Centered Service Plan (PCSP).

CARE enters a waiver effective date based on the effective date of the PCSP 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. Case Resource Managers may only assign a Waiver Recipient Aid Category (RAC) once the steps above are complete.

Should a waiver RAC be assigned but a person has a loss of financial eligibility during the coverage period, ProviderOne will post edits. The usual MMIS edits apply to claims under the HCBS waivers. For example, the following will be verified: the individual is eligible for the specified HCBS waiver, the service is covered under the waiver, the provider is a qualified provider with a current contract, and the claim details are consistent with the service authorization completed by the DDA case resource manager.

b.) Service was included in the participant's approved person-centered service plan to ensure that PCSPs reflect the current needs of the individual, PCSPs are updated as needed and at least annually (please see Appendix H-1a.i for a description of the steps taken to ensure PCSPs 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 PCSPs to ensure that services claimed against the Basic Plus waiver are contained in the approved PCSP.

c.) The services were provided.

Monitoring of the provision of services is outlined in Appendix H-1b.i. Steps taken include:

- QCC file reviews verify the authorization matches the PCSP 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 PCSP.
- The State participates in the National Core Indicators Survey, which includes waiver related questions. This annual face-to-face sampling of waiver participants enables DDA management to evaluate PCSP outcomes from the recipient's perspective.

State has DDA Policy 6.10 Client Overpayments, DSHS Administrative Policy 10.02, Vendor/Provider Overpayment and Debt and Social Services Authorization Manual which provide guidance to staff on how to process inappropriate billings. Any inappropriate billings are removed from the State's claim for Federal Financial Participation.

State has multiple processes in place to ensure that participants are not coerced or otherwise pressured to use particular providers. State Case Resource Managers ask participants during the annual Person-Centered Service Plan reassessment if they are satisfied with their providers or if they wish to change providers. The Assessment Meeting Wrap-up, completed during the assessment, has several questions about services and service providers (My case manager explained that I can choose or change my service provider(s); If I had concerns or issues about my service plan, they have been or are being addressed; We discussed any questions I had about my DDA services; My case manager explained how I can make a complaint that is not related to an appeal of DDA services). Following the assessment, participants receive a Person Centered Service Plan Meeting Survey asking about the assessment process, including: Were you given a choice of providers? Did you choose where and how the services will be provided? Did your case manager review last year's plan and ask what supports you want to continue and what should change? Participants also have the opportunity to participate in the National Core Indicators surveys which ask questions about provider choice and participant satisfaction with services.

Revised PMs D.a.1, D.a.2, D.d.1, D.d.2, D.d.3, D.d.4 & D.d.5 all measure various means of verification that planned services were provided.

- 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:

The State makes most payments for client services through ProviderOne. ProviderOne is an unified Medicaid payments system that provides enforcement and assurance that case resource managers and providers are compliant with rules and policy. Once a provider is authorized for a service that the provider must claim, the provider provides the service and submits the claim directly into the MMIS ProviderOne system. Payments are issued by EFT or Warrant. In ProviderOne payments are based on an authorization by the case resource manager however there is not an invoice processed. Both providers and clients are notified of creation or changes to authorization. The provider then submits an online claim for payment based on the units provided. Claims are specific to the date of service. Providers can claim as often as daily if they choose. Payment can be made as frequently as weekly. A report of time worked by date will be required before payment will be made.

ProviderOne is an unified Medicaid payments system that provides enforcement and assurance that case resource managers and providers are compliant with rules and policy.

Example of benefits of ProviderOne:

- Client and provider eligibility is checked at the authorization and at the claim. If a client does not have the correct financial eligibility or does not meet waiver criteria such as having an individualized assessment or is not ICF/IID eligible an authorization error will populate preventing payment prompting the case resource manager to either resolve the error or work with the client to help them meet eligibility criteria. If providers do not have the correct contract or correct credential, if required, for the authorized service an authorization error will populate and payment will not be made. Washington utilizes one system to process claims pertaining to the services provided to waiver participants. For Individual Providers of respite, payments are processed through their employer, the CDE. The CDE uses the State's MMIS system for all claims. CDE's phase-in was completed May 31, 2022. No new services will be claimed by Individual providers through the ProviderOne billing system. Poaitive Behavior Support and Consultation was removed from this waiver effective September 1, 2022.*

- ☐ Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ☐ Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a

monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

- ☐ *The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.*
- ☐ *The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.*
- ☒ *The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.*

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Payment to providers for most services is made directly by the State Operating Agency through the MMIS. Funding for Day Programs/Individualized Technical Assistance/Individual Supported Employment/Group Supported Employment services is provided by the State Operating Agency to Counties. Some Counties are direct service providers. Most contract with and reimburse direct service providers. All payments to counties are made via the MMIS.

28 Counties are the limited fiscal agent contracted by DDA to provide Individualized Technical Assistance, Individual Supported Employment/Group Supported Employment and Community Inclusion services. These counties contract with providers to provide these services and pay these providers for services delivered. 11 Counties contracted by DDA are direct service providers of the same three services. DDA, as the contracting agency, oversees county contracts, provides contract review and on-site oversight of county contract operations including on-site reviews of contracted providers, billing documentation and other data based on the Contractor Compliance Review Checklist. For counties who are direct service providers, DDA will provide on-site monitoring which includes client file reviews, service hours reported, activity progress and outcome status, relationship of clients' file notes describing services to reporting documents to DDA PCSPs, direct service staff file reviewed for qualifications, background check, etc. The Medicaid agency reviews DDA county contract files, records, billing statements and other documentation to oversee the operations of this limited fiscal agent.

Payments for respite provided by Individual Providers employed by the CDE or agency providers are authorized and processed by DSHS/DDA staff using the State's MMIS. The payment system maintains data associated with the waiver participant and their respite provider including names, identifying number, service begin/end dates, unit rate, amount paid, and service name.

- ☐ *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

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:

State Operated Living Alternatives (SOLA) provides Residential Habilitation, Stabilization Services - Crisis Diversion Bed and counties provide or contract with providers to provide Individual Supported Employment/Group Supported Employment, Individualized Technical Assistance and Community Inclusion.

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.

- ☒ **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.**
- ☐ **This waiver is a part of a concurrent ?1115/?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 ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.**
- ☐ **If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.**

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver 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.

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:

DSHS/DDA is the authorizing agency for all services payments. All payments and appropriations are managed through the State's MMIS in accordance with an MOU between DSHS and the Health Care Authority (Single State Medicaid Agency). The legislature make appropriations directly to DDA and HCA manages payments to vendors per the MOU between HCA and DSHS via the MMIS.

