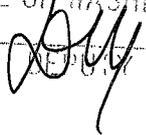


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COURT OF APPEALS  
DIVISION II

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STATE OF WASHINGTON  
BY 

No. 40809-1-II  
COURT OF APPEALS FOR DIVISION II  
STATE OF WASHINGTON

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RESA RAVEN,

Respondent,

v.

WASHINGTON STATE DSHS,

Appellant.

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AMICUS CURIAE BRIEF OF  
DISABILITY RIGHTS WASHINGTON  
IN SUPPORT OF RESPONDENT'S BRIEF

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## I. INTRODUCTION

This case involves a disagreement between a Professional Guardian, the Department of Social and Health Services (DSHS), and a guardianship judge over the extent of the Guardian's duty to involuntarily institutionalize the Guardian's ward. Although a nursing facility may appear to be a simple solution for securing care, it still does not guarantee safety, and it is a restrictive and segregated setting that many individuals would not choose. Ida's<sup>1</sup> choice was to stay in her own home.

For two reasons, Ida's Guardian was correct that it was not her role to force Ida into a nursing facility. First, the Guardian lacked authority to involuntarily place Ida in a facility because to do so would have been discriminatory and a prohibited deprivation of liberty absent due process. RCW 11.92.190; *Olmstead v. L.C. ex. rel. Zimring*, 527 U.S. 581, 119 S. Ct. 2176 (1999); *Addington v. Texas*, 441 U.S. 418, 99 S. Ct. 1804 (1979). Secondly, the Guardian's actions were consistent with the legal requirements and standards of practice for a professional guardian. RCW 11.92.043; *In re Guardianship of Ingram*, 102 Wn.2d 827, 689 P.2d 1363 (1984). Thus, the Guardian's decision to keep Ida home does not constitute "neglect" under RCW 74.34.020(12). By the same token, the

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<sup>1</sup> Ida is the individual that DSHS determined had been neglected under RCW 74.34. To comply with the confidentiality requirements of this statute, this brief will refer to her by first name, "Ida," rather than a formal title disclosing her last name.

Guardian's refusal to place Ida in a nursing facility should not result in strict liability for ensuring adequate community services.

## II. INTEREST AND IDENTITY OF AMICUS CURIAE

Disability Rights Washington (DRW) is a federally mandated and funded nonprofit organization that promotes the dignity, equality, and self-determination for people with disabilities in Washington State. RCW 71A.10.080; 42 U.S.C. § 15001 *et. seq.*; 42 U.S.C. § 10801 *et. seq.*; 29 U.S.C. § 794e; Decl. of Stroh in Support of Motion for Leave to File Amicus Curiae Brief, ¶ 2. To guard individual rights against a misapplication of Washington's law or a misunderstanding of a guardian's power to control Medicaid services, this brief addresses whether the DSHS Review Decision and Final Order ("Review Decision") "ignores significant restrictions on a guardian's authority to detain a ward in a care facility." Corr. Opening Br. of Resp., at 3.

## III. STATEMENT OF THE CASE

### A. Ida had a long history of competently refusing traditional medical care.

Ida was a retired nurse and naturopath who had been "very active in pursuing alternative medicine throughout her life." AR 2116; *see also* AR 2104. In 1996, she moved with her husband from Anchorage, Alaska to Olympia, where Ida's daughter was living. *Id.* When Ida's own health

declined, her personal healthcare choices became subject to scrutiny. In 2001, DSHS's Adult Protective Services (APS) investigated to determine whether Ida was "self-neglecting" due to a disability. AR 106, FOF 23.

APS interviewed Ida, noting:

[Ida] continues to espouse a natural way of living. She takes vitamins and distrusts the medical establishment even though or because of her past occupation as a nurse...she is very outspoken and independent.

*Id.* The APS investigation determined allegations of self-neglect were unsubstantiated largely "due to [Ida]'s long history and lifestyle pattern of independence and reliance on naturopathic and alternative medicine." AR 106, FOF 20. Ida's consistent healthcare choices were evident in her refusal of treatment for glaucoma and cataracts, her habit of rarely taking medications, and her initial resistance to help when she fell and suffered a fracture in 1996. AR 102, FOF 12; AR 98, FOF 3. Both the Administrative Law Judge and Board of Appeals concluded "[t]here is no persuasive evidence that Ida was incompetent when she expressed resistance to receiving appropriate health care." AR 104-105, FOF 19-20.

**B. Ida did not want to be placed in a nursing home.**

After her fibular fracture in 1996, Ida agreed to temporarily go to a nursing facility to recover. AR 104, FOF 18. However, after she returned home, she made it clear she did not want to be placed in a nursing home.

AR 112, FOF 43. In 2001, an Emergency Room physician noted her unwillingness to go to a group home or a nursing home. AR 105, FOF 21; AR 2108. In March 2002, Ida stated to her AAA case manager and hospice caregiver that “she wanted to remain at home” despite her daughter’s unsuccessful efforts to place her in a nursing facility “against her expressed interests.” AR 106, FOF 27-28.

After Ida was deemed to need a limited guardian to give consent for medical care, a Guardian was appointed in 2004. Based on conversations with Ida and her relatives, and her records review, the Guardian made a good faith determination “that Ida, when competent, consistently refused to be placed in a nursing home or other long term care facility.” AR 110, FOF 38; AR 112, FOF 42-43; AR 108, FOF 32.

**C. Community care was interrupted and difficult to access.**

Ida had been receiving in-home care services funded by Washington’s Community Options Program Entry System (COPES), a Waiver allowing Medicaid to fund community based services to low-income elderly individuals with disabilities. AR 719, 752; 42 U.S.C. § 1396n(c); COPES Waiver Application, Exhibit 1, at 3. As a COPES Medicaid recipient, Ida’s resources were so limited that the guardianship court approved a reduced guardianship fee equal to the COPES participation amount. AR 1554. Through the COPES program, Medicaid recipients such as Ida may

receive services like personal care and skilled nursing in order to implement care plans developed based on an assessment of their needs. *Id.*; WAC 388-106-0305. The purpose of the COPES program is to maintain Medicaid recipients who would be placed in a nursing facility in their own homes. *Id.*

Ida, however, had difficulty accessing adequate community based care, due to a number of contributing factors, in addition to her own resistance to care. AR 721 (documenting client's noncompliance with skin protocol). First, Ida lost her home nursing when her primary care physician terminated services. AR 115-116, FOF 49. Ida went for almost two years without a physician, despite her Guardian's efforts to secure a replacement. AR 115-119, FOF 49-58 (limited number of Medicaid or Medicare physicians, most of whom had declined to accept Ida as a patient; lack of physicians making home visits; lack of Medicaid-covered nonemergency ambulance transportation). It was not until Ida was discharged from the emergency room with hospice care in 2005 that she was able to access a physician. AR 119, FOF 58-59. When the hospice provider became involved with Ida's case, the Guardian decreased her home visits, relying on hospice staff to provide her with updates and requests. AR 113, FOF 44. When there were issues, Ida's Guardian called meetings with providers to problem-solve. AR 119-21, FOF 59-60

(describing several care conferences the Guardian convened to discuss issues with Ida's providers and AAA case manager).

