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

Data Aggregation and Analysis:

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

Performance Measure:
D.d.1. Number & percent of waiver PCSPs with services that are delivered in accordance with the type, scope, amount, duration, and frequency as specified in the PCSP. N = Number of waiver PCSPs with services that are delivered in accordance with the type, scope, amount, duration, and frequency as specified in the PCSP. D = All waiver PCSPs reviewed.

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

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

collection/generation *(check each that applies):*	*(check each that applies):*	
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☒ **Other** Specify: Quality Compliance Coordinator (QCC) Team within DDA.	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
D.e.1. # & % of waiver participant records that contain annual assessment meeting wrap-up that verifies that waiver participant had a choice between/among waiver services & providers. N = # of wvr participant records that contain annual assessment meeting wrap-up that verifies that wvr participant had a choice between/among waiver services & providers. D = All waiver part records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CARE System data

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

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

Data Aggregation and Analysis:

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

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.

QIPs for Performance Measures D.d.2, D.d.3 and D.e.1 are located at Main B. Optional

PM D.a.1, D.a.2, D.a.5, D.a.7 and D.c.3 are 100% annual reviews based on data from the CARE system that is analyzed by the Waiver Team and reviewed by DDA management. PM D.d.5 is an annual representative sample drawn from the Medicaid Service Verification Survey that is analyzed by the Waiver Team and reviewed by DDA management.
D.a.3; D.a.4; D.c.1; D.d.1; D.d.2; D.d.3; D.d.4; D.e.1: The QCC Team completes an annual audit of randomly selected files across all DDA waivers. The list for the QCC Team audit is generated to produce a random sample representative of all waivers with a 95% confidence level with a +/-5% margin of error. The findings from these reviews are collected in a database. All findings are expected to be corrected within 90 days. Corrections are monitored by QCC Team members.
A valid sample is produced for the QCC audit. The remaining file review is strictly an additional measure to assist with ongoing quality assurance.
The audit protocol includes (among others) the following questions with a target of 100% compliance:
• Have all identified waiver funded services been provided within 90 days of the annual PCSP effective date?
• Is there a ProviderOne or Individual ProviderOne authorization for all Waiver funded services identified in the current PCSP that should have occurred in the three (3) months prior to this review?
• Are all the current services authorized in ProviderOne or Individual ProviderOne Screen identified in the PCSP?
(Authorizations are audited as a proxy for claims data. The ProviderOne and Individual ProviderOne electronically prevents a provider from claiming payment for an amount and rate higher than what is authorized.)
• Are the authorized service amounts equal or less than the amounts identified in the PCSP?
• Is the effective date of this year's annual PCSP no later than the last day of the 12th month of the previous annual PCSP effective date?
• Is there evidence that the Wrap-Up discussion occurred at the DDA annual or initial assessment?
• Is there a signed Voluntary Participation statement from the annual or initial assessment in the client file?
D.a.2: The DDA assessment allows for entry and addressing of personal goals. An annual report is generated at DDA Central Office and annually reviewed by DDA management to identify assessments with one or more personal goals to verify personal goals are acknowledged and addressed. Data are available in a computer-based system which provide 100% analysis of individual results.
D.a.5: An annual report is created and reviewed by DDA management to verify that emergency plans are documented in waiver participants' PCSPs.
D.a.6: DDA management annually compares data on response rates to NCI questions and responses from waiver year to waiver year. DDA constructs pie charts for questions and analyzes the outcome of the survey with the HCA Medicaid Agency Waiver Management Committee and stakeholders. DDA uses this information to assist with the development of the Waiver training curriculum as well as to develop needed policy changes.
D.c.1: Monthly reports are prepared and reviewed by DDA management for a review of the progress toward achieving 100% timely assessments of need. The data is analyzed by comparing the actual number of assessments completed on time to the regional monthly targets and to the assessments that were due. Regional Waiver Specialists review Assessment Activity Reports on a monthly basis and send information to case resource managers for follow-up to promote timeliness of assessments.
D.c.2: Person-Centered Service Plan Meeting Survey: A PCSP Meeting survey is mailed to waiver participants within one month of the PCSP planning meeting. This survey gives participants an opportunity to respond to a series of questions about the PCSP process. The survey is mailed from DDA Central Office based on a random sample representative of all waivers with a 95% confidence level and a +/-5% margin of error. Information collected is analyzed and reviewed by DDA management annually and by the HCA Medicaid Agency Waiver Management Committee.
Questions in the Person-Centered Service Plan Meeting Survey include:
• Did you get to choose who came to your meeting?
• Did you get to choose the time and place of your meeting?
• Were you given the opportunity to lead your meeting?
• Were your personal goals discussed in developing your plan?
• Were you given a choice of services?
• Did you choose where and how the services will be provided?
• Did your case resource manager review last year's plan and ask what supports you want to continue and what should change?

- Were any concerns you may have had addressed in your new plan?
- Did you receive information about resources and services available to meet your goals?
- Were you given a choice of providers?
- Were plans made to meet any health and safety concerns you may have had?
- Did you receive information regarding planning for emergencies, such as an earthquake or other natural disaster?
- Do you know who to contact if your needs change before your next assessment?

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.

All results are reviewed by program managers on the QCC Team and by senior DDA management at least annually. Individual client issues discovered during annual reviews are corrected by CRMs and with oversight by the QCC Team. Systemic issues discovered in the course of annual reviews are brought by the QCC Team to senior DDA management for necessary policy, procedure or other corrective actions. In addition, the Washington State Developmental Disabilities Council (DDC) also participates in an annual review of QIS data analysis and remediation.