☐ **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:

Group Care Home/Group Training Home

The claim for federal funding (FFP) for respite care in group homes and group training homes is based on the cost of respite services only. The rate for respite does not include the cost of room and board.

Child Foster Care

Payment for respite care in a foster home is only made for the cost of respite services. The rate for respite does not include the cost of room and board.

Staffed Residential Home

Payment for respite care in a staffed residential home resident is made only for the cost of respite services. The rate for respite does not include the cost of room and board.

Child Foster Group Care

Payment for respite care in a foster group care facility is made only for the cost of respite services. The rate for respite does not include the cost of room and board.

Adult Family Home

The basic rate for an adult family home for respite services covers the cost of room and board and is made under a separate payment code. That payment is off-set by client income/SSI payments. State payments for room and board are account-coded to all state dollars (i.e., are not account-coded against the administration's home and community-based services waiver).

Adult Residential Care (Assisted Living Facility)

The basic rate for adult residential care for respite services covers the cost of room and board and is made under a separate payment code. That payment is off-set by client income/SSI payments. State payments for room and board are account-coded to all state dollars (i.e., are not account-coded against the administration's home and community-based services waiver).

The rates claimed for 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 | | 52490.00 | 52490.00 | 370085.00 | 4497.00 | 374582.00 | 322092.00 |
| 2 | | 53514.00 | 53514.00 | 377303.00 | 4585.00 | 381888.00 | 328374.00 |
| 3 | | 54557.00 | 54557.00 | 384660.00 | 4674.00 | 389334.00 | 334777.00 |
| 4 | | 55621.00 | 55621.00 | 392161.00 | 4765.00 | 396926.00 | 341305.00 |
| 5 | | 56706.00 | 56706.00 | 399808.00 | 4858.00 | 404666.00 | 347960.00 |

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 | 12000 | | 12000 |
| Year 2 | 12000 | | 12000 |
| Year 3 | 13500 | | 12000 |

| 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 4 | 13500 | | 12000 |
| Year 5 | 13500 | | 12000 |

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.

State derived regression formula $Y = 4.33X + 306$ from ALOS's of waiver years 2015-2016 through 2018-2019 from accepted CMS 372 reports (311.1, 314.3, 317.4 & 324.5) to project ALOS for WY1-WY5 of 336.

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 and methodology for these estimates is as follows:

State utilized regression formulas to project participant counts and expenditures for the following waiver services. Regression formulas were derived from actual participant count and expenditure data from accepted CMS 372 reports for waiver years 2015-2016 through draft CMS 372 for 2019-2020. State is utilizing this methodology for some of the services to determine if this methodology provides more accurate projected participant counts and expenditures. Services that employed the regression formulas did not get the 5% participant count increases. Unit costs were inflated by the CPI-M leaving units of service to be the "plug" value given the regression derived values for participant counts and expenditures.

- Respite – Count: $Y = 270X + 3156$ and Expenditures: $Y = 1729958.42X + 16203415.31$
- Stabilization Services – Crisis Diversion Bed – Count: $.2X + 2.6$ and Expenditures: $Y = 31759.86X + 525667.97$
- Community Engagement – Count: $Y = 212.4X - 213.2$ and Expenditures: $Y = 45156.42X - 524915.06$
- Environmental Adaptations – Count: $Y = 4.3X + 30.9$ and Expenditures: $Y = 35232.12X + 152940.52$
- Community Inclusion – Count: $Y = -10.9X + 677.3$ and Expenditures: $Y = 157896.57X + 1577537.73$
- Individual Supported Employment/Group Supported Employment – Count: $Y = 138.7X + 4902.5$ and Expenditures: $Y = 1109189.87X + 35030297.82$
- Individualized Technical Assistance – Count: $Y = 3.4X + 47.8$ and Expenditures: $Y = 11432.688X + 47805.96$
- Specialized Equipment and Supplies – Count: $Y = 57.1X - 71.7$ and Expenditures: $Y = 31589.712X - 11900.868$
- Staff/Family Consultation – Count: $Y = 31.9X - 31.3$ and Expenditures: $Y = 55273.13X - 74306.398$
- Transportation – Count: $Y = 121.5X - 33.3$ and Expenditures: $Y = 25967.317X + 118874.671$
- Wellness Education – Count: $Y = 490.8X + 33.4$ and Expenditures: $Y = 17052.363X - 6621.517$

State utilized Basic Plus WY5 (2021-2022) approved waiver application data as a baseline for participant counts and expenditures for WY1 of renewal and inflated unit costs by CPI-M of 1.95% per year and increased participant counts by 5% per year based on professional judgement (State has historically used this trend based on professional judgement and CMS has accepted this methodology) for the following services:

- Risk Assessment
- Skilled Nursing
- Extermination of Bed Bugs
- Occupational Therapy
- Physical Therapy
- Speech, Hearing and Language Services
- Specialized Habilitation
- Stabilization Services – Specialized Habilitation
- Stabilization Services – Staff/Family Consultation
- Therapeutic Adaptations

State estimated counts and expenditures for the following new service using the CPI-M of 1.95% per year to inflate unit costs and increased participant counts by 5% per year:

- Assistive Technology

The increase of the availability of Individualized Technical Assistance service from 3 to 6 months will not impact expected utilization and costs for this service but rather the efficiency of Case/Resource Managers authorizing this service in one step rather than in two separate authorizations for two three-month periods.

The increase in Specialized Habilitation from \$4,000 to \$6,192 will not have a significant impact on utilization and costs for this service. Because the aggregate budget limit covers a variety of services, including Specialized Habilitation, most clients will continue to use a variety of services and not Specialized Habilitation exclusively. The addition of medical transport agencies to the Transportation services will not significantly impact expected utilization and costs for this service but will provide access to a small group of participants unable to utilize this service previously.

The addition of parenting skills to Staff/Family Consultation Services will not significantly impact utilization and costs for this service due to the predicted small number of participants who will avail themselves of this service. The removal of prior approvals for purchases under \$550 for Specialized Equipment and Supplies and Assistive Technology will not impact the expected utilization and costs for these services but will improve efficiency for Case/Resource Managers who authorize these services.

The State utilized the only available data and professional judgement to project participant counts and expenditures for Therapeutic Adaptations.

Two examples from accepted CMS 372 reports demonstrate the validity of the 5% participant growth rate for services. While the unduplicated participant count increased 15.5% from 2015-2016 to 2018-2019, respite participant count increased 23.5% and community access/inclusion increased 28.5% over the same period.

