DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region 10
2201 Sixth Avenue, MS/RX 43
Seattle, Washington 98121

DEC 2 1 2009

Susan Dreyfus, Secretary
Department of Social and Health Services
Post Office Box 45010
Olympia, Washington 98504-5010

RE: Washington State Plan Amendment (SPA) Transmittal Number #09-019

Dear Ms. Dreyfus:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved State Plan Amendment (SPA) Transmittal Number #09-019 for the Washington Adult Day Health (section 1915(i) of the Social Security Act) home and community-based service (HBCS). The effective date of the amendment is January 1, 2010.

The SPA changes supplement 4 to Attachment 3.1-A, pages 1 through 25, and Supplement B to Attachment 4.1-B, page 1. These changes authorize the state to implement the optional 1915(i) State plan HBCS, by providing adult day health benefits for elderly and disabled individuals.

Upon publication of the final regulations concerning Section 1915(i) Washington would need to come into compliance with any requirements imposed by the final regulations not already met by the State.

The State has chosen the option to place the following limits on the number of eligible participants who can receive 1915(i) State plan Adult Day Health services:

Year	Unduplicated Participants
1	1769
2	1278
3	923
4	667
5	482

This approval is subject to your agreement to serve no more individuals than those indicated in this letter. If Washington wishes to serve more individuals or make any other alterations to this 1915(i) benefit, a SPA must be submitted for approval. The State assures that it will amend its State plan to increase the annual participant limit if the attrition rates for this program are not as high as anticipated, and would otherwise result in a participant enrollment count after year one that is higher than the annual limits.

CMS appreciates the efforts and cooperation of your staff during the review. If you have any questions please contact me or have your staff contact Lydia Skeen at (206) 615-2339 or Lydia.Skeen@cms.hhs.gov.

Sincerely,

Barbara K. Richards

Barbara K. Richards
Associate Regional Administrator
Division of Medicaid and Children's Health
Operations

cc:
Douglas Porter, Assistant Secretary, Health and Recovery Services Administration
Chris Imhoff, Office Chief, Home and Community Based Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **09-019**

2. STATE: Washington

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
~~July 1, 2009~~ Jan. 1, 2010 (P&I)

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2009 $(946,081)
b. FFY 2010 $(3,723,407)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supplement 4 to Attachment 3.1-A pages 1 through ~~23~~ 25 (P+I)
Supplement B to Attachment 4.19-B page 1 26 (P&I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

~~Supplement 4 to Attachment 3.1-A pages 1 through 23~~ (P+I)
~~Supplement B to Attachment 4.19-B page 1~~ (P+I)

10. SUBJECT OF AMENDMENT:

Adult Day Health

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Exempt

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Susan N Dreyfus

13. TYPED NAME:
Susan N. Dreyfus

14. TITLE:
Secretary

15. DATE SUBMITTED: 6/18/09

16. RETURN TO:
Ann Myers
Department of Social and Health Services
Health and Recovery Services Administration
POB 5504
Olympia, WA 98504-5504

(MS: 45504)

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: JUN 18 2009

18. DATE APPROVED: DEC 21 2009

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:
Barbara K. Richards

21. TYPED NAME: BARBARA K. RICHARDS

22. TITLE: Associate Regional Administrator
Division of Medicaid &
Children's Health

23. REMARKS:

P&I changes authorized by the State on 6/22/09.
P&I changes authorized by the State on 8/27/09.
P&I changes authorized by the State on 12/02/09.
P&I changes authorized by the State on 12/09/09.

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates)*:

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
X	HCBS Adult Day Health
	The department reimburses Adult Day Health providers at a flat fee, per-day-per-client rate for all services rendered. Payment will not exceed the prevailing charges in the locality for comparable services under comparable conditions. The agency's rates were set as of 01/01/2010 and are effective for services on or after that date. All rates are published on the agency's website. The fee schedule and any annual/periodic adjustments to the fee schedule are published in annual Management Bulletins available to the public on the ADSA website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of adult day health services.
☐	HCBS Habilitation
☐	HCBS Respite Care

For Individuals with Chronic Mental Illness, the following services:

☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Psychosocial Rehabilitation
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

1915(i) State Plan Home and Community Based Services Administration and Operation

The State implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below.