PM D.a.1, D.a.7 and D.c.3 are 100% reviews based on data from the CARE system. PM D.d.5 is a representative sample drawn from the Medicaid Service Verification Survey.
D.a.1, D.a.2, D.a.5, D.a.7 & D.c.3 – CARE data findings are analyzed by management, and based on the analysis necessary steps are taken to increase compliance. D.d.5 – Medicaid Service Verification Survey results are analyzed by management, and based on the analysis necessary steps are taken to increase compliance.
D.a.3; D.a.4; D.c.1; D.d.1; D.d.2; D.d.3; D.d.4; D.e.1: Waiver File Reviews (Annual QCC audit):
Findings from QCC Team and Supervisor file reviews are analyzed by management, and based on the analysis necessary steps are taken to increase compliance. For example:
* Annual Waiver Training curriculum is developed in part to address audit findings.
* Policy clarifications occur as a result of audit findings.
* Analyses of findings assist regions to recognize personnel issues.
* Analysis of audit finding may impact format and instructions on forms.
* Analysis of findings has led to revision in Waiver WAC to clarify rule.
* Analysis of findings has led regions to revise regional processes.

D.a.6: The National Core Indicators Survey:
Washington State's Developmental Disabilities Administration (DDA) participates in a national study that assesses performance and outcome indicators for state developmental disabilities service systems. This study allows the administration to compare its performance to service systems in other states and within our state from year to year.
There are currently 46 performance and outcome indicators to be assessed covering the following domains:
* Consumer Outcomes
* System Performance
* Health, Welfare, & Rights
* Service Delivery System Strength & Stability
In addition, DDA has added some waiver specific questions to assist with assuring PCSPs are implemented as written and that health and welfare needs are being addressed. Findings are analyzed by management and shared with stakeholders. The Washington State Developmental Disabilities Council (DDC) participates in the survey process both in visiting clients and analyzing results.

D.c.2: Person-Centered Service Plan Meeting Survey: DDA compares data on response rates to the Person-Centered Service Plan Meeting Survey and responses from waiver year to waiver year. DDA constructs pie charts for questions and analyzes the outcome of the survey with the HCA Medicaid Agency Waiver Management Committee and stakeholders. DDA uses this information to assist with the development of the Waiver training curriculum as well as to develop needed policy changes.
* Annual Waiver Training curriculum is developed in part to address audit findings.
* Policy clarifications occur as a result of audit findings.
* Analysis of audit finding may impact format and instructions on forms.
D.d.5 State utilizes Medicaid Service Verification Survey as an additional tool to identify and correct issues with the waiver service delivery system.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

assessment meeting wrap-up, which includes verification that the waiver participant had a choice between/among waiver services and providers.

Sub-Assurance-client has a choice of providers and services

Performance Measure D.e.1: The percentage of waiver participant records that contain the annual assessment meeting wrap-up, which includes verification that the waiver participant had a choice between/among waiver services and providers. N = Number of waiver participant records containing the annual assessment meeting wrap-up. D = All waiver participant records reviewed.

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 to discuss choice of providers and services and make any changes
• At 6 month plan review, CRMs document on plan review screen that the client was satisfied OR made changes to services or 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.

Update for D.e.1:
• For D.e.1, State used a representative sample, 95% confidence level with a +/- 5% margin of error for all 3 waiver years. The sample universe increased from WY2 to WY3 as a correction to show the entire sample universe of total waiver participants. Sample size instead of sample universe was used in WY1 and WY2 in error. 2 new mandatory questions added to CARE System on 12/30/22, (Checkbox) "Provider options were discussed and client had a choice of qualified providers." And (Checkbox) "Services were discussed and client had a choice of services." Will adjust data source to CARE system, 100% data in next waiver renewal.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

a) Providers are not required to have an independent financial audit of their financial statements. Agency providers are required to submit a cost report. If the department has reason to be concerned, the department will request an audit by Operations Review and Consultation or the State Auditors Office. Operations Review and Consultation is within DSHS. The State Auditors Office is a state agency outside the Department of Social and Health Services.

b) The Office of Rates Management 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. First, only claims that have an approved authorization can be paid. If a claim is determined to be inappropriate, the authorization will be amended and an adjustment will be made to the claim that will cause it to reprocess, deny, and the resulting debt that is created will be sent to the Office of Financial Recovery for collection. FFP is revised to match the corrected authorization.

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

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.

The State implemented EVV for Personal Care, Skills Acquisition, Respite and Relief Care provided by individual providers and home care agencies effective January 1, 2021. EVV utilizes a 21st Century Cures Act compliant mobile application, Time4Care, to capture and report the six required data elements: 1) type of service performed including service delivery detail, activities and visit notes; 2) who received the service; 3) real time capture of date of the service; 4) who provided the service; 5) real time capture of location of service delivery via GPS; and 6) when the service begins and ends using real time clock in/clock out functionality.

• EVV is used to monitor the State's financial integrity and accountability and reduce fraud, waste and abuse. The EVV application, Time4Care, has the following features:

- *is 21st Century Cures Act compliant;*
- *allows for the control and flexibility of service delivery;*
- *the application is simple to use and records time offline without an internet connection;*
- *Time4Care is integrated with the WA IPOne web portal;*
- *Error trapping – Time4Care lets providers know in real time if there are problems with their data entries;*

- *Time4Care is designed to mitigate fraud, waste and abuse.*

This waiver provides Skilled Nursing, the only Home Health Care Service which is subject to the State's fully implemented EVV system.

The State's EVV system allows the location data, time-in and time-out data provided by the EVV system to be seen as a component of the State's MMIS, ProviderOne, which permits detailed monitoring of Skilled Nursing service delivery to waiver participants in their homes.

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):*
Record reviews, on-site
If 'Other' is selected, specify:

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

☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level with a +/- 5% margin of error*
☒ ***Other*** *Specify:* *Quality Compliance Coordinator (QCC) Team within DDA.*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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

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):*
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):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level with a +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*

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

Data Aggregation and Analysis:

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

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

I.a.1:
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.*

I.a.1. Annual waiver file review:
Findings from Waiver Team and Supervisor file reviews are analyzed by DDA staff and reviewed by DDA management. Based on the analysis necessary steps are taken to increase compliance. For example:
- *Annual Waiver Training curriculum is developed in part to address review findings.*
- *Personnel issues are identified.*
- *Form format and instructions are modified.*
- *Waiver WAC is revised to clarify waiver rules.*
- *Regional processes are revised.*

Providers whose service authorization included a rate higher than the contracted rate are reviewed to determine the appropriate course of action. Overpayments are processed as necessary.