(CPI-M for WY2-WY5 is based on the August 2020-August 2021 percentage increase of 1.95% - Source: U.S. Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers: Medical Care, retrieved from FRED, Federal Reserve Bank of St. Louis; <http://fred.stlouisfed.org/series/CPIMEDSL>, September 2021).

In the approved waiver, the State used a regression formula based on CMS 372 data from 2015-2016 to project ISE/GSE participant counts for WYs 1-5. In the proposed waiver amendment effective 1-1-2023, the State used actual ISE/GSE participant counts in WY1 as the new base line for proposed WY1 and increases based on annual Transition Student additions to Basic Plus and modest annual increases of older workers based on data from 2017-2022 in the CARE system for older workers. Estimates of CI increases for Basic Plus are based on current participant counts for WY1 with annual increases based on professional judgement as provider capacity is increased in the counties over time. The State relied on the professional judgement of State's CI program managers to determine the anticipated increase in number of users for CI client interest over time from WY1-WY5. Professional judgement of State's CI program managers has also been informed by the performance of CI during the COVID-19 pandemic when participants pulled back from participating in CI. DDA partnered with the DSHS Research and Data Analysis Division to develop the rate study which was completed 10-1-2022. Average cost per unit of service and average units per user were products of this rate study. Data from 13 Individual Supported Employment providers who delivered 243,026 hours of services across 15 counties in the July 2021 to February 2022 reporting period were employed supplemented by Bureau of Labor Statistics wage survey and Consumer Price Index data. The average cost per unit for ISE/GSE and CI were updated in WY1 in error; both were returned to original WY1 values. Units of service for both ISE/GSE and CI are changed from "each" to "hour" for WYs 2-5.

For the waiver amendment effective March 1, 2023, Remote Supports participants, units of service and cost per unit of service are projected from State's experience with Distance Based Observation and Reporting (DBOR) which DDA now calls Remote Supports. Participant count, units of service and cost per unit of service for WY1 are based on current participant counts, units of service and cost per unit of service based on State's experience with DBOR during the COVID-19 pandemic from 3-1-2020 through 10-1-2022. Participant counts are projected to increase by 10% per year based on professional judgement of DDA program managers informed by State's experience with Distance Based Observation and Reporting during the COVID-19 pandemic from 3-1-2020 through 10-1-2022, units of service are projected to be stable across WY1-5 and costs per unit of service are projected to increase by the CPI of 7.85% per year. U.S. Bureau of Labor Statistic, Consumer Price Index for All Urban Consumers: All items in U.S. City Average (CPIAUCSP), retrieved from FRED, Federal Reserve Bank of St. Louis, July 2021-July 2022.

- 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:

State derived regression formula $Y = 6772X + 5086$ from actual Factor D' of waiver years 2015-2016 through 2018-2019 from accepted CMS 372 reports (\$5,704, \$26,938, \$27,248 & \$28,174) to project Factor D' for WY1 of \$52,490. State inflated WY2-WY5 by CPI-M of 1.95% to project WY2 of \$53,514, WY3 of \$54,557, WY4 of \$55,621 & WY5 of \$56,706. Personal Care was transitioned to State Plan CFC for 2015-2016. The State applied a consistent methodology for all regression estimates using four years of accepted CMS 372 data.

(CPI-M for WY2-WY5 is based on the August 2020-August 2021 percentage increase of 1.95% - Source: U.S. Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers: Medical Care, retrieved from FRED, Federal Reserve Bank of St. Louis; <http://fred.stlouisfed.org/series/CPIMEDSL>, September 2021).

- 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:

State derived regression formula $Y = 29499.3X + 163590.5$ from actual Factor G of waiver years 2015-2016 through 2018-2019 from the State's MMIS (\$201,139, \$219,347, \$234,425 & \$294,444) to project Factor G for WY1 of \$370,086. State inflated WY2-WY5 by CPI-M of 1.95% to project WY2 of \$377,303, WY3 of \$384,660, WY4 of \$392,161 & WY5 of \$399,808.

(CPI-M for WY2-WY5 is based on the August 2020-August 2021 percentage increase of 1.95% - Source: U.S. Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers: Medical Care, retrieved from FRED, Federal Reserve Bank of St. Louis; <http://fred.stlouisfed.org/series/CPIMEDSL>, September 2021).

- 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:

State derived regression formula $Y = 392X + 1753$ from actual Factor G' of waiver years 2015-2016 through 2018-2019 from the State's MMIS (\$1,917, \$2,548, \$3,591 & \$2,876) to project Factor G' for WY1 of \$4,497. State inflated WY2-WY5 by CPI-M of 1.95% to project WY2 of \$4,585, WY3 of \$4,674, WY4 of \$4,765 & WY5 of \$4,858.

(CPI-M for WY2-WY5 is based on the August 2020-August 2021 percentage increase of 1.95% - Source: U.S. Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers: Medical Care, retrieved from FRED, Federal Reserve Bank of St. Louis; <http://fred.stlouisfed.org/series/CPIMEDSL>, September 2021).

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 | |
|--|--|
| Community Inclusion | |
| Individual Supported Employment/Group Supported Employment | |
| Respite | |
| Occupational Therapy | |
| Physical Therapy | |
| Speech, Hearing and Language Services | |
| Assistive Technology | |
| Community Engagement | |
| Environmental Adaptations | |
| Extermination of Bed Bugs | |
| Individualized Technical Assistance | |
| Remote Supports | |
| Risk Assessment | |
| Sexual Health Therapy | |
| Skilled Nursing | |
| Specialized Equipment and Supplies | |
| Specialized Habilitation | |
| Stabilization Services- Staff/Family Consultation Services | |
| Stabilization Services-Crisis Diversion Bed | |
| Stabilization Services-Specialized Habilitation | |
| Staff/Family Consultation Services | |
| Therapeutic Adaptations | |
| Transportation | |
| Wellness Education | |