Nevertheless, these meetings were unsuccessful in fully resolving Ida's care issues. In 2006, she was authorized 280 hours of Medicaid funded personal care services that her Service Summary outlined and assigned to her home care agency, but she never received this amount of care due to the lack of available staff at her home care agency to fill these hours. AR 754; AR. 101, FOF 9; AR 121, FOF 60; AR 132, FOF 84. There was no enforcement mechanism in DSHS's contract with the home care agency to ensure the agency fully staffed her case. *Id.* The home care agency simply stated it was "always looking" for more staff. *Id.* Other care agencies were approached, but they pointed out significant staffing challenges in finding employees able to work half-hour and one hour shifts, after 5:00, or on weekends to implement her care plan. AR 132, FOF 85. Ida's Guardian determined that trying to hire individual providers through WorkSource was not a viable option because individual providers lack the training and supervision provided to agency staff. AR 122-23, FOF 62. As a result, Ida only had staff for two daily shifts - far less than her plan outlined. AR 132, FOF 84; AR 100, FOF 7-8.

In May 2006, Ida's hospice provider terminated services. AR 123-24, FOF 63-64. That month, Ida's Guardian requested direction from the

Thurston County Superior Court, which had appointed her as Ida's limited guardian. AR 124, FOF 67. In explaining Ida's current circumstances, the Guardian acknowledged that "ideally Ida would be in a skilled nursing facility." AR 124, FOF 67. The guardianship judge provided the following direction:

And so while persons cannot be placed in facilities without their consent or against their will, I believe the nursing home statute, as well as the order I entered back in March of 2004, provides that [Ida] loses certain rights, unless exercised by you, and one of those rights is to consent to or refuse medical treatment consistent with RCW 7.70.067; and, additionally, and I quote, 'To decide who shall provide care and assistance.'

AR 125, FOF 68 (brackets included in Review Decision Finding of Fact).

Although his response included a caveat that restrictions on RCW 11.92.190 could possibly "trump" his direction, the judge suggested the guardian pursue institutionalization, despite his recognition that "[Ida] would resist and fight." *Id.*; AR 126, FOF 68.

**D. Ida did not meet the criteria for an involuntary commitment.**

Months later, still at home, Ida started services from a new hospice provider. AR 128, FOF 75. Ida continued to need additional staff to fill the support hours that had been authorized. AR 129, FOF 75. The new hospice provider believed Ida should be institutionalized in a nursing facility. AR 129, FOF 75-76. Ida's guardian continued to conclude she "lacked the authority" to institutionalize Ida "against her will" without a

clinical determination that Ida met the involuntary commitment criteria. AR 129, FOF 77. Up until the last few months of Ida's life, she remained in her own home per her wishes. AR 131-32, FOF 83.

Ida's hospice provider referred her for an involuntary commitment evaluation. AR 129, FOF 77. It was determined that she did not meet the criteria. *Id.* Even prior to this, Ida's rejections of formal medical treatment had been under scrutiny by the mental health system on several occasions. With the exception of one time in 2001 when she was involuntarily committed, mental health clinicians repeatedly determined that Ida did not meet the involuntary commitment criteria under Washington's Involuntary Treatment Act, RCW 71.05. AR 106, FOF 24-25. In one instance, Ida's daughter called the police when Ida refused a medical evaluation, but "Ida did not meet the criteria for an involuntary committal." AR 107, FOF 29. In late 2003, and again in 2004, Ida was evaluated and not found detainable. AR 107, FOF 30.

#### **IV. ARGUMENT**

##### **A. Guardians may not institutionalize wards against their will.**

Washington's Guardianship statute explicitly prohibits placement in a "residential treatment facility that provides nursing or other care" against a ward's wishes. RCW 11.92.190. That statute expressly voids "any court order...which purports to authorize such involuntary detention or purports

to authorize a guardian or limited guardian to consent to such involuntary detention on behalf of an incapacitated person.” *Id.* Only the State has the authority to involuntarily institutionalize an individual, and only if the State meets its burden to show the individual satisfies commitment criteria set forth in RCW 10.77, RCW 71.05, or RCW 72.23. *Id.* Thus, even an adjudication of incapacitation does not divest an individual of the right to refuse institutionalization.

The statutory protections of RCW 11.92.190 against the loss of liberty by institutionalization is not unlike other protections found in RCW 11.92. In *In re Ingram*, the Washington Supreme Court explored the terrain of substitute decision-making for an individual whose life depended on the medical treatment at issue. 102 Wn.2d 827 (1984). In that case, the Court reviewed the protective requirements of RCW 11.92.040(3) to determine whether the procedure at issue necessitated a court order. *Id.* The Court found the removal of the person’s larynx to require a Court order, finding the procedure to be an “invasive surgery resulting in the loss of speech” that could be considered “more severe than amputation of a limb.” *Id.*, at 838. Analogously, involuntary institutionalization is a severe limitation on an individual’s liberty, and thus warrants protections found in RCW 11.92.190.

The limitation on guardians' authority to place their wards in a facility operates in tandem with their affirmative "Additional Duties" listed in RCW 11.92.043. These include the obligation to "maintain the incapacitated person in the setting least restrictive to the incapacitated person's freedom and appropriate to the incapacitated person's personal care needs." RCW 11.92.043. This statute is consistent with the Certified Professional Guardian (CPG) Standard 404 for "Residential Decisions," which include an overarching duty to "ensure that the incapacitated person resides in the least restrictive environment that is appropriate and available." CPG Standards, Exhibit 2.

Another affirmative duty enumerated in RCW 11.92.043 is for guardians to "assert the incapacitated person's rights." These rights include federal rights to receive services in the most integrated and least restrictive settings appropriate to their needs. In 1999, the U.S. Supreme Court recognized unnecessary institutionalization as a form of unlawful discrimination. *Olmstead*, 527 U.S. 581. The *Olmstead* Court based its landmark decision on two important observations about the inherent effects of segregated care:

***First***, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life. ***Second***, confinement in an institution severely diminishes the everyday life activities of

individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.”

*Id.*, at 600-601(internal citations omitted, emphases added). The *Olmstead*

Plaintiffs argued that Congress’s passage of the Americans with

Disabilities Act sought to eliminate these discriminatory effects, quoting

testimony by the ADA’s principle sponsor, Senator Lowell Weicker:

“For years, this country has maintained a public policy of protectionism toward people with disabilities. We have created monoliths of isolated care in institutions and segregated educational settings. It is that isolation and segregation that has become the basis of the discrimination faced by many disabled people today. Separate is not equal. It was not for blacks; it is not for the disabled.”

*Olmstead*, Br. of Respondent, 1999 WL 144128 (U.S.) at 25.

Congress passed the ADA finding that “historically, society has tended to isolate and segregate individuals with disabilities, and...such forms of discrimination...continue to be a serious and pervasive social problem.”