I.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):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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

c. Timelines

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

- ◉ ***No***
- ○ ***Yes***

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

Appendix I: Financial Accountability

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

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

All negotiated rates comply with Federal and Washington State minimum wage requirements.
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 2023, and are reviewed every July.
With respect to rates established by DDA, the most recent rate comparison was conducted in the January of 2019. 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 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.
While the Public Assistance Cost Allocation plan for the DDA (submitted as a PDF attachment) does not list specific waivers, the cost accounting system allocates the Medicaid portion to the specific funding of the clients served. A portion of the cost of all DDA staff (e.g., regional staff associated with community-based services, Central Office staff including the waiver unit staff & administrative & management staff) who provide administrative and/or technical support to the waiver program is charged as Title XIX administration & allocated by the funding source of the clients served (both state plan & waiver).
There will be no administrative charges for the IFS waiver until client services under the approved waiver are provided & paid, since the portion of staff costs charged to Title XIX administration is based on either caseload or expenditures for Title XIX services.

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

Rates do not vary by geographical location.
Community Engagement: Flat Fee
Peer Mentoring: Flat Fee

Person-Centered Plan Facilitation: Flat Fee
Nurse Delegation: Flat Fee set by legislature
Skilled Nursing: Flat Fee set by legislature
Supported Parenting: Flat Fee aligned with staff/family consultation

Assistive Technology, Specialized Clothing, 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 annually if rate comparisons indicate prevailing market rates have increased significantly (e.g., 20%+).

Community Engagement, Peer Mentoring, Person Centered Plan Facilitation: Rates are standardized & state-wide based on the skills required. Rates will be adjusted as necessary based on the demand for the services, availability of providers, & adjustments in rates made to providers of services that require similar skill levels. Rate changes may be initiated by providers or by DDA. DDA will review the adequacy of the rates annually using rate comparisons. Rates will be changed if current rates will result in providers terminating their contracts & rate comparisons indicate IFs Waiver payment rates are at least 20% less than those for individuals with comparable skills.

Extended State Plan Services (Occupational Therapy, Physical Therapy and Speech, Hearing & Language Services): These services are paid via ProviderOne, Washington State's approved MMIS. These rates are established by the HCA & are updated every January with any possible new codes, & rates are changed every July to align with new RVUs, State GPCI, and State specific conversion factor. The most recent update was in July 2023, and are reviewed every July.

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 2023.
Waiver services rates have been reviewed in the last five years on varying schedules. Residential habilitation provider rates were last reviewed and many rebased in 2019, assistive technology, specialized equipment and supplies, environmental adaptations, nursing, person centered plan facilitation, staff/family consultation, supported parenting, respite, and community engagement rates were reviewed and rebased when appropriate, in 2021/2022, and peer mentoring, specialized habilitation, music and equine therapy, and risk assessment were reviewed in 2022 for potential rebasing, and determined not necessary in 2023; the State will review rates again in 2024/2025 for possible rebasing.
Service rates are not determined geographically.
Continued 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 CARE includes a Waiver Screen that contains the type of waiver an individual is on, the waiver begin date, and waiver end date (if any). A waiver effective date for the individual is entered into the Waiver Screen by CARE once the necessary waiver eligibility confirmation steps have been completed. These include verification of the need for ICF/IID Level of Care (LOC) and financial eligibility (as established by financial workers in the Long Term Care & Specialty Programs Unit within DDA), documentation of Voluntary Participation statement (Form #10-424), verification of disability per criteria established in the SSA, and completion of an Person-Centered Service Plan (PCSP). CARE enters a waiver effective date based on the effective date of the person-centered service plan (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 outlined above are complete. Should a waiver RAC be assigned but a participant has a lost of financial eligibility during the coverage period, ProviderOne will post edits.

The usual MMIS edits will be applied to billings under the IFS Waiver. I.e., the following will be verified: the individual is on the IFS Waiver, the service is covered under the IFS Waiver, the provider is a valid provider of the service, the provider is a qualified provider with a current contract, and the specifics of the claim are consistent with the service authorization completed by the DDA case resource manager.

b.) Service was included in the participant's approved person-centered service plan to assure the pre-payment process for validating provider billings. PCSPs are updated as needed and at least annually (please see Appendix H-1.b.3 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 IFS Waiver are contained in the approved PCSP.

c.) The services were provided.

Monitoring of the provision of services is outlined in Appendix H-1-b-4. Steps taken include:

• QCC file reviews verify the authorization matches the 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.

Services provided in state operated settings are not billed through the MMIS. These State-operated services have the same assurances of validation as
State-contracted services paid through the MMIS:

- *The person is enrolled and meets eligibility requirements for the waiver program on the date of service.*
- *The service type, scope, amount, duration and frequency are identified in the approved service plan.*
- *There is documentation of the service and the state operated setting meets certification, licensing, training and other requirements.*
- *Individuals receiving waiver services in state operated settings receive case management visits at least annually or when there is a significant change.*

The state's CARE system compiles the information for the essential tests along with residence leave to settings such as hospitals or nursing facilities to identify dates of service that are eligible to claim match and are reconciled monthly prior to claim of match.

The state adjusts FFP whenever an incorrect billing is identified. This is done by adjusting the claim in MMIS. The state adjusts billings when reconciliations reveal a change in status or eligibility of a client. The state also adjusts billings when reconciliations reveal inappropriate billings (duplicate billings, billings for non-waiver services, etc.) and removes them from claims for FFP.

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.

Continued at Main.A.Attachment #2

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.

Services provided in state operated settings are not billed through the MMIS. These State-operated services have the same assurances of validation as State-contracted services paid through the MMIS:
• The person is enrolled and meets eligibility requirements for the waiver program on the date of service.
• The service type, scope, amount, duration, and frequency are identified in the approved service plan.
• There is documentation of the service, and the state operated setting meets certification, licensing, training, and other requirements.
• Individuals receiving waiver services in state operated settings receive case management visits at least annually or when there is a significant change.