1. Services. *(Specify service title(s) for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Adult Day Health

2. State wideness. *(Select one)*:

X	The State implements the 1915(i) State plan HCBS benefit statewide, per §1902(a)(1) of the Act.
O	The State implements this benefit without regard to the state wideness requirements in §1902(a)(1) of the Act. State plan HCBS will only be available to individuals who reside in the following geographic areas or political subdivisions of the State. *(Specify the areas to which this option applies)*:

3 State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one)*:

X	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	O	The Medical Assistance Unit *(name of unit)*:	
	x	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
		(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	Aging and Disability Services Administration
O	The State plan HCBS benefit is operated by *(name of agency)*		
	a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

4. Distribution of State plan HCBS Operational and Administrative Functions

X *(By checking this box the State assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☐	☐	☑
2 State plan HCBS enrollment managed against approved limits, if any	☑	☐	☐	☐
3 Eligibility evaluation	☑	☐	☐	☑
4 Review of participant service plans	☑	☐	☐	☑
5 Prior authorization of State plan HCBS	☑	☐	☐	☑
6 Utilization management	☑	☐	☐	☐
7 Qualified provider enrollment	☑	☐	☐	☐
8 Execution of Medicaid provider agreement	☑	☐	☐	☐
9 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☐	☐
10 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☐	☐	☐
11 Quality assurance and quality improvement activities	☑	☐	☐	☑

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

4. Distribution of State plan HCBS Operational and Administrative Functions (cont)

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

The Medicaid agency contracts with Area Agencies on Aging (AAAs) to perform the operational and administrative functions at the local level that are listed in the preceding table. In all cases, the Medicaid agency has a contract that sets forth the responsibilities and performance requirements of the AAA. The contract is available through the Medicaid agency.

(By checking the following boxes the State assures that):

5. X **Conflict of Interest Standards.** The State assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the State, when such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement):*

6. X **Fair Hearings and Appeals.** The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. X **No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. X **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NUMBER SERVED

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	January 1, 2010	December 31, 2010	1,769
Year 2			
Year 3			
Year 4			
Year 5			

2. X **Annual Reporting.** *(By checking this box the State agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

3. **Optional Annual Limit on Number Served.** *(Select one):*

O	The State does not limit the number of individuals served during the year or at any one time. **Skip to item #5.**
X	The State chooses to limit the number of *(check each that applies):*

	X	Unduplicated individuals served during the year. *(Specify in column **A** below):*
	☐	Individuals served at any one time ("slots"). *(Specify in column **B** below):*

	Annual Period	From	To	A	B
				Maximum Number served annually *(Specify):*	Maximum Number served at any one time *(Specify):*
	Year 1	1/1/10	12/31/10	1769	
	Year 2	1/1/11	12/31/11	1278	
	Year 3	1/1/12	12/31/12	923	
	Year 4	1/1/13	12/31/13	667	
	Year 5	1/1/14	12/31/14	482	
☐	The State chooses to further schedule limits within the above annual period(s). *(Specify):*				

4. **Waiting List.** *(Select one only if the State has chosen to implement an optional annual limit on the number served):*

O	The State will not maintain a waiting list.
X	The State will maintain a single list for entrance to the State plan HCBS benefit. State-established selection policies: are based on objective criteria; meet requirements of the Americans with Disabilities Act and all Medicaid regulations; and ensure that only individuals enrolled in the State plan HCBS benefit receive State plan HCBS once they leave/are taken off of the waiting list.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

FINANCIAL ELIGIBILITY

1. X **Income Limits.** *(By checking this box the State assures that):* Individuals receiving State plan HCBS are in aneligibility group covered under the State's Medicaid State plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL). Individuals with incomes up to 150% of the FPL who are only eligible for Medicaid because they are receiving 1915(c) waiver services may be eligible to receive services under 1915(i) provided they meet all other requirements of the 1915(i) State plan option. The State has a process in place that identifies individuals who have income that does not exceed 150% of the FPL.

2. **Medically Needy.** ***(Select one):***

X	The State does not provide State plan HCBS to the medically needy.	
O	The State provides State plan HCBS to the medically needy *(select one):*	
	O	The State elects to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
	O	The State does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III).

NEEDS BASED EVALLUATION/REEVALUATION

1. **Responsibility for Performing Evaluations / Reevaluations.** Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*select one*):

X	Directly by the Medicaid agency
X	By Other (*specify State agency or entity with contract with the Medicaid/State agency*):
	Revaluations may also be conducted by case managers from Area Agencies on Aging

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Needs Based Evaluation/Reevaluation (cont)

2. Qualifications of Individuals Performing Evaluation/Reevaluation. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

In addition to meeting the following minimum qualifications, staff must pass a background check prior to being hired and receive mandatory training prior to completing any evaluations.

Evaluations are performed by case managers who can be a Registered Nurse (licensed in the State), a Social Worker or a Case Resource Manager.

For Social Workers, minimum qualifications are as follows:
A Master's degree in social services, human services, behavioral sciences, or an allied field and two years of paid social service experience equivalent to a Social Worker 2.