42 U.S.C. § 12101(a)(2); See also Michael L. Perlin, *I Ain’t Gonna Work on Maggie’s Farm No More: Institutionalization, Segregation, Community Treatment, the ADA and the Promise of Olmstead*, 17 T.M. Cooley L. Rev. 53, 63 (2000). Since *Olmstead*, courts across the country have applied the ADA “Integration Mandate” to specifically guard against unnecessary institutionalization in nursing facilities. See e.g. *Townsend v. Quasim*, 328 F.3d 511, 517-18 (2003); *Fisher v. Oklahoma Health Care*

*Authority*, 335 F.3d 1175, 1178, 14 A.D. 1005, (10th Cir. 2003); *State of Connecticut Office of Protection and Advocacy for Persons with Disabilities v. Connecticut*, 706 F. Supp.2d 266, 275 (D. Conn. 2010); *Pennsylvania Protection and Advocacy, Inc. v. Pennsylvania Dept. of Public Welfare*, 402 F.3d 374, 378, 16 A.D. 1144, (3rd Cir. 2005); *Radaszewski ex rel. Radaszewski v. Maram*, 383 F.3d 599, 607 (7th Cir. 2004). These cases, along with Washington’s establishment of community-based care programs like COPES, set forth a clear policy firmly rejecting the notion that institutional nursing facilities are the only settings appropriate to the needs of long-term care clients. RCW 74.39A.005; DSHS Long Term Care Manual, Chapter 1, Exhibit 3, at 2 (“Our objective is a system that delivers seamless medical, habilitative, mental health, long-term care, employment and supportive services in the person’s own community”).

Moreover, in addition to being discriminatory under the ADA, involuntary institutionalization “constitutes a significant deprivation of liberty that requires due process protection.” *Addington v. Texas*, 441 U.S. 418, 99 S. Ct. 1804 (1979). The Fourteenth Amendment prohibits involuntary placement in a facility without a showing that the individual has a mental illness and poses some danger to self or others. *Id.* In *Addington*, the U.S. Supreme Court acknowledged that “[l]oss of liberty

calls for a showing that the individual suffers from something more serious than is demonstrated by idiosyncratic behavior.” *Id.*, at 427. The Court determined that States must show an individual meets the civil commitment criteria with clear and convincing evidence – rather than a mere preponderance of evidence - because the loss of liberty resulting from an involuntary commitment for any reason is so significant. *Id.*; *Santosky v. Kramer*, 45 U.S. 745, 755-56; 102 S. Ct. 1388 (1982) (“*Addington* teaches that...the minimum standard of proof tolerated by the due process requirement reflects...the weight of the private and public interests affected”); See also, *Mays v. State*, 116 Wash. App. 864, 68 P.3d 1114 (2003) (extending due process requirement to other forms of involuntary treatment). Indeed, the deprivation of liberty incident to an involuntary admission is so significant that courts have prohibited States under the Fourteenth Amendment from indefinitely committing individuals, and have required States to provide all involuntary patients with adequate treatment. *Jackson v. Indiana*, 406 U.S. 715, 92 S. Ct. 1845 (1972); *State v. Hurst*, 159 Wash. App. 803; 244 P.3d 954 (2010); *Youngberg v. Romeo*, 457 U.S. 307, 322, 102 S. Ct. 2452 (1982); *Ohlinger v. Watson*, 652 F.2d 775, 778 (9th Cir. 1981); *Sharp v. Weston*, 233 F.3d 1166, 1172 (9<sup>th</sup> Cir 2000). Such a deprivation of liberty thus requires more than a guardian’s unilateral judgment.

Contrary to DSHS's reading of RCW 11.92.190 as merely preventing a "*facility* from detaining an individual against the individual's will," the plain language of RCW 11.92.190 unambiguously voids any court order purporting to give guardians authority to force their wards into any residential care facility. Br. of Appellant at 30. This should be interpreted with the understanding that the plain language guards against unlawful discrimination and significant deprivation of individual liberty. The State has no authority to force an individual into residential facility absent due process and a subsequent showing of mental illness leading to danger for self or others. *Addington*, 441 U.S. 418; RCW 71.05.150 *et. seq.*. The State, therefore, cannot validly grant such authority to guardians.

Ida had been evaluated on several occasions to determine whether she should be involuntarily institutionalized. With the exception of one time, she was repeatedly found not to meet the involuntary commitment criteria. Her Guardian chose to respect her decision to stay home and did not attempt to unlawfully deprive Ida of her liberty interests. The guardianship Court's misinformed instructions to institutionalize Ida against her will begs for clarification from this Court that the Guardian's decision to decline the Court's suggestions does not constitute neglect as defined in RCW 74.34.020(12). While the Review Decision is correct in concluding the "decision not to place Ida in a residential treatment

facility” does not form a basis for neglect in and of itself, this conclusion must be clarified to omit its qualifier, “at least early on in the guardianship.” AR 162, COL 45. No State and federal law permits a guardian – limited or full - to force a ward into a facility *at any time*.

**B. Guardians must honor their wards’ autonomy and preferences.**

It is also incorrect to conclude that the Guardian was not prevented “from taking Ida to a care facility to see if she would agree to stay.” Br. of Appellant at 30; AR 162, CL 44. At all times during her appointment, the Guardian was required to make healthcare decisions in accordance with RCW 7.70.065, Washington’s statute on Informed Consent. RCW 11.92.043(5). RCW 7.70.065(1)(c) explicitly states that the appointed guardian “must first determine in good faith that that patient, if competent, would consent to the proposed health care.” RCW 7.70.065(1)(c). The guardian must only follow a “best interest” standard “[i]f such a determination cannot be made.” *Id.*

The Informed Consent statute reflects what courts have determined appropriate for substitute decision-making. In *Ingram*, the Court ultimately decided to honor the patient’s right to refuse potentially life-sustaining treatment. *In re Ingram*, 102 Wn.2d at 838. In reaching this conclusion, the Court relied on its own and other courts’ jurisprudence to determine “the goal is to do what the ward would do, if she were

competent to make the decision.” *Id.*; *See also, In re Guardianship of Grant*, 109 Wash.2d 545, 567, 747 P.2d 445 (1987). Moreover, CPG Standards also explicitly recognize the duty of a guardian to bifurcate his or her decision-making into a two step process. Exhibit 2. The “primary standard” requires the guardian to “make reasonable efforts to ascertain the incapacitated person’s historic preferences” and to “give significant weight to such preferences.” Exhibit 2, CPG Standard 402.1. These standards reserve the “best interest” basis for “[w]hen the competent preferences of an incapacitated person *cannot be ascertained.*” Exhibit 2, CPG Standard 402.2 (emphasis added).

Thus, regardless of whether or not Ida would have actively protested institutionalization, Ida’s preference was to continue living in her own home with her husband. Her choice was evident to her physicians, her family, and her Guardian. The decision to honor her preference applies the requirements in statute, case law, and guardianship standards, all of which guard against the coercive approach suggested by DSHS.