The State is a limited fiscal agent for waiver services performed by 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. Service authorizations for waiver services performed by state employees are processed and documented through the CARE system's person-centered service plan in the same manner as all other waiver services.

○ ***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:

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.

The State is a limited fiscal agent for waiver services performed by 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. Service authorizations for waiver services performed by state employees are processed and documented through the CARE system's person-centered service plan in the same manner as all other waiver services.

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care

entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

- ◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ◉ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ○ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

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:

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

- ○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***

○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

◉ ***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 Financial Participation (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 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 DDA's home and community-based services IFS Waiver).

Adult Residential Care Facility
The basic rate for adult residential care 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 DDA's home and community-based services IFS Waiver).

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***

○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

☐ ***Nominal deductible***

☐ ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***

○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1		17535.00	17535.00	356491.00	2900.00	359391.00	341856.00
2		18590.00	18590.00	413807.00	2819.00	416626.00	398036.00
3		19645.00	19645.00	471124.00	2737.00	473861.00	454216.00
4		20700.00	20700.00	528441.00	2655.00	531096.00	510396.00
5		21755.00	21755.00	585758.00	2574.00	588332.00	566577.00

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	9000	9000
Year 2	9000	9000
Year 3	9000	9000
Year 4	9000	9000
Year 5	9000	9000

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 = 33.29X + 150.59 from ALOSs of accepted CMS 372 reports for 2016-2017 through 2020-2021(154.7, 241.1, 271.4, 286.8, and 298.3) to project ALOS for WY1 of 284, WY2 of 317 and WY3-WY5 of 350.

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:*

Regression formulas based on IFS participant counts and service expenditures in accepted IFS CMS 372 reports from waiver years 2015-2016 through 2020-2021 were used to project base participant counts and base expenditures for WY1-5 in the renewal for the following services:

- *Respite –*
  - *Count Regression: Y = 454.48571X + 999.46667*
  - *Expenditures Regression: Y = 1125422.11429X + 612900.93333*
- *Community Engagement –*
  - *Count Regression: Y = 14.82857X + 9.26667*
  - *Expenditures Regression: Y = 15881.85714 + 2736.33333*
- *Environmental Adaptations –*
  - *Count Regression: Y = 6.2X + 0.8*
  - *Expenditures Regression: Y = 37906.54286X + 44250.4*
- *Specialized Equipment & Supplies –*
  - *Count Regression: Y = 222.42857X – 342*
  - *Expenditures Regression: Y = 135233X – 217793*
- *Transportation –*
  - *Count Regression: Y = 8.62857X + 14.46667*
  - *Expenditures Regression: Y = 1774.91429X + 1395.8*
- *Wellness Education –*
  - *Count Regression: Y = 945.74286X + 29.73333*
  - *Expenditures Regression: Y = 25155.17143X – 21709.6*
- *Assistive Technology –*
  - *Count Regression: Y = 32.85714X – 2.33333*
  - *Expenditures Regression: Y = 18790.17143X + 5163.4*

Unit costs for services estimated using regression formulas are based on WY5 values from the previous waiver cycle and are not inflated due to the latest CPI-M index trends (downward - reference at the end of this section). Units of service are calculated as a "plug" value with unit costs from WY5 values, and participant counts and total expenditures being givens from the regression formulas.

Additional DCYF participant counts and expenditures are added to the services base counts and base expenditures for the projected 595 additional DCYF participants (distribution of projected DCYF enrollees by waiver was derived by calculating the distribution of all current waiver clients age 20 and younger by waiver as a percentage of all waiver enrollees age 20 and younger across all waivers (data from WY2)) added in WY1 for services projected using the regression methodology above and for services using the annual percentage increase below. Additional participant counts and expenditures are derived from the percentage distribution of waiver services in WY5 of the previous waiver cycle (for example, 58.2% of waiver participants utilized respite; therefore 58.2% X 595 additional DCYF participants = 346 participants who will likely utilize respite in WY1). The following services added the following projected DCYF participant counts in WY1:

- *Respite 346*
- *Community Engagement 12*
- *Environmental Adaptations 3*
- *Specialized Equipment & Supplies 21*
- *Staff/Family Consultation 2*
- *Transportation 6*
- *Wellness Education 414*
- *Assistive Technology 14*
- *Specialized Habilitation 3*
- *Specialized Clothing 2*
- *Person-Centered Plan Facilitation 1*
- *Stabilization Services – Specialized Habilitation 1*
- *Stabilization Services – Staff/Family Consultation 1*

The services not using the regression methodology are projected to experience 3% annual count increases from the base counts in WY5 of the previous waiver cycle based on the professional judgement of State staff. The State relies on the professional judgement of staff with over ten years of experience writing over 102 approved waiver amendment and renewal applications for Washington State's five developmental disability 1915(c) waivers. Professional judgement is seasoned by preparing ten years of CMS 372 reports with data from Washington State's MMIS. Because CPI-M data for the most recent year (June 2022 – May 2023) shows a 4.3% decrease in this index, service unit costs are projected with no increases for WY1-5. Units of service will be based on units of

service in WY5 of the previous waiver cycle. Modifying the transportation service definition will likely increase users and units of service to meet the level of currently projected users and units of service as current actual number of users and units of service are below projected numbers.
The State notes that the increases in utilization for Staff/Family Consultation Services are based on two components as explained in J-2-c-I; the first component is the base count from WY5 of the previous waiver cycle that increases at a 3% rate each waiver year; and the second component is the projected increase based on DCYF children and youth which for this service is 2 participants added in WY1.
U.S. Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers: Medical Care Services in U.S. City Average [CUSR0000SAM2], retrieved from FRED, Federal Reserve Bank of St. Louis, June 27, 2023.