OR

A Bachelor's degree in social services, human services, behavioral sciences, or an allied field, and three years of paid social service experience performing functions equivalent to a Social Worker 2.
NOTE: A two year Master's degree in one of the above fields that included a practicum will be substituted for one year of paid social service experience.
NOTE: Employees must successfully complete the formal training course sponsored by their division within one year of their appointment.
NOTE: Equivalent social service experience would include the previous classes of Caseworker 3 or higher.

OR

For current employees the following experience qualifies for promotion to a Social Worker 3: A Bachelor's degree and three years of experience as a Caseworker 3, Social Worker 1A or B, Social Worker 2, Casework Supervisor Trainee, Casework Supervisor, Juvenile Rehabilitation Supervisor 1 or 2, or Juvenile Rehabilitation Counselor 2 in State service.

For Case/Resource Manager minimum qualifications are as follows:

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

Job classification descriptions are available from the Medicaid agency.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Needs Based Evaluation/Reevaluation (cont)

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

Case managers complete Level of Care evaluations using the automated assessment tool (CARE). CARE is used for both initial evaluations and re-evaluations. The re-evaluation process does not differ from the initial evaluation process. Evaluations are completed initially, at annual review, and when a significant change occurs.

Information about the person's support needs is obtained via a face to face interview. Evaluators also obtain and verify information by collateral contacts with formal and informal supports including physicians, home health agencies, caregivers and family.

The CARE assessment collects information pertaining to participant eligibility for HCBS including the need for skilled nursing or rehabilitative therapy and the need for assistance with personal care. Based on this evaluation, case managers determine eligibility for HCBS.

4. X **Needs-based HCBS Eligibility Criteria.** *(By checking this box the State assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs and capabilities and may take into account the individual's ability to perform two or more ADLs, the need for assistance, and other risk factors: *(Specify the needs-based criteria):*

To be eligible for State plan HCBS an individual must:

1. Be assessed as having an unmet need for skilled nursing or skilled rehabilitative therapy; and
   a. There is a reasonable expectation that these services will improve, restore or maintain health status, or in the case of a progressive disabling condition, will either restore or slow the decline of health and functional status or ease related pain or suffering; and
   b. Be at risk for deteriorating health, deteriorating functional ability, or institutionalization; and
   c. Have a chronic or acute health condition that you are not able to safely manage due to a cognitive, physical, or other functional impairment.

   and

2. Be assessed to have a need for assistance demonstrated by:
   a. The need for assistance with three ADLs, one of which may be body care (application of lotions/ointments, toenails trimmed, dry bandage changes, or passive range of motion). Or
   b. Hands on assistance with one ADL which may include body care (application of lotions/ointments, toenails trimmed, dry bandage changes, or passive range of motion).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Needs Based Evaluation/Reevaluation (cont)

5. X **Needs-based Institutional and Waiver Criteria.** *(By checking this box the State assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the State has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	**NF (& NF LOC waivers)**	**ICF/MR (& ICF/MR LOC waivers)**	**Applicable Hospital* LOC (& Hospital LOC waivers)**
To be eligible for State plan HCBS an individual must: 1. Be assessed as having an unmet need for skilled nursing or skilled rehabilitative therapy; and a. There is a reasonable expectation that these services will improve, restore or maintain health status, or in the case of a progressive disabling condition, will either restore or slow the decline of health and functional status or ease related pain or suffering; and b. Be at risk for deteriorating health, deteriorating functional ability, or institutionalization; and c. Have a chronic or acute health condition that you are not able to safely manage due to a cognitive, physical, or other functional impairment. And	Functional criteria for NFLOC mean one of the following applies. The individual: Needs daily care provided by a nurse. or Needs assistance with three Activities of Daily Living (does not include body care or turning and repositioning). or Needs hands on assistance with 2 ADLs which may include turning and repositioning. or Has a cognitive impairment and needs hands on assistance with 1 ADL which may include turning and repositioning	DDD determines eligibility for ICF/MR level of care when an individual is assessed in the CARE tool as: (1) At age birth through five years old the total of level of care score is five or more; or (2) At age six through fifteen years old the total of level of care score is seven or more. (3)At age sixteen or older, eligibility for ICF/MR level of care requires that scores meet at least one of the following: (a) a percentile rank that is over nine percent for three or more of the six subscales in the Support Intensity Scale (SIS) support needs scale; (b) a percentile rank that is over twenty-five percent for two or more of the six subscales in the SIS support needs scale;	Washington State does not have a Long Term Care/Chronic Care hospital equivalent. *Long Term Care/Chronic Care Hospital