**C. Individuals will face increased risk of institutionalization if guardians are held ultimately responsible under strict liability.**

It would also be unjust to find neglect based on a strict liability standard for securing care in the community when institutionalization is rejected. Requiring “effective *results,*” the Review Decision starkly

concludes “*Attempts* at remedying Ida’s untenable situation were not enough” after Ida’s Guardian decided against placing Ida in a nursing facility. AR 168, CL 55 (Emphases in original). The Review Decision goes further to hold the Guardian “ultimately responsible” to “ensure” Ida’s needs were actually met. *Id.*, CL 56. DSHS echoes this conclusion, arguing that “[b]y failing to secure sufficient *in-home* care for Ida, Ms. Raven perpetuated neglect.” Br. of Appellant, at 28 and 30 (emphasis in original). As the Pierce County Superior Court found, Ida had limited resources, limiting the Guardian’s ability to ensure adequate care. CP 6, COL 7; CP 7, COL 11; VRPP, Exhibit 4 at CP 90 (contrasting Ida with “wealthy” people who can hire private nurses). The strict liability proposed by DSHS not only places an unjustifiable burden on guardians of indigent individuals, but also threatens individual rights and autonomy.

When services are Medicaid funded, placing ultimate responsibility on the Guardian shifts responsibility to the party with the least amount of control over care resources. Medicaid is a state and federal healthcare program established for people with low-incomes. 42 U.S.C. § 1396; *Wilder v. Virginia Hosp. Ass’n*, 496 U.S. 498, 502, 110 S. Ct. 2510, (1990). The Medicaid COPES waiver funding Ida’s in-home services also has stringent eligibility requirements including financial criteria. Exhibit 1, at 3; WAC 388-106-0310(3). Individuals receiving Medicaid long-term

care services are unlikely to have private financial resources in the control of their guardians that could be used to access non-Medicaid services.

The obligation for guardians to secure any Medicaid services should be determined in light of guardians' ability to ensure a sufficient quantity and quality of Medicaid providers. In Washington, DSHS and the local AAA agency are designated with these responsibilities. Exhibit 1, at 11-131; AR 722; 42 U.S.C. § 1396a(a)(5) and (30) (requiring designation of a state agency to operate and administer the Medicaid program, which includes ensuring access to adequately qualified providers); 42 C.F.R. § 447.204; *Antrican v. Buell*, 158 F. Supp.2d 663 (E.D.N.C. 2001) (finding state violated Medicaid law where there were few Medicaid dental providers); 42 U.S.C. § 1396n(c)(2)(a) (health and welfare assurances).

In Ida's case, one of the most significant barriers to her care was the lack of Medicaid providers. She went without a doctor when her guardian could not find a Medicaid physician who would accept her. AR 115-119. She lost her hospice care, and had a limited choice of home care agencies. AR 123-24, FOF 63-64; AR 132, FOF 84-85. Unlike DSHS, Ida's Guardian had no contractual or regulatory relationship with Ida's home care agency. AR 132, FOF 84; AR 654. Ida's providers were obligated to implement her plan of care, and her home health agency was specifically required to provide services "as outlined" in her Service Summary, but it

is the State, not the guardian, who has the authority to enforce these requirements. WAC 246-335-090; WAC 388-71-0515(2). Ida's Guardian did not have a viable recourse to enforce an obligation for the home care agency to provide for all the personal care hours in Ida's plan. Even if she had exercised authority as Guardian to terminate Ida's home care agency, "effective *results*" would have been limited by the lack of alternative providers who could perform better. If there is a scarcity of enrolled Medicaid providers, or the State fails to enforce state regulations, guardians of Medicaid recipients have no effective remedies to *ensure* adequate care services in the community.

If guardians are held ultimately responsible and strictly liable for ensuring that care is provided, then nursing facilities that offer a complete package of healthcare services will become guardians' safe harbor from liability whenever the State fails to ensure accessibility of adequate community services. *See* 42 C.F.R. § 483.1 *et. seq* (requiring nursing facilities to furnish host of healthcare services). Guardians of indigent Medicaid recipients would be exposed to grave and permanent consequences based on their failure to access long-term care resources that are well beyond their reach and control. *See* RCW 43.43.830; RCW 74.39A.050. This kind of liability would generate tremendous pressure on guardians to consent to institutionalization in the face of limited provider

networks, State cuts to Medicaid benefits,<sup>2</sup> or any other challenge facing individuals seeking services to live at home. A misapplication of RCW 74.34 that places “ultimate responsibility” for “effective results” on the guardians will ultimately result in harm to the rights and autonomy of this law’s intended beneficiaries.

## V. CONCLUSION

An individual’s preference for community based care is a critical choice that guardians, the State, and courts are all obligated to respect. Washington law should not be applied to needlessly strip people with disabilities of their autonomy and civil rights to make this choice. For these reasons, DRW respectfully urges the Court to reach a decision that does not punish guardians or hold guardians unreasonably accountable when they rightfully choose to honor their wards’ expressed preference to stay in their own homes.

Dated this 15<sup>th</sup> day of August, 2011.

By   
\_\_\_\_\_  
Susan Kas, WSBA No. 36592

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<sup>2</sup>For example, see *M.R. v. Dreyfus*, 767 F. Supp.2d 1149 (W.D. Wash. 2011) (regarding State’s reduction in Medicaid personal care services); *Ryan v. Dreyfus*, 2009 WL 2914139 (W.D. Wash. 2009) (regarding State’s termination of Medicaid adult day health services for approximately 949 adults with disabilities); see also Medicaid Purchasing Administration’s *Agency Plan for 6.287 Percent GF-S Allotment Reduction*, Exhibit 5, (DSHS proposal to eliminate Adult Hospice in response to Executive Order 10-04, Exhibit 6).

**CERTIFICATE OF SERVICE**

I certify, under penalty of perjury pursuant to the laws of the State of Washington, that on August 15, 2011 a true and correct copy of the foregoing document was served upon counsel listed below by first class mail and email:

Catherine Hoover  
Assistant Attorney General  
PO Box 40124  
Olympia, WA 98504-0124  
[CatherineH1@atg.wa.gov](mailto:CatherineH1@atg.wa.gov)

Jeff Crollard  
1904 Third Avenue, Suite 1030  
Seattle, WA 98101  
[jbc@crollardlaw.com](mailto:jbc@crollardlaw.com)

I declare under penalty of perjury of the laws of the state of Washington that the forgoing is true and correct.

DATED August 15, 2011 at Seattle, Washington.