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 = 1055X + 13315.2 from actual Factor D' of waiver years 2016-2017 through 2020-2021 from accepted CMS 372 reports ($14,861, $17,066, $17,727, $8,156, and $24,591) to project Factor D' for WY1 of $17,535, WY2 of $18,590, WY3 of $19,645, WY4 of $20,700, and WY5 of $21,755. Projected Factor D' includes managed care premiums, fee for services expenditures and Community First Choice expenditures.

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 = 57316.81X + 127223.324 from actual Factor G of waiver years 2016-2017 through 2020-2021 from the State's MMIS ($213,746.61, $231,327.94, $271,684.78, $326,229.62, and $452,879.82) to project Factor G for WY1 of $356,491, WY2 of $413,807, WY3 of $471,124, WY4 of $528,441 and WY5 of $585,758.

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 = -81.56X + 3226.298 from actual Factor G' of waiver years 2016-2017 through 2020-2021 from the State's MMIS ($2,876.72, $3,213.85, $3,489.89, $2,503.57, and $2,824.06) to project Factor G' for WY1 of $2,900, WY2 of $2,819, WY3 of $2,737, WY4 of $2,655, and WY5 of $2,574.

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	
Respite	
Occupational Therapy	
Physical Therapy	
Speech, Hearing and Language Services	
Assistive Technology	
Community Engagement	
Environmental Adaptations	
Nurse Delegation	
Peer Mentoring	
Person-Centered Plan Facilitation	
Remote Supports	
Risk Assessment	

Waiver Services	
Sexual Health Therapy	
Skilled Nursing	
Specialized Clothing	
Specialized Equipment and Supplies	
Specialized Habilitation	
Stabilization Services - Crisis Diversion Bed	
Stabilization Services - Specialized Habilitation	
Stabilization Services - Staff/Family Consultation	
Staff/Family Consultation	
Supported Parenting	
Therapeutic Adaptations	
Transportation	
Vehicle Modifications	
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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							**5701436.16**
Respite	☐	Hour	3140	57.90	31.36	**5701436.16**	
Occupational Therapy Total:							**149.01**
Occupational Therapy	☐	Hour	1	1.30	114.62	**149.01**	
Physical Therapy Total:							**149.01**
Physical Therapy	☐	Hour	1	1.30	114.62	**149.01**	
Speech, Hearing and Language Services Total:							**149.01**
Speech, Hearing and	☐					**149.01**	

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	6979333.73
Total Estimated Unduplicated Participants:	**9000**
Factor D (Divide total by number of participants):	
Services included in capitation:	
Services not included in capitation:	775.48
Average Length of Stay on the Waiver:	284

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Language Services		Hour	1	1.30	114.62		
Assistive Technology Total:							**93587.09**
Assistive Technology	☐	Each	142	0.80	823.83	**93587.09**	
Community Engagement Total:							**76782.00**
Community Engagement	☐	Hour	80	33.50	28.65	**76782.00**	
Environmental Adaptations Total:							**214728.01**
Environmental Adaptations	☐	Each	29	1.90	3897.06	**214728.01**	
Nurse Delegation Total:							**270.14**
Nurse Delegation	☐	Hour	1	5.20	51.95	**270.14**	
Peer Mentoring Total:							**476.74**
Peer Mentoring	☐	Hour	8	2.60	22.92	**476.74**	
Person-Centered Plan Facilitation Total:							**17326.06**
Person-Centered Plan Facilitation	☐	Hour	19	11.70	77.94	**17326.06**	
Remote Supports Total:							**34962.24**
Remote Supports	☐	Hour	4	922.00	9.48	**34962.24**	
Risk Assessment Total:							**2304.13**
Risk Assessment	☐	Each	1	1.30	1772.41	**2304.13**	
Sexual Health Therapy Total:							
Sexual Health Therapy	☐						
Skilled Nursing Total:							**4229.94**
Skilled Nursing	☐	Hour	2	55.25	38.28	**4229.94**	
Specialized Clothing Total:							**8591.56**

	GRAND TOTAL:	
	Total: Services included in capitation:	
	Total: Services not included in capitation:	*6979333.73*
	Total Estimated Unduplicated Participants:	***9000***
	Factor D (Divide total by number of participants):	
	Services included in capitation:	
	Services not included in capitation:	*775.48*
	Average Length of Stay on the Waiver:	*284*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Clothing	☐	Each	31	1.30	213.19	8591.56	
Specialized Equipment and Supplies Total:							337956.38
Specialized Equipment and Supplies	☐	Each	567	0.90	662.27	337956.38	
Specialized Habilitation Total:							96621.12
Specialized Habilitation	☐	Hour	53	25.32	72.00	96621.12	
Stabilization Services - Crisis Diversion Bed Total:							113535.63
Stabilization Services - Crisis Diversion Bed	☐	Day	3	39.00	970.39	113535.63	
Stabilization Services - Specialized Habilitation Total:							18686.88
Stabilization Services - Specialized Habilitation	☐	Hour	19	13.66	72.00	18686.88	
Stabilization Services - Staff/Family Consultation Total:							30602.16
Stabilization Services - Staff/Family Consultation	☐	Hour	19	22.37	72.00	30602.16	
Staff/Family Consultation Total:							56419.20
Staff/Family Consultation	☐	Hour	30	26.12	72.00	56419.20	
Supported Parenting Total:							1668.94
Supported Parenting	☐	Hour	2	9.10	91.70	1668.94	
Therapeutic Adaptations Total:							14400.80
Therapeutic Adaptations	☐	Each	1	1.30	11077.54	14400.80	

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	6979333.73
Total Estimated Unduplicated Participants:	9000
Factor D (Divide total by number of participants):	
Services included in capitation:	
Services not included in capitation:	775.48
Average Length of Stay on the Waiver:	284

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation Total:							**9533.26**
Transportation	☐	Mile	55	254.90	0.68	**9533.26**	
Vehicle Modifications Total:							**13142.22**
Vehicle Modifications	☐	Each	6	1.30	1684.90	**13142.22**	
Wellness Education Total:							**131626.05**
Wellness Education	☐	Month	4199	8.10	3.87	**131626.05**	