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

5. Needs-Based/Level of Care (LOC) Criteria (cont)

State plan HCBS needs-based eligibility criteria	**NF (& NF LOC waivers)**	**ICF/MR (& ICF/MR LOC waivers)**	**Applicable Hospital* LOC (& Hospital LOC waivers)**
2. Be assessed to have a need for assistance demonstrated by: a. The need for assistance with three ADLs, one of which may be body care (application of lotions/ointments, toenails trimmed, dry bandage changes, or passive range of motion). Or b. Hands on assistance with one ADL which may include body care (application of lotions/ointments, toenails trimmed, dry bandage changes, or passive range of motion).		(c) a percentile rank that is over fifty percent in at least one of the six subscales in the SIS support needs scale; (d) a support score of one or two for any of the questions listed in the SIS exceptional medical support needs scale; (e) a support score of one or two for at least one of the following items in the SIS exceptional behavior support needs scale: (i) Prevention of assaults or injuries to others; (ii) Prevention of property destruction (e.g., fire setting, breaking furniture); (iii) Prevention of self-injury; (iv) Prevention of PICA (ingestion of inedible substances); (v) Prevention of suicide attempts; (vi) Prevention of sexual aggression; or (vii) Prevention of wandering. (f) a support score of two for any of the questions listed in the SIS exceptional behavior support needs scale; or (g) meet or exceed any of the qualifying scores for one or more of the selected SIS questions	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Needs Based Evaluation/Reevaluation (cont)

(By checking the following boxes the State assures that):

6. X **Reevaluation Schedule**. Needs-based eligibility reevaluations are conducted at least every twelve months.

7. X **Adjustment Authority**. The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

8. X **Residence in home or community**. The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. *(Specify any residential settings, other than an individual's home or apartment, in which residents who will be furnished State plan HCBS may reside. Describe the criteria by which the State determines that these settings are not institutional in character such as privacy and unscheduled access to food, activities, visitors, and community pursuits outside the facility):*

In addition to living in private homes or apartments, participants may also choose to live in state licensed Adult Family Homes or Boarding Homes with contracts to provide Assisted Living, Adult Residential Care,or Enhanced Adult Residential Care.

Participants residing in these settings have visitors at times convenient to the participant and privacy for visitation is available. Participants have either private rooms or share a room with one other individual, except in Assisted Living settings where participants live in individual apartments. Participants have their own possessions, clothing, and personal items. Service settings are located with access to community resources and activities.

Washington's legislature has codified their intent that choice, participation, privacy, and the opportunity to engage in religious, political, recreational, and other social activities foster a sense of self-worth and enhance the quality of life for long-term care residents. In addition, the statue includes the intent that the resident has the right to a safe, clean, comfortable and homelike environment.

State statute requires that residents who choose to live in these settings be provided with, among others, the right to: choose activities, schedules, and health care consistent with his or her interests; assessments and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. These choices include unscheduled access to food and community activities. In all settings, residents have unrestricted access to food and snack items which they have purchased.

Participants have a choice of any Adult Family Home or Boarding Home with a contract to provide adult residential services. Participants who choose Assisted Living services live in private apartments. Adult Family Homes and Boarding Homes with contracts to provide Adult Residential Care or Enhanced Adult Residential Care offer rooms shared with one other individual or private rooms. When participants share a room, the participant receives notice before the participant's roommate in the facility is changed. A participant has the right to share a double room with his or her spouse or domestic partner when participants who are married to each other or in a domestic relationship with each other live in the same facility and both spouses or both domestic partners consent to the arrangement.

Residential settings are licensed through the State Residential Care Services Division. The State determines that these rights are respected and preserved through the licensing inspection process, which includes observations and interviews that determine compliance with licensing rules and related statutes. In addition to licensing inspections, the State investigates complaints from residents or the public, including those about possible resident rights violations and takes action to ensure that rights are not violated. The Residential Care Services Division handles issues related to roommate choices during inspections or complaint investigations and ensures that the facility addresses these issues to the satisfaction of the residents involved.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

PERSON CENTERED PLANNING AND SERVICE DELIVERY

(By checking the following boxes the State assures that):

1. X There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:

- An objective face-to-face evaluation by an independent agent trained in assessment of need for home and community-based services and supports;
- Consultation with the individual and others as appropriate;
- An examination of the individual's relevant history, medical records, care and support needs, and preferences;
- Objective evaluation of the inability to perform, or need for significant assistance to perform 2 or more ADLs (as defined in § 7702B(c)(2)(B) of the Internal Revenue Code of 1986); and
- Where applicable, an evaluation of the support needs of the individual (or the individual's representative) to participant-direct.
- A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.