  
\_\_\_\_\_  
Mona Rennie

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

### I. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

- Added Healthcare for Workers with Disabilities as an eligibility group
- Caregiver/Recipient Training Service new providers:
  - Behavior Intervention Specialist
  - Chronic Disease Self management Trainer
  - Pharmacist
  - Community Mental Health Agency
  - Center for Independent Living

- Used current CMS definition of Community Transition Services

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

### 1. Request Information (1 of 3)

- A. The State of Washington requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
- B. Program Title (optional - this title will be used to locate this waiver in the finder):  
COPEs renewal 2009
- C. Type of Request: renewal

Migration Waiver - this is an existing approved waiver

Renewal of Waiver:

Provide the information about the original waiver being renewed

Base Waiver Number: 0049

Amendment Number

(if applicable):

Effective Date: (mm/dd/yy) 04/01/09

Exhibit 1

Waiver Number: WA.0049.R06.00

Draft ID: WA.03.06.00

Renewal Number: 06

## D. Type of Waiver (select only one):

Regular Waiver

## E. Proposed Effective Date: (mm/dd/yy)

04/01/09

Approved Effective Date: 04/01/09

**1. Request Information (2 of 3)**

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

 Hospital

Select applicable level of care

 Hospital as defined in 42 CFR §440.10

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

 Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160 Nursing Facility

Select applicable level of care

 Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155

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

 Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140 Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)

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

**1. Request Information (3 of 3)**

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

Select one:

 Not applicable Applicable

Check the applicable authority or authorities:

 Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I Waiver(s) authorized under §1915(b) of the Act.

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

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

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

- §1915(b)(2) (central broker)
- §1915(b)(3) (employ cost savings to furnish additional services)
- §1915(b)(4) (selective contracting/limit number of providers)
- A program operated under §1932(a) of the Act.

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

- A program authorized under §1915(i) of the Act.
- A program authorized under §1915(j) of the Act.
- A program authorized under §1115 of the Act.

Specify the program:

## 2. Brief Waiver Description

**Brief Waiver Description.** *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Community Options Program Entry System (COPEs) provides home and community-based services targeted to aged and disabled individuals who are at nursing facility level of care. This waiver is for individuals who receive waiver services in their homes or in a residential facility such as an Adult Family Home or Boarding Home.

The waiver is administered by the State Department of Social and Health Services (DSHS) through the Aging and Disabilities Services Administration (ADSA). The State determines initial financial and functional eligibility for services. Ongoing residential case management is provided by ADSA local Home and Community Services offices, and in-home case management is provided by local Area Agencies on Aging (AAA).

The goal of this waiver is to support participants in their own homes or in residential facilities rather than in a nursing facility or other more restrictive settings. The objective of the waiver is to develop and implement supports and services to successfully maintain individuals in their homes and communities. Each applicant participates in completing an individual assessment and developing a written plan of care that is tailored to meet their individual needs. The waiver includes the following services:

- Personal Care
- Personal Emergency Response System (PERS)
- Environmental Modifications
- Skilled Nursing
- Transportation
- Home Health Aide Services
- Adult Day Care
- Caregiver/Recipient Training Services
- Home Delivered Meals
- Specialized Medical Equipment
- Nurse Delegation
- Community Transition Services

Individuals may choose to self direct their personal care.

The waiver serves over 30,000 individuals (unduplicated yearly count) who meet financial and functional criteria. More information on the waiver and other aging and disability services in Washington State can be found at: <http://www.adsa.dshs.wa.gov>.

## 3. Components of the Waiver Request

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

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

- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one):*
- Yes. This waiver provides participant direction opportunities. *Appendix E is required.*

No. This waiver does not provide participant direction opportunities. *Appendix E is not required.*
- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the State's demonstration that the waiver is cost-neutral.

#### 4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i) (III) of the Act in order to use institutional income and resource rules for the medically needy *(select one):*
- Not Applicable
- No
- Yes
- C. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act *(select one):*
- No
- Yes
- If yes, specify the waiver of statewide that is requested *(check each that applies):*
- Geographic Limitation.** A waiver of statewide is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.  
*Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*
- 
- Limited Implementation of Participant-Direction.** A waiver of statewide is requested in order to

make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

*Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

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## 5. Assurances

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

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
  2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
  3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
  2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s)

specified for this waiver.

- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

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*Note: Item 6-I must be completed.*

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:  
In preparation for renewal of the (COPEs) Waiver, input about COPEs services was obtained from individuals from all areas of Washington State who have a vested interest in the services provided by this waiver. Outreach was made to Tribes, individuals using services provided through the waiver, service providers, advocates, and Aging and Disability Services (ADSA) and Area Agencies on Aging (AAA) case management staff.

Input on COPEs services was primarily gathered through focused group discussions facilitated by ADSA staff. Input was collected from 292 participants attending a total of 16 meetings between May 8 and August 21, 2008.

In addition to focused discussions, input was also collected through written responses to a short survey. This survey was distributed by email as a follow up to participants in focused group discussions and was in turn distributed by them to other members of their respective organizations. The survey was mailed directly to 29 Tribal Chairpersons in Washington State and to 200 individuals enrolled in the COPEs Waiver. In total, 61 survey responses were received.

Results of this input have been incorporated into the renewal application.

The State routinely secures public input by working closely with the following:

- State Legislature
- Other divisions and state agencies, (Mental Health, Alcohol and Substance Abuse, Vocational Rehabilitation, Department of Health, Medical)

The Medicaid Agency meets regularly with the following to share information and obtain input on program design and quality of care:

- State Quality Assurance Advisory Committee which includes family members, clients, providers, and other stakeholders
- County Coordinators for Human Services
- The Washington Association of Area Agencies on Aging
- Provider associations: Home Care, Home Health, Nursing Facility
- Boarding Home and Adult Family Home Advisory Boards
- Governor's Disability Council
- Senior Lobby
- Senior Council on Aging (Governor's Committee)
- Older Adults Advisory Committee (Mental Health)
- Northwest Justice Project
- Quarterly Case Management Meetings

Input on waiver development is also obtained from participant satisfaction surveys.

The State maintains a government to government relationship with the federally recognized Tribes in the state. This includes written accords, a formal process for consultation and process for informal input.

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

through the Medicaid Agency.

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

## 7. Contact Person(s)

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

Last Name:   
 First Name:   
 Title:   
 Agency:   
 Address:   
 Address 2:   
 City:   
 State:   
 Zip:   
 Phone:  Ext:   TTY  
 Fax:   
 E-mail:

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

Last Name:   
 First Name:   
 Title:   
 Agency:   
 Address:   
 Address 2:   
 City:   
 State:   
 Zip:   
 Phone:  Ext:   TTY  
 Fax:   
 E-mail:

## 8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are *readily* available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:	Kathy Leitch State Medicaid Director or Designee
Submission Date:	Feb 27, 2009
Last Name:	Marshburn
First Name:	Stan
Title:	Interim Secretary
Agency:	Department of Social and Health Services
Address:	P.O. Box 45010
Address 2:	
City:	Olympia
State:	Washington
Zip:	98504-5010
Phone:	(360) 902-7800
Fax:	(360) 902-7848
E-mail:	marshsb@dshs.wa.gov

### **Attachment #1: Transition Plan**

Specify the transition plan for the waiver:

NA

### **Additional Needed Information (Optional)**

Provide additional needed information for the waiver (optional):

--

### **Appendix A: Waiver Administration and Operation**

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

The waiver is operated by the State Medicaid agency.

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

**The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

**Aging and Disability Services Administration**

(Complete item A-2-a).