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	6979333.73
Total Estimated Unduplicated Participants:	**9000**
Factor D (Divide total by number of participants):	
Services included in capitation:	
Services not included in capitation:	775.48
Average Length of Stay on the Waiver:	284

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
Respite Total:							**6854543.36**
Respite	☐	Hour	3595	60.80	31.36	**6854543.36**	
Occupational Therapy Total:							**149.01**
Occupational Therapy	☐	Hour	1	1.30	114.62	**149.01**	
Physical Therapy Total:							**149.01**
Physical Therapy	☐	Hour				**149.01**	

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	8383116.65
Total Estimated Unduplicated Participants:	**9000**
Factor D (Divide total by number of participants):	
Services included in capitation:	
Services not included in capitation:	931.46
Average Length of Stay on the Waiver:	317

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			1	1.30	114.62		
Speech, Hearing and Language Services Total:							**149.01**
Speech, Hearing and Language Services	☐	Hour	1	1.30	114.62	**149.01**	
Assistive Technology Total:							**100919.18**
Assistive Technology	☐	Each	175	0.70	823.83	**100919.18**	
Community Engagement Total:							**92911.95**
Community Engagement	☐	Hour	94	34.50	28.65	**92911.95**	
Environmental Adaptations Total:							**259154.49**
Environmental Adaptations	☐	Each	35	1.90	3897.06	**259154.49**	
Nurse Delegation Total:							**270.14**
Nurse Delegation	☐	Hour	1	5.20	51.95	**270.14**	
Peer Mentoring Total:							**476.74**
Peer Mentoring	☐	Hour	8	2.60	22.92	**476.74**	
Person-Centered Plan Facilitation Total:							**18237.96**
Person-Centered Plan Facilitation	☐	Hour	20	11.70	77.94	**18237.96**	
Remote Supports Total:							**34962.24**
Remote Supports	☐	Hour	4	922.00	9.48	**34962.24**	
Risk Assessment Total:							**2304.13**
Risk Assessment	☐	Each	1	1.30	1772.41	**2304.13**	
Sexual Health Therapy Total:							
Sexual Health Therapy	☐						

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	*8383116.65*
Total Estimated Unduplicated Participants:	**9000**
Factor D (Divide total by number of participants):	
Services included in capitation:	
Services not included in capitation:	*931.46*
Average Length of Stay on the Waiver:	317

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Skilled Nursing Total:							**4229.94**
Skilled Nursing	☐	Hour	2	55.25	38.28	**4229.94**	
Specialized Clothing Total:							**8868.70**
Specialized Clothing	☐	Each	32	1.30	213.19	**8868.70**	
Specialized Equipment and Supplies Total:							**470277.93**
Specialized Equipment and Supplies	☐	Each	789	0.90	662.27	**470277.93**	
Specialized Habilitation Total:							**100267.20**
Specialized Habilitation	☐	Hour	55	25.32	72.00	**100267.20**	
Stabilization Services - Crisis Diversion Bed Total:							**113535.63**
Stabilization Services - Crisis Diversion Bed	☐	Day	3	39.00	970.39	**113535.63**	
Stabilization Services - Specialized Habilitation Total:							**19670.40**
Stabilization Services - Specialized Habilitation	☐	Hour	20	13.66	72.00	**19670.40**	
Stabilization Services - Staff/Family Consultation Total:							**32212.80**
Stabilization Services - Staff/Family Consultation	☐	Hour	20	22.37	72.00	**32212.80**	
Staff/Family Consultation Total:							**62061.12**
Staff/Family Consultation	☐	Hour	33	26.12	72.00	**62061.12**	
Supported Parenting Total:							**1668.94**
Supported Parenting	☐	Hour				**1668.94**	

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	8383116.65
Total Estimated Unduplicated Participants:	**9000**
Factor D (Divide total by number of participants):	
Services included in capitation:	
Services not included in capitation:	931.46
Average Length of Stay on the Waiver:	317

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			2	9.10	91.70		
Therapeutic Adaptations Total:							**14400.80**
Therapeutic Adaptations	☐	Each	1	1.30	11077.54	**14400.80**	
Transportation Total:							**11332.61**
Transportation	☐	Mile	64	260.40	0.68	**11332.61**	
Vehicle Modifications Total:							**13142.22**
Vehicle Modifications	☐	Each	6	1.30	1684.90	**13142.22**	
Wellness Education Total:							**167221.15**
Wellness Education	☐	Month	5144	8.40	3.87	**167221.15**	

GRAND TOTAL:		
Total: Services included in capitation:		
Total: Services not included in capitation:		8383116.65
Total Estimated Unduplicated Participants:		**9000**
Factor D (Divide total by number of participants):		
Services included in capitation:		
Services not included in capitation:		931.46
Average Length of Stay on the Waiver:	317	

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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							**7999528.32**
Respite	☐	Hour	4049	63.00	31.36	**7999528.32**	
Occupational							**149.01**

GRAND TOTAL:		
Total: Services included in capitation:		
Total: Services not included in capitation:		9765849.19
Total Estimated Unduplicated Participants:		**9000**
Factor D (Divide total by number of participants):		
Services included in capitation:		
Services not included in capitation:		1085.09
Average Length of Stay on the Waiver:	350	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Therapy Total:							
Occupational Therapy	☐	Hour	1	1.30	114.62	**149.01**	
Physical Therapy Total:							**149.01**
Physical Therapy	☐	Hour	1	1.30	114.62	**149.01**	
Speech, Hearing and Language Services Total:							**149.01**
Speech, Hearing and Language Services	☐	Hour	1	1.30	114.62	**149.01**	
Assistive Technology Total:							**119949.65**
Assistive Technology	☐	Each	208	0.70	823.83	**119949.65**	
Community Engagement Total:							**108987.46**
Community Engagement	☐	Hour	109	34.90	28.65	**108987.46**	
Environmental Adaptations Total:							**287603.03**
Environmental Adaptations	☐	Each	41	1.80	3897.06	**287603.03**	
Nurse Delegation Total:							**270.14**
Nurse Delegation	☐	Hour	1	5.20	51.95	**270.14**	
Peer Mentoring Total:							**476.74**
Peer Mentoring	☐	Hour	8	2.60	22.92	**476.74**	
Person-Centered Plan Facilitation Total:							**18237.96**
Person-Centered Plan Facilitation	☐	Hour	20	11.70	77.94	**18237.96**	
Remote Supports Total:							**34962.24**
Remote Supports	☐	Hour	4	922.00	9.48	**34962.24**	
Risk Assessment Total:							**2304.13**
Risk	☐					**2304.13**	