2. X Based on the independent assessment, the individualized plan of care:

- Is developed by a person-centered process in consultation with the individual, the individual's: treating physician, health care or supporting professional, or other appropriate individuals, as defined by the State, and where appropriate the individual's family, caregiver, or representative;
- Identifies the State plan HCBS necessary for the individual, and furnishes (or, funds, if the individual elects to participant-direct the purchase of such services), all HCBS which the individual needs and for which the individual meets service-specific additional needs-based criteria (if any);
- Takes into account the extent of, and need for, any family or other supports for the individual;
- Prevents the provision of unnecessary or inappropriate care;
- Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
- Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Person Centered Planning and Service Delivery (cont)

3. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. *(Specify qualifications):*

In addition to meeting the following minimum qualifications, staff must pass a background check prior to being hired and receive mandatory training prior to completing any evaluations.

Evaluations are performed by case managers who can be a Registered Nurse (licensed in the State), a Social Worker or a Case Resource Manager.

For Social Workers, minimum qualifications are as follows:
A Master's degree in social services, human services, behavioral sciences, or an allied field and two years of paid social service experience equivalent to a Social Worker 2.

OR

A Bachelor's degree in social services, human services, behavioral sciences, or an allied field, and three years of paid social service experience performing functions equivalent to a Social Worker 2.
NOTE: A two year Master's degree in one of the above fields that included a practicum will be substituted for one year of paid social service experience.
NOTE: Employees must successfully complete the formal training course sponsored by their division within one year of their appointment.
NOTE: Equivalent social service experience would include the previous classes of Caseworker 3 or higher.

OR

For current employees the following experience qualifies for promotion to a Social Worker 3: A Bachelor's degree and three years of experience as a Caseworker 3, Social Worker 1A or B, Social Worker 2, Casework Supervisor Trainee, Casework Supervisor, Juvenile Rehabilitation Supervisor 1 or 2, or Juvenile Rehabilitation Counselor 2 in State service.

For Case/Resource Manager minimum qualifications are as follows:

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

Job classification descriptions are available from the Medicaid agency.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Person Centered Planning and Service Delivery (cont)

4. **Responsibility for Plan of Care Development**. There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. *(Specify qualifications):*

In addition to meeting the following minimum qualifications, staff must pass a background check prior to being hired and receive mandatory training prior to completing any evaluations.

Evaluations are performed by case managers who can be a Registered Nurse (licensed in the State), a Social Worker or a Case Resource Manager.

For Social Workers, minimum qualifications are as follows:
A Master's degree in social services, human services, behavioral sciences, or an allied field and two years of paid social service experience equivalent to a Social Worker 2.

OR

A Bachelor's degree in social services, human services, behavioral sciences, or an allied field, and three years of paid social service experience performing functions equivalent to a Social Worker 2.
NOTE: A two year Master's degree in one of the above fields that included a practicum will be substituted for one year of paid social service experience.
NOTE: Employees must successfully complete the formal training course sponsored by their division within one year of their appointment.
NOTE: Equivalent social service experience would include the previous classes of Caseworker 3 or higher.

OR

For current employees the following experience qualifies for promotion to a Social Worker 3: A Bachelor's degree and three years of experience as a Caseworker 3, Social Worker 1A or B, Social Worker 2, Casework Supervisor Trainee, Casework Supervisor, Juvenile Rehabilitation Supervisor 1 or 2, or Juvenile Rehabilitation Counselor 2 in State service.

For Case/Resource Manager minimum qualifications are as follows:

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

Job classification descriptions are available from the Medicaid agency.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Person Centered Planning and Service Delivery (cont)

5. **Supporting the Participant in Plan of Care Development**. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the plan of care development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

Service plan development always includes the participant and their legal representative (if applicable). Participants may include any other individuals of their choice to participate. ADSA encourages participants to include family and other informal supports as appropriate to the participant's situation.

At the time of assessment, case managers review the "Client's Rights and Responsibilities (DSHS 16-172)" document with participants. This document outlines their right to participate in the development of their plan of care and ensure that their preferences and the services they wish to receive are included in their plan of care.

The Client's Rights and Responsibilities form states:

If you are a client of Aging and Disability Services you have a right to:

- Be treated with dignity, respect and without discrimination;
- Not be abused, neglected, financially exploited, abandoned;
- Have your property treated with respect;
- Not answer questions, turn down services, and not accept case management services you do not want to receive. However, it may not be possible for Aging and Disability

Services Administration to offer some services if you do not give enough information;

- Be told about all services you can receive and make choices about services you want or don't want;
- Have information about you kept private within the limits of the laws and DSHS regulations;
- Be told in writing of agency decisions and receive a copy of your care plan;
- Not be forced to answer questions or do something you don't want to;
- Talk with your social service worker's supervisor if you and your social service worker do not agree;
- Request an Administrative hearing;
- Have interpreter services provided to you free of charge if you cannot speak or understand English well;
- Take part in and have your wishes included in planning your care;
- Choose, fire, or change a qualified provider you want; and
- Receive the results of the background check for any individual provider you choose.