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

Specify the division/unit name:

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

## Appendix A: Waiver Administration and Operation

### 2. Oversight of Performance.

- a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

The COPES waiver is administered by the Department of Social and Health Services (DSHS), the Single State Medicaid Agency in Washington State. The Secretary of DSHS is signatory for all aspects of waiver operation including waiver applications, amendments, 372 reports and all other CMS communications. The mechanics of submitting CMS web-based waiver reports and applications have been delegated to the Assistant Secretary for Aging and Disability Services (ADSA) subsequent to the Secretary's approval. The Assistant Secretary for ADSA reports directly to the Secretary of DSHS.

A copy of the DSHS organizational chart is available to CMS.

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

**As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.**

## Appendix A: Waiver Administration and Operation

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3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):
- Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**  
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*
- 
- No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

## Appendix A: Waiver Administration and Operation

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4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):
- Not applicable**
- Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.  
Check each that applies:
- Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.
- Specify the nature of these agencies and complete items A-5 and A-6:*
- The Medicaid agency contracts with 13 Area Agencies on Aging (AAAs) to perform certain operational and administrative functions at the local level. AAAs are single or multi-county entities. Two AAAs are operated by tribes (Colville Indian AAA and Yakama Nation AAA). 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.
- Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

## Appendix A: Waiver Administration and Operation

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

**Appendix A: Waiver Administration and Operation**

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Performance assessment and oversight of non-state entities is performed by the Medicaid agency (ADSA) with methods and frequency as follows:

AAA billings are reviewed on a monthly basis by ADSA fiscal staff and the assigned ADSA AAA Specialist. This includes monitoring expenditures against contract balances, ensuring that billed services are in accordance with the AAA's approved Area Plan, etc. ADSA also monitors monthly to ensure that required staffing ratios are maintained for case management, nursing, and supervisory positions.

ADSA Quality Assurance Specialists (QAS) perform a variety of monitoring activities each review cycle. A review cycle is 18 months. The focus of each review cycle is determined by an analysis of the previous years monitoring results to ensure remediation and improvement. Reviews also focus on ensuring that the CMS protocols are addressed and Washington is in compliance with state and federal regulations. During the 2006-2007 review cycles, QAS staff performed desk compliance audits of 6% of the active regional/AAA clients. The sample size is determined based on accepted statistical sampling methods.

Each QA monitoring cycle includes a review of the information that is disseminated to potential waiver enrollees as well as training materials for staff. Level of care evaluations are reviewed for accuracy and eligibility. Subcontracts are reviewed to ensure that services outlined in the contract are delivered by qualified providers to recipients as outlined in their plan of care. The State Unit on Aging (SUA) which is responsible for AAA contract management participates in each QAS monitoring cycle including being on site for the QAS entrance/exit conferences and approval of Corrective Action Plans.

In addition to QA monitoring, ADSA completes on site contract and fiscal monitoring every two years. In years when there is not a full review, desk reviews and follow-up on corrective actions are completed on a defined schedule. Monitoring includes whether providers are qualified, that payments are accurate, that authorized services address current needs and that informal supports are reflected. ADSA also monitors the remaining AAA programs based on a risk assessment tool.

ADSA follows the requirements of the Single Audit Act and OMB CIRCULAR A-133 in determining audit requirements for AAAs and sub-contractors.

The State Auditor's Office performs yearly audits of County-based AAAs. AAAs that are not a division of county government are audited annually by a certified public accounting firm.

**Appendix A: Waiver Administration and Operation**

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.

*Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Local Non-State Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

**Appendix A: Waiver Administration and Operation**

**Quality Improvement: Administrative Authority of the Single State Medicaid Agency**

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

**a. Methods for Discovery: Administrative Authority**

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

**i. Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:**

**Percent of waiver participants who received a redetermination of LOC by the AAA within annual timeframe N=All waiver participants reviewed who received a timely annual redetermination of LOC by AAA D= All waiver participants reviewed**

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: 18 months	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: 18 months

**Performance Measure:**

Percent of service plan completed by AAA for waiver participants that address their assessed needs and personal goals by the provision of waiver services or other means  
 N=Number of service plans completed by AAA reviewed that address all assessed needs and personal goals  
 D=Number of service plans completed by AAA reviewed

**Data Source (Select one):**

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: 18 months	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: 18 months

**Performance Measure:**

Percent of waiver participants whose POC was reviewed and updated by the AAA within annual timeframe N=All waiver participants reviewed whose POC was reviewed and updated by the AAA within annual timeframe D= All AAA waiver participants reviewed

**Data Source (Select one):**

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: 18 months	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: 18 months

**Performance Measure:**

Percent of records reviewed where services identified in the POC are authorized  
 N=Number of AAA records reviewed where all services identified in the POC are authorized  
 D=Number of AAA records where the POC identifies services

**Data Source (Select one):**

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative

		Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: 18 months	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: 18 months

**Performance Measure:**

Percent of correct AAA waiver service authorizations  
 Numerator: Number of correct AAA waiver service authorizations reviewed  
 Denominator: Number of AAA waiver service authorizations reviewed

**Data Source (Select one):**

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence

		Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: 18 months	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: 18 months

**Performance Measure:**

The percent of providers determined by AAA to meet qualifications prior to service authorization  $N = \text{Number of providers reviewed that AAA determined met provider qualifications}$   $D = \text{Number of providers reviewed that AAA contracted}$

**Data Source (Select one):**

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%

<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: 18 months	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input checked="" type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: 18 months

**Performance Measure:**

Percent of Area Agencies on Aging (AAA) reviewed that correctly executed Medicaid provider agreements  
 N: Number of AAAs reviewed that correctly executed Medicaid provider agreements  
 D: Number of AAAs reviewed

**Data Source (Select one):**

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

Percent of AAAs that monitor four participant records per case manager per year N:  
Number of AAAs that monitor four participant records per case manager per year D:  
Number of AAAs

**Data Source (Select one):**

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: 18 months	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: 18 months

- 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.

QA and fiscal corrective actions plans are required for areas where required proficiency levels are not achieved or if improvement is not evident based upon previous corrective actions. Corrective action plans are evaluated and individualized prior to approval to ensure that plan will effectively address areas of needed improvement. AAAs are required to perform discovery and remediation activities. Training elements of corrective action plans are coordinated through DSHS and DSHS staff is made available to provide training and technical support to AAA staff. AAAs are required to provide QA with an update at six months to report on their progress toward implementing corrective actions.

**b. Methods for Remediation/Fixing Individual Problems**

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

QA and fiscal corrective actions plans are required for areas where required proficiency levels are not achieved or if improvement is not evident based upon previous corrective actions. Corrective action plans include how individual problems are corrected as they are discovered. Some issues, such as health and safety, require immediate action. Corrective action plans are evaluated and individualized prior to approval to ensure that plan will effectively address areas of needed improvement. Training elements of corrective action plans are coordinated through DSHS and DSHS staff is made available to provide training and technical support to AAA staff. AAAs are required to provide QA with an update at six months to report on their progress toward implementing corrective actions.