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	9765849.19
Total Estimated Unduplicated Participants:	**9000**
Factor D (Divide total by number of participants):	
Services included in capitation:	
Services not included in capitation:	1085.09
Average Length of Stay on the Waiver:	350

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assessment		Each	1	1.30	1772.41		
Sexual Health Therapy Total:							
Sexual Health Therapy	☐						
Skilled Nursing Total:							**4229.94**
Skilled Nursing	☐	Hour	2	55.25	38.28	**4229.94**	
Specialized Clothing Total:							**9145.85**
Specialized Clothing	☐	Each	33	1.30	213.19	**9145.85**	
Specialized Equipment and Supplies Total:							**603195.52**
Specialized Equipment and Supplies	☐	Each	1012	0.90	662.27	**603195.52**	
Specialized Habilitation Total:							**102009.60**
Specialized Habilitation	☐	Hour	56	25.30	72.00	**102009.60**	
Stabilization Services - Crisis Diversion Bed Total:							**113535.63**
Stabilization Services - Crisis Diversion Bed	☐	Day	3	39.00	970.39	**113535.63**	
Stabilization Services - Specialized Habilitation Total:							**19728.00**
Stabilization Services - Specialized Habilitation	☐	Hour	20	13.70	72.00	**19728.00**	
Stabilization Services - Staff/Family Consultation Total:							**32256.00**
Stabilization Services - Staff/Family Consultation	☐	Hour	20	22.40	72.00	**32256.00**	
Staff/Family Consultation Total:							**63941.76**

	GRAND TOTAL:	
	Total: Services included in capitation:	
	Total: Services not included in capitation:	*9765849.19*
	Total Estimated Unduplicated Participants:	***9000***
	Factor D (Divide total by number of participants):	
	Services included in capitation:	
	Services not included in capitation:	*1085.09*
	Average Length of Stay on the Waiver:	*350*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Staff/Family Consultation	☐	Hour	34	26.12	72.00	63941.76	
Supported Parenting Total:							1668.94
Supported Parenting	☐	Hour	2	9.10	91.70	1668.94	
Therapeutic Adaptations Total:							14400.80
Therapeutic Adaptations	☐	Each	1	1.30	11077.54	14400.80	
Transportation Total:							13140.86
Transportation	☐	Mile	72	268.40	0.68	13140.86	
Vehicle Modifications Total:							13142.22
Vehicle Modifications	☐	Each	6	1.30	1684.90	13142.22	
Wellness Education Total:							202687.38
Wellness Education	☐	Month	6090	8.60	3.87	202687.38	

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	9765849.19
Total Estimated Unduplicated Participants:	9000
Factor D (Divide total by number of participants):	
Services included in capitation:	
Services not included in capitation:	1085.09
Average Length of Stay on the Waiver:	350

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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	11176089.10
Total Estimated Unduplicated Participants:	9000
Factor D (Divide total by number of participants):	
Services included in capitation:	
Services not included in capitation:	1241.79
Average Length of Stay on the Waiver:	350

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							**9152704.51**
Respite	☐	Hour	4504	64.80	31.36	**9152704.51**	
Occupational Therapy Total:							**149.01**
Occupational Therapy	☐	Hour	1	1.30	114.62	**149.01**	
Physical Therapy Total:							**149.01**
Physical Therapy	☐	Hour	1	1.30	114.62	**149.01**	
Speech, Hearing and Language Services Total:							**149.01**
Speech, Hearing and Language Services	☐	Hour	1	1.30	114.62	**149.01**	
Assistive Technology Total:							**138980.12**
Assistive Technology	☐	Each	241	0.70	823.83	**138980.12**	
Community Engagement Total:							**125051.52**
Community Engagement	☐	Hour	124	35.20	28.65	**125051.52**	
Environmental Adaptations Total:							**329691.28**
Environmental Adaptations	☐	Each	47	1.80	3897.06	**329691.28**	
Nurse Delegation Total:							**270.14**
Nurse Delegation	☐	Hour	1	5.20	51.95	**270.14**	
Peer Mentoring Total:							**536.33**
Peer Mentoring	☐	Hour	9	2.60	22.92	**536.33**	
Person-Centered Plan Facilitation Total:							**19149.86**
Person-Centered Plan Facilitation	☐	Hour	21	11.70	77.94	**19149.86**	
Remote Supports Total:							**34962.24**

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	*11176089.10*
Total Estimated Unduplicated Participants:	**9000**
Factor D (Divide total by number of participants):	
Services included in capitation:	
Services not included in capitation:	*1241.79*
Average Length of Stay on the Waiver:	350

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Remote Supports	☐	Hour	4	922.00	9.48	34962.24	
Risk Assessment Total:							2304.13
Risk Assessment	☐	Each	1	1.30	1772.41	2304.13	
Sexual Health Therapy Total:							
Sexual Health Therapy	☐						
Skilled Nursing Total:							4233.77
Skilled Nursing	☐	Hour	2	55.30	38.28	4233.77	
Specialized Clothing Total:							9423.00
Specialized Clothing	☐	Each	34	1.30	213.19	9423.00	
Specialized Equipment and Supplies Total:							735517.06
Specialized Equipment and Supplies	☐	Each	1234	0.90	662.27	735517.06	
Specialized Habilitation Total:							105652.80
Specialized Habilitation	☐	Hour	58	25.30	72.00	105652.80	
Stabilization Services - Crisis Diversion Bed Total:							113535.63
Stabilization Services - Crisis Diversion Bed	☐	Day	3	39.00	970.39	113535.63	
Stabilization Services - Specialized Habilitation Total:							20714.40
Stabilization Services - Specialized Habilitation	☐	Hour	21	13.70	72.00	20714.40	
Stabilization Services - Staff/Family Consultation Total:							33868.80
Stabilization	☐					33868.80	