Person Centered Planning and Service Delivery (cont)

6. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the plan of care):*

Participants are given free choice of all approved qualified providers of Adult Day Health. During the assessment and care planning process, case managers provide participants information about Adult Day Health Centers. Case Managers also provide assistance in locating providers. The case manager authorizes the service after the participant has chosen an ADH provider.

7. **Process for Making Plan of Care Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the plan of care is made subject to the approval of the Medicaid agency):*

ADSA is an administration within DSHS, the State Medicaid Agency. ADSA sets policy and provides oversight for the development of Plans of Care. All plans are developed using the approved assessment tool CARE (Comprehensive Assessment Report Evaluation).

ADSA determines participant eligibility and requires the use of the department's electronic assessment and service planning tool, CARE. ADSA case managers directly authorize all initial service plans. AAA case managers conduct reevaluations for participants served by Home and Community Services Division of ADSA. ADSA has direct electronic access to all service plans. ADSA Quality Units conduct quality assurance activities on all service plans.

ADSA has a comprehensive quality monitoring process, which begins with either an on-site or off-site file reviews. File reviews are conducted at 18 to 24 month intervals with preliminary data available annually. Reviews assess consumer satisfaction and the accuracy and quality of service plans. Inter-rater reliability reviews are conducted in the participant's home. Monitoring includes file reviews by staff assigned to state quality monitoring units. These reviews are conducted on a randomly selected and statistically valid sample of participant files with a confidence interval of +/- 5% and a confidence level of 95%.

The findings from all reviews are collected, analyzed and recorded. Findings must be resolved within 3 to 40 days. Corrections are monitored by the Quality Units and local regional management. Based on the analysis necessary steps are taken. Quality assurance processes may result in corrective actions, adjustments to training curriculum, policy clarifications, forms revision, revisions to Washington Administrative Code and targeting criteria for the next review cycle.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Person Centered Planning and Service Delivery (cont)

8. **Maintenance of Plan of Care Forms**. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

X	Medicaid agency	☐	Operating agency	☐	Case manager
X	Other *(specify):*	Local offices maintain written copies of service plans for three years. Electronic copies of the CARE assessment including the service plan are maintained by the Medicaid agency.			

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

SERVICES

1. State plan HCBS. *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Adult Day Health
Service Definition (Scope):	
Adult day health is a supervised daytime program providing nursing and rehabilitative therapy services to adults with medical or disabling conditions that require the intervention or services of a registered nurse, or a licensed speech therapist, occupational therapist or physical therapist acting under the supervision of the participant's physician when required. Services provided are specified in the participant's service plan and encompass both health and social services needed to ensure the optimal functioning of the participant. Transportation between the participant's place of residence and the adult day health site is included as a component of adult day health services and is reflected in the rate paid to adult day health providers.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*	
X	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Service Title: Adult Day Health (cont)

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Adult Day Health Centers		Certified under Washington Administrative code which defines Adult Day Health Center employee requirements. (WAC 388-71-0702 through 388-71-0826)	The Adult Day Health Center must have a Core provider agreement with State Medicaid Agency. Minimum staffing requirements for adult day health centers include an administrator, program director, registered nurse, activity coordinator, a PT/OT or speech therapist, and a social worker. The administrator and program director may be the same person. Employee qualifications are as follows: The program administrator must have a master's degree and one year of supervisory experience in health or social services (full-time equivalent), or a bachelor's degree and two years of supervisory experience in a social or health service setting. The degree may be in nursing. The program director must have a bachelor's degree in health, social services or a related field with one year of supervisory experience (full-time equivalent) in a social or health service setting. Upon approval by the department, a day health center may request an exception for an individual with an associate's or vocational degree in health, social services, or a related field with four years of experience in a health or social service setting, of which two years must be in a supervisory position. Therapists must have valid state credentials and one year of experience in a social or health setting. Rehabilitative therapeutic assistants must be certified with valid state credentials, have at least one year of applicable experience and meet all statutory requirements. A certified or registered nursing assistant must meet the requirements of RCW 18.88A.020.