- ii. **Remediation Data Aggregation**

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

Responsible Party (check each that	Frequency of data aggregation and
------------------------------------	-----------------------------------

<i>applies):</i>	<i>analysis (check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: 6 months

**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 Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

# CHAPTER 1

## Policies

### Purpose of Chapter

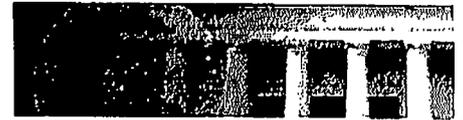
The purpose of this chapter is to provide basic policies and philosophy of the Aging and Long Term Care Network in Washington State. This set of policies and procedures provides an overall framework for Aging & Disability Services Administration (ADSA) and the Area Agencies on Aging (AAAs) to develop and implement their service delivery systems.

This chapter contains:

- Section I    Aging & Disability Services Administration Mission and Vision Statements
- Section II   Description of Area Agencies on Aging
- Section III   Listing of Local Area Agencies on Aging
- Section IV   Guiding Principles and Values to Implement the Aging and Disability Services Administration Mission and Vision Statements
- Section V    Policy Assumptions and System Building Strategies for the Aging, Disability, and Long Term Care Network
- Section VI   Targeting of Older Americans Act Funding
- Section VII   Funding Formula
- Section VIII   Confidentiality
- Section IX   Use of Area Agency on Aging (AAA) Funds to Serve Residents of Long Term Care (LTC) Facilities
- Section X    Code of Ethics

## **SECTION I. Aging & Disability Services Administration Mission and Vision Statements**

ADSA updates its mission and vision statement every four years in concert with publication of the administration's four year strategic plan. The mission and vision statements are available on the ADSA internet and intranet sites. The 2009-2013 ADSA Mission and Vision Statements are as follows:



## Reg 400-Standards of Practice Regulation

### 400 Standards of Practice

The following standards apply to all Certified Professional Guardians (Guardian). Standards apply only to the degree that the court has granted the authority contemplated in a given standard.

#### 401 General

A guardian shall exercise care and diligence when making decisions on behalf of an incapacitated person. The civil rights and liberties of the incapacitated person shall be protected. The independence and self-reliance of the incapacitated person shall be maximized to the greatest extent consistent with their protection and safety.

401.1 The guardian shall at all times be thoroughly familiar with RCW 11.88, RCW 11.92, GR 23, these standards, and any other regulations or statutes which govern the conduct of the guardian in the management of affairs of an incapacitated person. When a question exists between the standards and a statute, timely direction shall be sought from the court. If a guardian is aware of a court order of the court in a specific case which may lead to a conflict with these regulations, the guardian shall disclose this to the court.

401.2 The guardian shall seek legal advice as necessary to know how the law applies to specific decisions.

401.3 The guardian shall provide reports and accountings that are timely, complete, accurate, understandable, and in a form acceptable to the court.

401.4 The guardian shall not act outside of the authority granted by the court.

401.5 The guardian shall protect the personal and economic interests of the incapacitated person and foster growth, independence, and self-reliance.

401.6 The guardian must know and acknowledge personal limits of knowledge and expertise and shall assure that qualified persons provide services to the incapacitated person.

401.7 Whenever feasible a guardian shall consult with the incapacitated person, and shall treat with respect, the feelings, values, and opinions of the incapacitated person. Wherever possible, the guardian shall acknowledge the residual capacity of the incapacitated person to participate in or make some decisions.

401.8 When the guardian has limited authority the guardian shall work cooperatively with the incapacitated person or with others who have authority in other areas for the benefit of the incapacitated person.

401.9 The guardian shall cooperate with and carefully consider the views and opinions of professionals, relatives, and friends who are knowledgeable about the incapacitated person.

401.10 The guardian shall seek independent professional evaluations, assessments, and *opinions when necessary* to identify the incapacitated person's needs and best interests.

401.11 The guardian shall recognize that his or her decisions are open to the scrutiny of other interested parties and, consequently, to criticism and challenge. Nonetheless, subject to orders of the court, the guardian alone is ultimately responsible for decisions made on behalf of the incapacitated person.

401.12 When possible, the guardian will defer to an incapacitated person's autonomous capacity to make decisions.

401.13 A guardian shall not disclose personal or other sensitive information about the incapacitated person to third parties except when necessary and appropriate to the needs of the incapacitated person.

401.14 The duties of a guardian to an incapacitated person are not conditioned upon the person's ability to compensate the guardian.

401.15 Guardians of the Person shall have meaningful in-person contact with their clients as needed and shall maintain telephone contact with care providers, medical staff, and others who manage aspects of care as needed and appropriate. Meaningful in-person contact shall provide the opportunity to observe the incapacitated person's circumstances and interactions with care givers.

401.16 Guardians of the Estate only shall maintain meaningful in-person contact with their clients as necessary to verify the individual's condition and status and that financial arrangements are appropriate.

401.17 All certified professional guardians and guardian agencies have a duty by statute to appoint a standby guardian. In appointing a standby guardian it is the best practice to appoint a certified professional guardian unless otherwise authorized by the local court with jurisdiction. (Amended January 9, 2006).

## **402 Decision Standards**

All decisions and activities of the guardian shall be made according to the applicable decision standard.

402.1 The primary standard is the Substituted Judgment Standard. This means that the guardian shall make reasonable efforts to ascertain the incapacitated person's historic preferences and shall give significant weight to such preferences. Competent preferences may be inferred from past statements or actions of the incapacitated person.

402.2 When the competent preferences of an incapacitated person cannot be ascertained, the guardian is responsible for making decisions which are in the best interests of the incapacitated person. A determination of the best interests of the incapacitated person shall include consideration of the stated preferences of the incapacitated person.

## **403 Ethics**

The guardian shall exhibit the highest degree of trust, loyalty, attentiveness, and fidelity in relation to the incapacitated person.

403.1 The guardian shall avoid self-dealing, conflict of interest, and the appearance of a conflict of interest. Self-dealing or conflict of interest arise when the guardian has some personal, family, or agency interest from which a personal benefit would be derived. Any potential conflict shall be disclosed to the court immediately.

403.2 All expenses paid or incurred on behalf of the incapacitated person by the guardian shall be documented, reasonable in amount, and incurred for the incapacitated person's welfare.

403.3 All compensation for the services of the guardian shall be documented, reasonable in amount, and incurred for the incapacitated person's welfare. The guardian shall not pay or advance himself/herself fees or expenses except as approved by the court.

403.4 Provision of compensated services other than guardianship services to an incapacitated person by the guardian shall be considered a potential conflict of interest, which must be fully disclosed.

403.5 An organization whose primary activities are provision of therapeutic, clinical, residential, or

medical services shall not act as guardian for one of its patients or clients. Employees, agents, or components of such an organization shall not act as guardian for one of its patients or clients.

403.6 The guardian shall disclose to the court and interested parties all compensation, fees and expenses requested, charged, or received in a guardianship case.

403.7 Payment of fees or other compensation for guardianship services by a party other than the incapacitated person is a potential conflict of interest which shall be fully disclosed.

403.8 The guardian shall protect the incapacitated person's rights and best interests against infringement by third parties.