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

- ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a),**

Section 1937). 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. If applicable, check the capitation box next to that service. 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 | Capitation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|--|--------------------------|------|---------|---------------------|-----------------|----------------|-------------|
| Community Inclusion Total: | | | | | | | 2841398.70 |
| Community Inclusion | <input type="checkbox"/> | Each | 590 | 497.00 | 9.69 | 2841398.70 | |
| Individual Supported Employment/Group Supported Employment Total: | | | | | | | 43957940.40 |
| Individual Supported Employment/Group Supported Employment | <input type="checkbox"/> | Each | 6012 | 110.00 | 66.47 | 43957940.40 | |
| Respite Total: | | | | | | | 30041098.75 |
| Respite | <input type="checkbox"/> | Hour | 5316 | 180.20 | 31.36 | 30041098.75 | |
| Occupational Therapy Total: | | | | | | | 930.73 |
| Occupational Therapy | <input type="checkbox"/> | Each | 2 | 1.74 | 267.45 | 930.73 | |
| Physical Therapy Total: | | | | | | | 20432.51 |
| Physical Therapy | <input type="checkbox"/> | Each | 8 | 8.36 | 305.51 | 20432.51 | |
| Speech, Hearing and Language Services Total: | | | | | | | 26075.89 |
| Speech, Hearing and Language Services | <input type="checkbox"/> | Hour | 13 | 29.80 | 67.31 | 26075.89 | |
| Assistive Technology Total: | | | | | | | 146205.00 |
| Assistive Technology | <input type="checkbox"/> | Each | 190 | 1.00 | 769.50 | 146205.00 | |
| Community Engagement Total: | | | | | | | 3087147.17 |
| Community Engagement | <input type="checkbox"/> | Hour | 1486 | 50.40 | 41.22 | 3087147.17 | |
| Environmental Adaptations Total: | | | | | | | 423383.87 |
| Environmental Adaptations | <input type="checkbox"/> | Each | 65 | 1.40 | 4652.57 | 423383.87 | |
| <p align="center">GRAND TOTAL:</p> <p>Total: Services included in capitation:</p> <p>Total: Services not included in capitation: 83609436.76</p> <p>Total Estimated Unduplicated Participants: 12000</p> <p>Factor D (Divide total by number of participants):</p> <p>Services included in capitation:</p> <p>Services not included in capitation: 6967.45</p> <p>Average Length of Stay on the Waiver: 336</p> | | | | | | | |

| Waiver Service/ Component | Capitation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|--|--------------------------|------|---------|---------------------|-----------------|----------------|------------|
| Extermination of Bed Bugs Total: | | | | | | | 39879.12 |
| Extermination of Bed Bugs | <input type="checkbox"/> | Each | 6 | 2.00 | 3323.26 | 39879.12 | |
| Individualized Technical Assistance Total: | | | | | | | 139088.48 |
| Individualized Technical Assistance | <input type="checkbox"/> | Each | 75 | 27.90 | 66.47 | 139088.48 | |
| Remote Supports Total: | | | | | | | 97086.60 |
| Remote Supports | <input type="checkbox"/> | Hour | 15 | 922.00 | 7.02 | 97086.60 | |
| Risk Assessment Total: | | | | | | | 18210.72 |
| Risk Assessment | <input type="checkbox"/> | Each | 11 | 1.00 | 1655.52 | 18210.72 | |
| Sexual Health Therapy Total: | | | | | | | |
| Sexual Health Therapy | <input type="checkbox"/> | | | | | | |
| Skilled Nursing Total: | | | | | | | 57942.72 |
| Skilled Nursing | <input type="checkbox"/> | Hour | 18 | 88.00 | 36.58 | 57942.72 | |
| Specialized Equipment and Supplies Total: | | | | | | | 249470.76 |
| Specialized Equipment and Supplies | <input type="checkbox"/> | Each | 385 | 0.60 | 1079.96 | 249470.76 | |
| Specialized Habilitation Total: | | | | | | | 567001.80 |
| Specialized Habilitation | <input type="checkbox"/> | Hour | 281 | 30.00 | 67.26 | 567001.80 | |
| Stabilization Services-Staff/Family Consultation Services Total: | | | | | | | 179180.64 |
| Stabilization Services-Staff/Family Consultation Services | <input type="checkbox"/> | Hour | 148 | 18.00 | 67.26 | 179180.64 | |
| Stabilization Services-Crisis Diversion Bed Total: | | | | | | | 779641.49 |
| Crisis Diversion Bed | <input type="checkbox"/> | Day | 4 | 234.60 | 830.82 | 779641.49 | |
| Stabilization Services- | | | | | | | 93222.36 |
| <p align="center">GRAND TOTAL:</p> <p align="right">Total: Services included in capitation:</p> <p align="right">Total: Services not included in capitation: 83609436.76</p> <p align="right">Total Estimated Unduplicated Participants: 12000</p> <p align="right">Factor D (Divide total by number of participants):</p> <p align="right">Services included in capitation:</p> <p align="right">Services not included in capitation: 6967.45</p> <p align="right">Average Length of Stay on the Waiver: 336</p> | | | | | | | |

| Waiver Service/ Component | Capi- tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|--|--------------------------|-------|---------|---------------------|-----------------|-------------------|------------|
| Specialized Habilitation Total: | | | | | | | |
| Stabilization Services- Specialized Habilitation | <input type="checkbox"/> | Hour | 77 | 18.00 | 67.26 | 93222.36 | |
| Staff/Family Consultation Services Total: | | | | | | | 367616.26 |
| Staff/Family Consultation Services | <input type="checkbox"/> | Hour | 224 | 24.40 | 67.26 | 367616.26 | |
| Therapeutic Adaptations Total: | | | | | | | 20694.00 |
| Therapeutic Adaptations | <input type="checkbox"/> | Each | 2 | 1.00 | 10347.00 | 20694.00 | |
| Transportation Total: | | | | | | | 326772.00 |
| Transportation | <input type="checkbox"/> | Mile | 939 | 580.00 | 0.60 | 326772.00 | |
| Wellness Education Total: | | | | | | | 129016.80 |
| Wellness Education | <input type="checkbox"/> | Month | 3960 | 9.00 | 3.62 | 129016.80 | |
| <p align="center">GRAND TOTAL:</p> <p>Total: Services included in capitation:</p> <p>Total: Services not included in capitation: 83609436.76</p> <p>Total Estimated Unduplicated Participants: 12000</p> <p>Factor D (Divide total by number of participants):</p> <p>Services included in capitation:</p> <p>Services not included in capitation: 6967.45</p> <p>Average Length of Stay on the Waiver: 336</p> | | | | | | | |