Verification of Provider Qualifications *(For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Adult Day Health Centers	AAAs certify that all requirements outlined in Washington Administrative Code have been met.	Annually

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	X	Provider managed

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Services (cont

2. X Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians. *(By checking this box the State assures that):* There are policies pertaining to payment the State makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the State makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS ; (b) how the State ensures that the provision of services by such persons is in the best interest of the individual; (c) the State's strategies for ongoing monitoring of services provided by such persons; (d) the controls to ensure that payments are made only for services rendered; and (e) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

The State does not make payment to legally responsible individuals, other relatives or legal guardians for furnishing state plan HCBS.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

PARTICIPANT-DIRECTION OF SERVICES

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. *(Select one):*

X	The State does not offer opportunity for participant-direction of State plan HCBS.
O	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
O	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the State. *(Specify criteria):*

2. Description of Participant-Direction. *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

3. Limited Implementation of Participant-Direction. *(Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

O	Participant direction is available in all geographic areas in which State plan HCBS are available.
O	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the State. Individuals who reside in these areas may elect self-directed service delivery options offered by the State, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. *(Specify the areas of the State affected by this option)*:

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

5. Financial Management. *(Select one):*

O	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
O	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Participant-Direction of Services (cont)

6. O **Participant–Directed Plan of Care.** *(By checking this box the State assures that):* Based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Is directed by the individual or authorized representative and builds upon the individual's preferences and capacity to engage in activities that promote community life;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual or representative;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques.

7. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the State facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can hire and supervise staff). *(Select one):*

X	The State does not offer opportunity for participant-employer authority.	
O	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Participant-Direction of Services (cont)

8. b. Participant–Budget Authority (individual directs a budget). *(Select one):*

X	The State does not offer opportunity for participants to direct a budget.
O	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the plan of care):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards):*

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

QUALITY IMPROVEMENT STRATEGY

(Describe the State's quality improvement strategy in the tables below):

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Data Metrics)*	**Discovery Activity (Source of Data)**	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Monitoring Responsibilities** *(Who analyzes and aggregates remediation activities)*	**Frequency** *of Analysis and Aggregation*
Service plans address assessed needs of enrolled participants, are updated annually, and document choice of services and providers.	1. Quality Monitoring Units Monitoring reports 2. CARE Management Reports	1. Recipient Record Reviews 2. CARE administrative data	1. ADSA Quality Units 2. ADSA management and local offices	1. 18-24 month review cycle 2. Continuous and ongoing	1. ADSA Quality Monitoring Units. Findings must be resolved within 3 to 40 days. 2. ADSA management and Regional management	1. 18-24 month review cycle with preliminary data available annually 2. Monthly, quarterly, annually
Providers meet required qualifications.	Contract monitoring reports	Provider contract monitoring	AAA contract staff	Initially and annually	ADSA Program Manager for Adult Day Health. Findings must be resolved within 3 to 40 days.	Continuous and on-going
The SMA retains authority and responsibility for program operations and oversight.	Fiscal/contract Monitoring Reports	AAA contract monitoring	ADSA State Unit on Aging	1. Desk monitoring occurs monthly 2. On site monitoring occurs annually	ADSA SUA A Corrective Action Plan addressing all findings must be submitted within 45 days after the completion of monitoring activities.	1. Annually 2. 18 months

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Quality Improvement Strategy (cont)

	Discovery Activities (cont)				Remediation (cont)	
The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to enrolled participants by qualified providers.	1. ADSA Quality Monitoring Units monitoring reports 2 Medicaid social service payment system reports 3. Payment Review Process Reports	1. Record reviews 2. Medicaid social service payment system 3. Review of payment data	1. ADSA Quality Monitoring Units 2. Medicaid social service payment system 3. ADSA management and local offices	1. 18-24 month review cycle 2. Continuously and ongoing 3. Continuously and ongoing	1. ADSA Quality Units, local management. Findings must be resolved within 3 to 40 days. 2. Medicaid social service payment system 3. ADSA management	1. 18-24 month review cycle with preliminary data available annually 2. Monthly, Quarterly, Annually 3. Quarterly, Annually
The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	1. ADSA Quality Monitoring Units Monitoring Reports 2. APS QA monitoring reports 3. APS reports 4. DDD incident reports	1. Record Review 2. APS record review 3. APS administrative data 4. DDD incident reports/data	1. ADSA Quality Monitoring Units 2. APS Supervisors/ Managers 3. ADSA management and local offices 4. DDD incident manager	1. 18 to 24 month review cycle 2. Annually 3. Continuously and ongoing 4. Continuously and ongoing	1. ADSA Quality Monitoring Units Findings must be resolved within 3 days. 2. ADSA APS Managers and local supervisors/managers 3. ADSA APS Managers, Executive management, Regional APS management 4. DDD Waiver Oversight Committee	1. 18-24 month review cycle with preliminary data Annually 2. Quarterly/ Annually 3. Annually 4. Annually