GRAND TOTAL:		
Total: Services included in capitation:		
Total: Services not included in capitation:		11176089.10
Total Estimated Unduplicated Participants:		9000
Factor D (Divide total by number of participants):		
Services included in capitation:		
Services not included in capitation:		1241.79
Average Length of Stay on the Waiver:	350	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services - Staff/Family Consultation		Hour	21	22.40	72.00		
Staff/Family Consultation Total:							**65822.40**
Staff/Family Consultation	☐	Hour	35	26.12	72.00	**65822.40**	
Supported Parenting Total:							**1668.94**
Supported Parenting	☐	Hour	2	9.10	91.70	**1668.94**	
Therapeutic Adaptations Total:							**14400.80**
Therapeutic Adaptations	☐	Each	1	1.30	11077.54	**14400.80**	
Transportation Total:							**14926.68**
Transportation	☐	Mile	81	271.00	0.68	**14926.68**	
Vehicle Modifications Total:							**15332.59**
Vehicle Modifications	☐	Each	7	1.30	1684.90	**15332.59**	
Wellness Education Total:							**236895.08**
Wellness Education	☐	Month	7036	8.70	3.87	**236895.08**	

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	11176089.10
Total Estimated Unduplicated Participants:	**9000**
Factor D (Divide total by number of participants):	
Services included in capitation:	
Services not included in capitation:	1241.79
Average Length of Stay on the Waiver:	350

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
Respite Total:							**10292966.66**
Respite	☐	Hour	4958	66.20	31.36	**10292966.66**	
Occupational Therapy Total:							**149.01**
Occupational Therapy	☐	Hour	1	1.30	114.62	**149.01**	
Physical Therapy Total:							**149.01**
Physical Therapy	☐	Hour	1	1.30	114.62	**149.01**	
Speech, Hearing and Language Services Total:							**149.01**
Speech, Hearing and Language Services	☐	Hour	1	1.30	114.62	**149.01**	
Assistive Technology Total:							**158010.59**
Assistive Technology	☐	Each	274	0.70	823.83	**158010.59**	
Community Engagement Total:							**140975.19**
Community Engagement	☐	Hour	139	35.40	28.65	**140975.19**	
Environmental Adaptations Total:							**371779.52**
Environmental Adaptations	☐	Each	53	1.80	3897.06	**371779.52**	
Nurse Delegation Total:							**270.14**
Nurse Delegation	☐	Hour	1	5.20	51.95	**270.14**	
Peer Mentoring Total:							**536.33**
Peer Mentoring	☐	Hour	9	2.60	22.92	**536.33**	
Person-Centered Plan Facilitation Total:							**19149.86**
Person-Centered Plan Facilitation	☐	Hour	21	11.70	77.94	**19149.86**	
Remote Supports Total:							**43702.80**

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	*12576957.58*
Total Estimated Unduplicated Participants:	***9000***
Factor D (Divide total by number of participants):	
Services included in capitation:	
Services not included in capitation:	*1397.44*
Average Length of Stay on the Waiver:	*350*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Remote Supports	☐	Hour	5	922.00	9.48	43702.80	
Risk Assessment Total:							2304.13
Risk Assessment	☐	Each	1	1.30	1772.41	2304.13	
Sexual Health Therapy Total:							
Sexual Health Therapy	☐						
Skilled Nursing Total:							4233.77
Skilled Nursing	☐	Hour	2	55.30	38.28	4233.77	
Specialized Clothing Total:							9700.15
Specialized Clothing	☐	Each	35	1.30	213.19	9700.14	
Specialized Equipment and Supplies Total:							867838.61
Specialized Equipment and Supplies	☐	Each	1456	0.90	662.27	867838.61	
Specialized Habilitation Total:							109296.00
Specialized Habilitation	☐	Hour	60	25.30	72.00	109296.00	
Stabilization Services - Crisis Diversion Bed Total:							113535.63
Stabilization Services - Crisis Diversion Bed	☐	Day	3	39.00	970.39	113535.63	
Stabilization Services - Specialized Habilitation Total:							20714.40
Stabilization Services - Specialized Habilitation	☐	Hour	21	13.70	72.00	20714.40	
Stabilization Services - Staff/Family Consultation Total:							33868.80
Stabilization	☐					33868.80	

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	12576957.58
Total Estimated Unduplicated Participants:	9000
Factor D (Divide total by number of participants):	
Services included in capitation:	
Services not included in capitation:	1397.44
Average Length of Stay on the Waiver:	350

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services - Staff/Family Consultation		*Hour*	*21*	*22.40*	*72.00*		
Staff/Family Consultation Total:							***67703.04***
Staff/Family Consultation	☐	*Hour*	*36*	*26.12*	*72.00*	***67703.04***	
Supported Parenting Total:							***1668.94***
Supported Parenting	☐	*Hour*	*2*	*9.10*	*91.70*	***1668.94***	
Therapeutic Adaptations Total:							***14400.80***
Therapeutic Adaptations	☐	*Each*	*1*	*1.30*	*11077.54*	***14400.80***	
Transportation Total:							***16721.68***
Transportation	☐	*Mile*	*89*	*276.30*	*0.68*	***16721.68***	
Vehicle Modifications Total:							***15332.59***
Vehicle Modifications	☐	*Each*	*7*	*1.30*	*1684.90*	***15332.59***	
Wellness Education Total:							***271800.94***
Wellness Education	☐	*Month*	*7981*	*8.80*	*3.87*	***271800.94***	

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	*12576957.58*
Total Estimated Unduplicated Participants:	***9000***
Factor D (Divide total by number of participants):	
Services included in capitation:	
Services not included in capitation:	*1397.44*
Average Length of Stay on the Waiver:	*350*