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. 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. If applicable, check the capitation box next to that service. 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 | Capi- tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|-----------------|------|---------|---------------------|-----------------|-------------------|------------|
| Community Inclusion Total: | | | | | | | 5836250.88 |
| <p align="center">GRAND TOTAL:</p> <p>Total: Services included in capitation:</p> <p>Total: Services not included in capitation: 110704810.72</p> <p>Total Estimated Unduplicated Participants: 12000</p> <p>Factor D (Divide total by number of participants):</p> <p>Services included in capitation:</p> <p>Services not included in capitation: 9225.40</p> <p>Average Length of Stay on the Waiver: 336</p> | | | | | | | |

| Waiver Service/ Component | Capitation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|--------------------------|------|---------|---------------------|-----------------|----------------|-------------|
| Community Inclusion | <input type="checkbox"/> | Hour | 724 | 108.00 | 74.64 | 5836250.88 | |
| Individual Supported Employment/Group Supported Employment Total: | | | | | | | 65550430.92 |
| Individual Supported Employment/Group Supported Employment | <input type="checkbox"/> | Hour | 5722 | 114.00 | 100.49 | 65550430.92 | |
| Respite Total: | | | | | | | 31770168.32 |
| Respite | <input type="checkbox"/> | Hour | 5586 | 177.90 | 31.97 | 31770168.32 | |
| Occupational Therapy Total: | | | | | | | 948.89 |
| Occupational Therapy | <input type="checkbox"/> | Each | 2 | 1.74 | 272.67 | 948.89 | |
| Physical Therapy Total: | | | | | | | 20831.11 |
| Physical Therapy | <input type="checkbox"/> | Each | 8 | 8.36 | 311.47 | 20831.11 | |
| Speech, Hearing and Language Services Total: | | | | | | | 28628.26 |
| Speech, Hearing and Language Services | <input type="checkbox"/> | Hour | 14 | 29.80 | 68.62 | 28628.26 | |
| Assistive Technology Total: | | | | | | | 156902.00 |
| Assistive Technology | <input type="checkbox"/> | Each | 200 | 1.00 | 784.51 | 156902.00 | |
| Community Engagement Total: | | | | | | | 3538958.02 |
| Community Engagement | <input type="checkbox"/> | Hour | 1698 | 49.60 | 42.02 | 3538958.02 | |
| Environmental Adaptations Total: | | | | | | | 464843.40 |
| Environmental Adaptations | <input type="checkbox"/> | Each | 70 | 1.40 | 4743.30 | 464843.40 | |
| Extermination of Bed Bugs Total: | | | | | | | 40656.72 |
| Extermination of Bed Bugs | <input type="checkbox"/> | Each | 6 | 2.00 | 3388.06 | 40656.72 | |
| Individualized Technical Assistance Total: | | | | | | | 150652.71 |
| Individualized Technical Assistance | <input type="checkbox"/> | Each | 78 | 28.50 | 67.77 | 150652.71 | |
| <p align="center">GRAND TOTAL:</p> <p align="center">Total: Services included in capitation:</p> <p align="center">Total: Services not included in capitation:</p> <p align="center">Total Estimated Unduplicated Participants:</p> <p align="center">Factor D (Divide total by number of participants):</p> <p align="center">Services included in capitation:</p> <p align="center">Services not included in capitation:</p> <p align="center">Average Length of Stay on the Waiver:</p> | | | | | | | |
| | | | | | | 110704810.72 | |
| | | | | | | 12000 | |
| | | | | | | 9225.40 | |
| | | | | | | 336 | |

| Waiver Service/ Component | Capitation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|--|--------------------------|------|---------|---------------------|-----------------|----------------|---|
| Remote Supports Total: | | | | | | | 118652.18 |
| Remote Supports | <input type="checkbox"/> | Hour | 17 | 922.00 | 7.57 | 118652.18 | |
| Risk Assessment Total: | | | | | | | 20253.60 |
| Risk Assessment | <input type="checkbox"/> | Each | 12 | 1.00 | 1687.80 | 20253.60 | |
| Sexual Health Therapy Total: | | | | | | | |
| Sexual Health Therapy | <input type="checkbox"/> | | | | | | |
| Skilled Nursing Total: | | | | | | | 62348.88 |
| Skilled Nursing | <input type="checkbox"/> | Hour | 19 | 88.00 | 37.29 | 62348.88 | |
| Specialized Equipment and Supplies Total: | | | | | | | 291990.50 |
| Specialized Equipment and Supplies | <input type="checkbox"/> | Each | 442 | 0.60 | 1101.02 | 291990.50 | |
| Specialized Habilitation Total: | | | | | | | 606844.50 |
| Specialized Habilitation | <input type="checkbox"/> | Hour | 295 | 30.00 | 68.57 | 606844.50 | |
| Stabilization Services-Staff/Family Consultation Services Total: | | | | | | | 191310.30 |
| Stabilization Services-Staff/Family Consultation Services | <input type="checkbox"/> | Hour | 155 | 18.00 | 68.57 | 191310.30 | |
| Stabilization Services-Crisis Diversion Bed Total: | | | | | | | 811445.16 |
| Crisis Diversion Bed | <input type="checkbox"/> | Day | 4 | 239.50 | 847.02 | 811445.16 | |
| Stabilization Services-Specialized Habilitation Total: | | | | | | | 99975.06 |
| Stabilization Services-Specialized Habilitation | <input type="checkbox"/> | Hour | 81 | 18.00 | 68.57 | 99975.06 | |
| Staff/Family Consultation Services Total: | | | | | | | 423049.47 |
| Staff/Family Consultation | <input type="checkbox"/> | Hour | 256 | 24.10 | 68.57 | 423049.47 | |
| GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver: | | | | | | | 110704810.72 12000 9225.40 336 |

| Waiver Service/ Component | Capitation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|--------------------------|-------|---------|---------------------|-----------------|----------------|------------|
| Services | | | | | | | |
| Therapeutic Adaptations Total: | | | | | | | 21097.54 |
| Therapeutic Adaptations | <input type="checkbox"/> | Each | 2 | 1.00 | 10548.77 | 21097.54 | |
| Transportation Total: | | | | | | | 352397.00 |
| Transportation | <input type="checkbox"/> | Mile | 1060 | 545.00 | 0.61 | 352397.00 | |
| Wellness Education Total: | | | | | | | 146175.29 |
| Wellness Education | <input type="checkbox"/> | Month | 4451 | 8.90 | 3.69 | 146175.29 | |
| GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: 110704810.72 Total Estimated Unduplicated Participants: 12000 Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: 9225.40 Average Length of Stay on the Waiver: | | | | | | | |
| | | | | | | | 336 |