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

System Improvement: *(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)*			
Methods for Analyzing Data and Prioritizing Need for System Improvement	**Frequency**	**Roles and Responsibilities**	**Method for Evaluating Effectiveness of System Changes**
ADSA uses a discovery and monitoring process to analyze the effectiveness of current systems. Performance is measured in terms of outcomes. Data from multiple data sources is analyzed to discover whether trends and patterns meet expected outcomes. The goal of quality monitoring in ADSA is to promote, encourage, empower and support continuous quality improvement. ADSA Quality Monitoring Units use a statistically valid sample with a confidence interval of +/- 5% and a confidence level of 95%. A random sample is pulled and monitored over a statewide18-24 month review cycle with preliminary data available annually. During the review cycle each of the 13 AAA and 6 ADSA Regions are monitored based on an established schedule. Findings must be resolved in 3 to 40 days. Corrections are monitored by the Quality Monitoring Units and local regional/AAA management. Findings are analyzed by management. Based on the analysis necessary steps are taken. Quality assurance processes may result in corrective actions, adjustments to training curriculum, policy clarifications, forms revision, WAC revisions and targeting criteria for the next review cycle.	18-24 month review cycle with preliminary results available annually. Training is conducted at regular intervals throughout the year.	The ADSA quality process monitors consumer satisfaction, program eligibility, accuracy and quality of file documents, and if policy & procedures, state and federal statutes including waiver requirements are met. Quality monitoring responsibility covers six state regional areas and 13 Areas on Aging each review cycle. Entrance and exit conferences are held as well as technical assistance throughout the process. Detailed reports are produced and discussed with regional offices and AAAs. Quality Monitoring Units verify that corrections have been made to critical areas (health & safety, eligibility, payment). All issues identified by the monitoring activities are addressed in the remediation plans developed by the Regional or AAA offices.	At a statewide level, evaluating the effectiveness of the 1915(i) option is an ongoing process performed by the program manager and other staff responsible for the administration of the 1915(i) option. Data related to 1915(i) option is available from a variety of resources. Numerous reports and aggregate data generated by the Quality monitoring process are available on a continuous basis for use by managers, supervisors and the Quality Unit staff. Reports are used for discovery, remediation and to identify strengths and areas of improvement, training needs, areas of deficiencies and identify corrective action plans. There is continuity and integration of report review throughout ADSA. Ongoing analysis of data is reviewed. If a trend becomes evident action is taken at the headquarters level without waiting for the completion of the review cycle. At the completion of each area's monitoring, data is analyzed and used to develop local corrective action plans, policy /procedural changes and training or guidance at the regional/AAA, unit, and/or worker level. Upon completion of the review cycle, statewide systemic data is analyzed for trends and patterns by managers, and executive staff. Decisions for action are made based on analysis and prioritization. These activities may include statewide training initiatives, policy and/or procedural changes and identification of quality improvement activities/projects. ADSA staff are responsible for: • Oversight of Area Agency on Aging (AAA) operations including implementation and compliance with contract requirements, state and federal laws and regulations, policies and procedures; approval and oversight of program budgets, billing for services provided, and Area Plan development and implementation; review of remediation (corrective action) plans submitted by AAAs to correct deficiencies in AAA operations and monitoring implementation of corrective actions; and review of monitoring reports submitted by AAAs for subcontractors to determine compliance with inter-local agreement and related laws and regulations. • Development of policy and procedures related to ADSA quality assurance/improvement activities, oversight of assessment, service planning and delivery models and monitoring

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

System Improvement: (cont) *(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)*			
Methods for Analyzing Data and Prioritizing Need for System Improvement	**Frequency**	**Roles and Responsibilities**	**Method for Evaluating Effectiveness of System Changes**
		Quality Monitoring Units review remediation plans to ensure that all required issues are addressed in the plans. ADSA executive staff review and approve remediation plans for implementation.	compliance to HCBS requirements. ADSA staff monitors for irregularities in payment authorizations through on-going review of Social Service Payment System (SSPS) reports. CARE generated reports are reviewed for program compliance and eligibility criteria. • Analyzing various Quality Monitoring Unit and CARE regional and statewide reports related to their programs to identify needed policy changes/clarifications, areas of improvement, and training. Executive management analyze the results of regional and statewide reports related to programs in order to identify and prioritize policy changes/clarifications, performance improvement activities, and training. The Quality Improvement Strategy is evaluated and adjusted prior to the beginning of a review cycle. In addition, it is also evaluated to determine if changes are needed. Workgroups consisting of ADSA HQ program managers, Home and Community Services and Area Agency on Aging Supervisors, case managers, and nurses evaluate the quality strategy/program. Modifications/expectations are made based on changes in federal or state rules and regulations, ADSA policy and procedures, CMS assurances, input from participants, providers, and analysis of data from various reports including recommendations from the previous review cycle. ADSA also seeks the assistance of CMS and other entities through grants, conferences, or "Best Practices" information, to continue to refine benchmarks for improvement and evaluate the system against those benchmarks