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. 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. If applicable, check the capitation box next to that service. 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 | Capitation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|--|--------------------------|------|---------|---------------------|-----------------|----------------|-------------|
| Community Inclusion Total: | | | | | | | 10762392.24 |
| Community Inclusion | <input type="checkbox"/> | Hour | 1206 | 108.00 | 82.63 | 10762392.24 | |
| Individual Supported Employment/Group Supported Employment Total: | | | | | | | 85425047.28 |
| Individual Supported Employment/Group Supported Employment | <input type="checkbox"/> | Hour | 6172 | 114.00 | 121.41 | 85425047.28 | |
| GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: 137952212.27 Total Estimated Unduplicated Participants: 13500 Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: 10218.68 Average Length of Stay on the Waiver: | | | | | | | |
| | | | | | | | 336 |

| Waiver Service/ Component | Capitation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|--|--------------------------|------|---------|---------------------|-----------------|----------------|-------------|
| Respite Total: | | | | | | | 33493655.52 |
| Respite | <input type="checkbox"/> | Hour | 5856 | 175.50 | 32.59 | 33493655.52 | |
| Occupational Therapy Total: | | | | | | | 967.37 |
| Occupational Therapy | <input type="checkbox"/> | Each | 2 | 1.74 | 277.98 | 967.37 | |
| Physical Therapy Total: | | | | | | | 23891.71 |
| Physical Therapy | <input type="checkbox"/> | Each | 9 | 8.36 | 317.54 | 23891.71 | |
| Speech, Hearing and Language Services Total: | | | | | | | 29187.31 |
| Speech, Hearing and Language Services | <input type="checkbox"/> | Hour | 14 | 29.80 | 69.96 | 29187.31 | |
| Assistive Technology Total: | | | | | | | 167158.20 |
| Assistive Technology | <input type="checkbox"/> | Each | 209 | 1.00 | 799.80 | 167158.20 | |
| Community Engagement Total: | | | | | | | 3986934.59 |
| Community Engagement | <input type="checkbox"/> | Hour | 1911 | 48.70 | 42.84 | 3986934.59 | |
| Environmental Adaptations Total: | | | | | | | 500987.84 |
| Environmental Adaptations | <input type="checkbox"/> | Each | 74 | 1.40 | 4835.79 | 500987.84 | |
| Extermination of Bed Bugs Total: | | | | | | | 48357.82 |
| Extermination of Bed Bugs | <input type="checkbox"/> | Each | 7 | 2.00 | 3454.13 | 48357.82 | |
| Individualized Technical Assistance Total: | | | | | | | 162029.87 |
| Individualized Technical Assistance | <input type="checkbox"/> | Each | 82 | 28.60 | 69.09 | 162029.87 | |
| Remote Supports Total: | | | | | | | 135423.36 |
| Remote Supports | <input type="checkbox"/> | Hour | 18 | 922.00 | 8.16 | 135423.36 | |
| Risk Assessment Total: | | | | | | | 20648.52 |
| Risk Assessment | <input type="checkbox"/> | Each | 12 | 1.00 | 1720.71 | 20648.52 | |
| Sexual Health | | | | | | | |
| <p align="center">GRAND TOTAL:</p> <p align="right">Total: Services included in capitation:</p> <p align="right">Total: Services not included in capitation: 137952212.27</p> <p align="right">Total Estimated Unduplicated Participants: 13500</p> <p align="right">Factor D (Divide total by number of participants):</p> <p align="right">Services included in capitation:</p> <p align="right">Services not included in capitation: 10218.68</p> <p align="right">Average Length of Stay on the Waiver: 336</p> | | | | | | | |

| Waiver Service/ Component | Capitation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|--------------------------|------|---------|---------------------|-----------------|----------------|------------|
| Therapy Total: | | | | | | | |
| Sexual Health Therapy | <input type="checkbox"/> | | | | | | |
| Skilled Nursing Total: | | | | | | | 66915.20 |
| Skilled Nursing | <input type="checkbox"/> | Hour | 20 | 88.00 | 38.02 | 66915.20 | |
| Specialized Equipment and Supplies Total: | | | | | | | 280061.26 |
| Specialized Equipment and Supplies | <input type="checkbox"/> | Each | 499 | 0.50 | 1122.49 | 280061.26 | |
| Specialized Habilitation Total: | | | | | | | 650163.00 |
| Specialized Habilitation | <input type="checkbox"/> | Hour | 310 | 30.00 | 69.91 | 650163.00 | |
| Stabilization Services-Staff/Family Consultation Services Total: | | | | | | | 205115.94 |
| Stabilization Services-Staff/Family Consultation Services | <input type="checkbox"/> | Hour | 163 | 18.00 | 69.91 | 205115.94 | |
| Stabilization Services-Crisis Diversion Bed Total: | | | | | | | 843246.81 |
| Crisis Diversion Bed | <input type="checkbox"/> | Day | 5 | 195.30 | 863.54 | 843246.81 | |
| Stabilization Services-Specialized Habilitation Total: | | | | | | | 106962.30 |
| Stabilization Services-Specialized Habilitation | <input type="checkbox"/> | Hour | 85 | 18.00 | 69.91 | 106962.30 | |
| Staff/Family Consultation Services Total: | | | | | | | 479191.10 |
| Staff/Family Consultation Services | <input type="checkbox"/> | Hour | 288 | 23.80 | 69.91 | 479191.10 | |
| Therapeutic Adaptations Total: | | | | | | | 21508.94 |
| Therapeutic Adaptations | <input type="checkbox"/> | Each | 2 | 1.00 | 10754.47 | 21508.94 | |
| Transportation Total: | | | | | | | 378878.28 |
| Transportation | <input type="checkbox"/> | Mile | 1182 | 517.00 | 0.62 | 378878.28 | |
| <p align="center">GRAND TOTAL:</p> <p align="center">Total: Services included in capitation:</p> <p align="center">Total: Services not included in capitation: 137952212.27</p> <p align="center">Total Estimated Unduplicated Participants: 13500</p> <p align="center">Factor D (Divide total by number of participants):</p> <p align="center">Services included in capitation:</p> <p align="center">Services not included in capitation: 10218.68</p> <p align="center">Average Length of Stay on the Waiver: 336</p> | | | | | | | |

| Waiver Service/ Component | Capitation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|--|--------------------------|-------|---------|---------------------|-----------------|----------------|------------|
| Wellness Education Total: | | | | | | | 163487.81 |
| Wellness Education | <input type="checkbox"/> | Month | 4941 | 8.80 | 3.76 | 163487.81 | |
| GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: 137952212.27 Total Estimated Unduplicated Participants: 13500 Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: 10218.68 Average Length of Stay on the Waiver: 336 | | | | | | | |

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. 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. If applicable, check the capitation box next to that service. 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 | Capitation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|--|--------------------------|------|---------|---------------------|-----------------|----------------|-------------|
| Community Inclusion Total: | | | | | | | 13539639.24 |
| Community Inclusion | <input type="checkbox"/> | Hour | 1473 | 108.00 | 85.11 | 13539639.24 | |
| Individual Supported Employment/Group Supported Employment Total: | | | | | | | 94401245.40 |
| Individual Supported Employment/Group Supported Employment | <input type="checkbox"/> | Hour | 6622 | 114.00 | 125.05 | 94401245.40 | |
| Respite Total: | | | | | | | 35237444.24 |
| Respite | <input type="checkbox"/> | Hour | 6126 | 173.10 | 33.23 | 35237444.24 | |
| Occupational Therapy Total: | | | | | | | 986.23 |
| Occupational Therapy | <input type="checkbox"/> | Each | 2 | 1.74 | 283.40 | 986.23 | |
| GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: 152237999.72 Total Estimated Unduplicated Participants: 13500 Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: 11276.89 Average Length of Stay on the Waiver: 336 | | | | | | | |

| Waiver Service/ Component | Capitation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|--|--------------------------|------|---------|---------------------|-----------------|----------------|------------|
| Physical Therapy Total: | | | | | | | 24357.45 |
| Physical Therapy | <input type="checkbox"/> | Each | 9 | 8.36 | 323.73 | 24357.45 | |
| Speech, Hearing and Language Services Total: | | | | | | | 31880.04 |
| Speech, Hearing and Language Services | <input type="checkbox"/> | Hour | 15 | 29.80 | 71.32 | 31880.04 | |
| Assistive Technology Total: | | | | | | | 179388.00 |
| Assistive Technology | <input type="checkbox"/> | Each | 220 | 1.00 | 815.40 | 179388.00 | |
| Community Engagement Total: | | | | | | | 4441893.46 |
| Community Engagement | <input type="checkbox"/> | Hour | 2123 | 47.90 | 43.68 | 4441893.46 | |
| Environmental Adaptations Total: | | | | | | | 538365.83 |
| Environmental Adaptations | <input type="checkbox"/> | Each | 78 | 1.40 | 4930.09 | 538365.83 | |
| Extermination of Bed Bugs Total: | | | | | | | 49300.86 |
| Extermination of Bed Bugs | <input type="checkbox"/> | Each | 7 | 2.00 | 3521.49 | 49300.86 | |
| Individualized Technical Assistance Total: | | | | | | | 173609.95 |
| Individualized Technical Assistance | <input type="checkbox"/> | Each | 85 | 29.00 | 70.43 | 173609.95 | |
| Remote Supports Total: | | | | | | | 162272.00 |
| Remote Supports | <input type="checkbox"/> | Hour | 20 | 922.00 | 8.80 | 162272.00 | |
| Risk Assessment Total: | | | | | | | 22805.51 |
| Risk Assessment | <input type="checkbox"/> | Each | 13 | 1.00 | 1754.27 | 22805.51 | |
| Sexual Health Therapy Total: | | | | | | | |
| Sexual Health Therapy | <input type="checkbox"/> | | | | | | |
| Skilled Nursing Total: | | | | | | | 71628.48 |
| Skilled Nursing | <input type="checkbox"/> | Hour | 21 | 88.00 | 38.76 | 71628.48 | |
| Specialized | | | | | | | 318137.64 |
| <p align="center">GRAND TOTAL:</p> <p align="right">Total: Services included in capitation:</p> <p align="right">Total: Services not included in capitation: 152237999.72</p> <p align="right">Total Estimated Unduplicated Participants: 13500</p> <p align="right">Factor D (Divide total by number of participants):</p> <p align="right">Services included in capitation:</p> <p align="right">Services not included in capitation: 11276.89</p> <p align="right">Average Length of Stay on the Waiver: 336</p> | | | | | | | |

| Waiver Service/ Component | Capitation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|--------------------------|-------|---------|---------------------|-----------------|----------------|------------|
| Equipment and Supplies Total: | | | | | | | |
| Specialized Equipment and Supplies | <input type="checkbox"/> | Each | 556 | 0.50 | 1144.38 | 318137.64 | |
| Specialized Habilitation Total: | | | | | | | 694882.50 |
| Specialized Habilitation | <input type="checkbox"/> | Hour | 325 | 30.00 | 71.27 | 694882.50 | |
| Stabilization Services-Staff/Family Consultation Services Total: | | | | | | | 219369.06 |
| Stabilization Services-Staff/Family Consultation Services | <input type="checkbox"/> | Hour | 171 | 18.00 | 71.27 | 219369.06 | |
| Stabilization Services-Crisis Diversion Bed Total: | | | | | | | 875097.72 |
| Crisis Diversion Bed | <input type="checkbox"/> | Day | 5 | 198.80 | 880.38 | 875097.72 | |
| Stabilization Services-Specialized Habilitation Total: | | | | | | | 114174.54 |
| Stabilization Services-Specialized Habilitation | <input type="checkbox"/> | Hour | 89 | 18.00 | 71.27 | 114174.54 | |
| Staff/Family Consultation Services Total: | | | | | | | 533669.76 |
| Staff/Family Consultation Services | <input type="checkbox"/> | Hour | 320 | 23.40 | 71.27 | 533669.76 | |
| Therapeutic Adaptations Total: | | | | | | | 21928.36 |
| Therapeutic Adaptations | <input type="checkbox"/> | Each | 2 | 1.00 | 10964.18 | 21928.36 | |
| Transportation Total: | | | | | | | 404451.20 |
| Transportation | <input type="checkbox"/> | Mile | 1303 | 485.00 | 0.64 | 404451.20 | |
| Wellness Education Total: | | | | | | | 181472.26 |
| Wellness Education | <input type="checkbox"/> | Month | 5432 | 8.70 | 3.84 | 181472.26 | |
| <p>GRAND TOTAL:</p> <p>Total: Services included in capitation:</p> <p>Total: Services not included in capitation: 152237999.72</p> <p>Total Estimated Unduplicated Participants: 13500</p> <p>Factor D (Divide total by number of participants):</p> <p>Services included in capitation:</p> <p>Services not included in capitation: 11276.89</p> <p>Average Length of Stay on the Waiver: 336</p> | | | | | | | |

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. 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. If applicable, check the capitation box next to that service. 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 | Capi- tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|--|--------------------------|------|---------|---------------------|-----------------|-------------------|--------------|
| Community Inclusion Total: | | | | | | | 15034040.64 |
| Community Inclusion | <input type="checkbox"/> | Hour | 1588 | 108.00 | 87.66 | 15034040.64 | |
| Individual Supported Employment/Group Supported Employment Total: | | | | | | | 103839590.40 |
| Individual Supported Employment/Group Supported Employment | <input type="checkbox"/> | Hour | 7072 | 114.00 | 128.80 | 103839590.40 | |
| Respite Total: | | | | | | | 36968419.49 |
| Respite | <input type="checkbox"/> | Hour | 6396 | 170.60 | 33.88 | 36968419.49 | |
| Occupational Therapy Total: | | | | | | | 1005.48 |
| Occupational Therapy | <input type="checkbox"/> | Each | 2 | 1.74 | 288.93 | 1005.48 | |
| Physical Therapy Total: | | | | | | | 27592.18 |
| Physical Therapy | <input type="checkbox"/> | Each | 10 | 8.36 | 330.05 | 27592.18 | |
| Speech, Hearing and Language Services Total: | | | | | | | 34672.90 |
| Speech, Hearing and Language Services | <input type="checkbox"/> | Hour | 16 | 29.80 | 72.72 | 34672.90 | |
| Assistive Technology Total: | | | | | | | 192030.30 |
| Assistive Technology | <input type="checkbox"/> | Each | 231 | 1.00 | 831.30 | 192030.30 | |
| Community Engagement Total: | | | | | | | 4889037.76 |
| Community Engagement | <input type="checkbox"/> | Hour | 2336 | 47.00 | 44.53 | 4889037.76 | |
| Environmental Adaptations Total: | | | | | | | 584046.76 |
| <p align="center">GRAND TOTAL:</p> <p>Total: Services included in capitation:</p> <p>Total: Services not included in capitation:</p> <p>Total Estimated Unduplicated Participants:</p> <p>Factor D (Divide total by number of participants):</p> <p>Services included in capitation:</p> <p>Services not included in capitation:</p> <p>Average Length of Stay on the Waiver:</p> | | | | | | | |
| | | | | | | 165704162.35 | |
| | | | | | | 13500 | |
| | | | | | | 12274.38 | |
| | | | | | | 336 | |

| Waiver Service/ Component | Capitation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|--|--------------------------|------|---------|---------------------|-----------------|----------------|------------|
| Environmental Adaptations | <input type="checkbox"/> | Each | 83 | 1.40 | 5026.22 | 584046.76 | |
| Extermination of Bed Bugs Total: | | | | | | | 50262.24 |
| Extermination of Bed Bugs | <input type="checkbox"/> | Each | 7 | 2.00 | 3590.16 | 50262.24 | |
| Individualized Technical Assistance Total: | | | | | | | 184702.50 |
| Individualized Technical Assistance | <input type="checkbox"/> | Each | 89 | 28.90 | 71.81 | 184702.50 | |
| Remote Supports Total: | | | | | | | 192292.32 |
| Remote Supports | <input type="checkbox"/> | Hour | 22 | 922.00 | 9.48 | 192292.32 | |
| Risk Assessment Total: | | | | | | | 23250.24 |
| Risk Assessment | <input type="checkbox"/> | Each | 13 | 1.00 | 1788.48 | 23250.24 | |
| Sexual Health Therapy Total: | | | | | | | |
| Sexual Health Therapy | <input type="checkbox"/> | | | | | | |
| Skilled Nursing Total: | | | | | | | 76510.72 |
| Skilled Nursing | <input type="checkbox"/> | Hour | 22 | 88.00 | 39.52 | 76510.72 | |
| Specialized Equipment and Supplies Total: | | | | | | | 358173.83 |
| Specialized Equipment and Supplies | <input type="checkbox"/> | Each | 614 | 0.50 | 1166.69 | 358173.83 | |
| Specialized Habilitation Total: | | | | | | | 745491.60 |
| Specialized Habilitation | <input type="checkbox"/> | Hour | 342 | 30.00 | 72.66 | 745491.60 | |
| Stabilization Services-Staff/Family Consultation Services Total: | | | | | | | 235418.40 |
| Stabilization Services-Staff/Family Consultation Services | <input type="checkbox"/> | Hour | 180 | 18.00 | 72.66 | 235418.40 | |
| Stabilization Services-Crisis Diversion Bed Total: | | | | | | | 906515.40 |
| Crisis Diversion | <input type="checkbox"/> | | | | | 906515.40 | |
| <p align="center">GRAND TOTAL:</p> <p align="right">Total: Services included in capitation:</p> <p align="right">Total: Services not included in capitation: 165704162.35</p> <p align="right">Total Estimated Unduplicated Participants: 13500</p> <p align="right">Factor D (Divide total by number of participants):</p> <p align="right">Services included in capitation:</p> <p align="right">Services not included in capitation: 12274.38</p> <p align="right">Average Length of Stay on the Waiver: 336</p> | | | | | | | |

| Waiver Service/ Component | Capi- tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|--|--------------------------|-------|---------|---------------------|-----------------|-------------------|------------|
| Bed | | Day | 5 | 202.00 | 897.54 | | |
| Stabilization Services- Specialized Habilitation Total: | | | | | | | 122940.72 |
| Stabilization Services- Specialized Habilitation | <input type="checkbox"/> | Hour | 94 | 18.00 | 72.66 | 122940.72 | |
| Staff/Family Consultation Services Total: | | | | | | | 588255.36 |
| Staff/Family Consultation Services | <input type="checkbox"/> | Hour | 352 | 23.00 | 72.66 | 588255.36 | |
| Therapeutic Adaptations Total: | | | | | | | 22355.96 |
| Therapeutic Adaptations | <input type="checkbox"/> | Each | 2 | 1.00 | 11177.98 | 22355.96 | |
| Transportation Total: | | | | | | | 430706.25 |
| Transportation | <input type="checkbox"/> | Mile | 1425 | 465.00 | 0.65 | 430706.25 | |
| Wellness Education Total: | | | | | | | 196850.90 |
| Wellness Education | <input type="checkbox"/> | Month | 5923 | 8.50 | 3.91 | 196850.90 | |
| <p align="center">GRAND TOTAL:</p> <p align="right">Total: Services included in capitation:</p> <p align="right">Total: Services not included in capitation: 165704162.35</p> <p align="right">Total Estimated Unduplicated Participants: 13500</p> <p align="right">Factor D (Divide total by number of participants):</p> <p align="right">Services included in capitation:</p> <p align="right">Services not included in capitation: 12274.38</p> <p align="right">Average Length of Stay on the Waiver: 336</p> | | | | | | | |