403.9 The guardian shall, whenever possible, provide requested information to the incapacitated person unless the guardian is reasonably certain that substantial harm will result from providing such information. This information shall include, but not be limited to, regular reports on the status of investments and operating accounts, and on the costs and disbursements necessary to manage the incapacitated person's estate, medical and other personal information related to the care of the incapacitated person.

403.10 Unless otherwise directed by the court, the guardian shall provide copies of all material filed with the court and notice of all hearings in the guardianship to the incapacitated person.

#### **404 Residential Decisions**

The guardian shall ensure that the incapacitated person resides in the least restrictive environment that is appropriate and available.

404.1 The guardian shall acknowledge the need to allow all persons the opportunity to engage in activities and live in conditions which are culturally and socially acceptable within the context of the incapacitated person's cultural and life values; or, when cultural and life values cannot be determined, conditions which are culturally and socially acceptable.

404.2 The guardian shall take reasonable measures to effectuate the incapacitated person's residential preferences.

404.3 The guardian shall know the current state of the law regarding limits on the guardian's authority as to residential decisions.

404.4 The guardian shall not remove the incapacitated person from his or her home or separate the incapacitated person from family and friends unless such removal is necessary to prevent significant harm or because of financial constraints. The guardian shall make reasonable efforts to ensure the incapacitated person resides at the incapacitated person's home or in a community setting.

404.5 The guardian shall, to the extent possible, select residential placements which enhance the quality of life of the incapacitated person, provide the opportunity to maximize the independence of the incapacitated person, and provide for physical comfort and safety.

404.6 A relocation should include consultation with professionals actively involved in the care of the incapacitated person, the incapacitated person, objective third parties and, whenever possible, appropriately involved family and friends of the incapacitated person.

404.7 The guardian shall, as necessary, thoroughly research and evaluate the incapacitated person's residential alternatives.

404.8 The guardian shall regularly monitor the incapacitated person's residential placement to ensure appropriateness and that such placement is the least restrictive alternative. The guardian shall consent to changes, as they become necessary, advantageous, or otherwise in the incapacitated person's best interests. The guardian shall consider that even changes within an existing residential facility have an impact on the quality of life of the incapacitated person.

404.9 Should the only available placement not be the most appropriate or least restrictive, the guardian shall regularly review alternatives to the placement and shall make reasonable efforts to arrange an appropriate and least restrictive residence.

## **405 Medical Decisions**

The guardian shall provide informed consent on behalf of the incapacitated person for the provision of care, treatment and services and shall ensure that such care, treatment and services represents the least restrictive form of intervention that is appropriate and available.

405.1 The guardian shall monitor the care, treatment, and services the incapacitated person is receiving to ensure that it is appropriate. The guardian shall consent to changes in service as necessary, advantageous, or in the best interests of the incapacitated person.

405.2 The guardian shall actively promote the health of the incapacitated person by arranging for regular preventive care including but not limited to dental care, diagnostic testing, and routine medical examinations.

405.3 The guardian shall be available at all times to respond to urgent need for medical decisions. The guardian shall provide directives regarding treatment or non-treatment to be followed by medical staff in emergencies.

405.4 In the event the only available treatment, care or services are not the most appropriate and least restrictive, the guardian shall advocate for the incapacitated person's right to appropriate and least restrictive treatment, care or services.

405.5 The guardian shall be fully informed as to risks and benefits to the incapacitated person prior to seeking advance court authorization for medical treatment when law requires such authorization.

405.6 The guardian shall be familiar with the law regarding the withholding or withdrawal of life-sustaining treatment.

## **406 Financial Management**

The guardian shall assure competent management of the property and income of the estate. In the discharge of this duty, the guardian shall exercise the highest level of fiduciary responsibility, intelligence, prudence, and diligence and avoid any self-interest.

406.1 The guardian shall know and obey the law related to managing an incapacitated person's estate. Such knowledge shall include statutes relating to the investment of assets, restrictions imposed on investing and expenditures by RCW 11.88 and 11.92, and laws relating to employment, income, and taxes. The guardian shall hire competent professionals as appropriate to assure compliance with all statutes and regulations relating to the management of funds.

406.2 The guardian shall maintain all bonding, blocking, and insurance requirements as may be required by the court.

406.3 The guardian shall manage the estate with the primary goal of providing for the needs of the incapacitated person.

406.4 In certain cases, guardian shall consider the needs of the incapacitated person's Dependents for support or maintenance, provided appropriate authority for such support is obtained in advance. The wishes of the incapacitated person as well as past behavior can be considered, bearing in mind both foreseeable financial requirements of the incapacitated person and the advantages and disadvantages to the incapacitated person of such support or maintenance.

406.5 The guardian shall exercise prudence in investment, shall periodically review the incapacitated person's situation and assets, and make recommendations regarding appropriate investments. In the exercise of prudence the guardian shall:

406.5.1 Not allow assets to sit idle except for good reasons.

406.5.2 Consider the tax consequences of decisions.

406.5.3 Consider the incapacitated person's long term ability to sustain costs of arrangements made by the guardian.

406.5.4 Consider the incapacitated person's ability to gain the benefits of specific decisions.

406.5.5 Consider the costs incurred in managing investments, including the costs of the guardian, those specialists hired by the guardian, and the costs of the investment vehicles.

406.5.6 Consider the incapacitated person's historical investment pattern and tolerance for risk, lifestyle needs, care and medical needs, estate considerations, tax consequences, and life expectancy.

406.6 When the available estate of the incapacitated person is sufficient, the guardian may petition the court for authority to make such gifts as are consistent with the wishes or past behavior of the incapacitated person, bearing in mind both foreseeable requirements of the incapacitated person and the advantages and disadvantages to the incapacitated person of such gifts, including tax consequences.

406.7 A guardian shall not accept a gift from an incapacitated person or their estate other than ordinary social hospitality.

406.8 When it is likely that the incapacitated person's estate will be exhausted, the guardian shall, as appropriate, make plans and take necessary steps to acquire public benefits on behalf of the incapacitated person. When implementing necessary changes in the incapacitated person's lifestyle, the guardian shall seek to minimize the stress of any transition.

406.9 There shall be no self-interest in the management of the estate by the guardian; the guardian shall exercise caution to avoid even the appearance of self-interest.

406.10 A guardian shall not commingle the funds of an incapacitated person with funds of the guardian or the funds of staff. A guardian may consolidate client accounts, using appropriate accounting software and procedures, including pro-rata assignment of interest earned and fees paid and accurate individual accounting for each client's funds, provided the guardian has received specific authority from the court to do so. Each payment from a consolidated account shall be from funds held in the account on behalf of the individual for whom the payment is made.

406.11 The guardian shall not borrow from an incapacitated person. A guardian shall not lend funds at interest to an incapacitated person.

406.12 The responsibility to protect and preserve the guardianship estate rests with the certified guardian appointed by the court. When the guardian is an agency, this responsibility is that of the agency and the certified guardians identified with the Certified Professional Guardian Board as the responsible guardians for the agency. While it may be appropriate and necessary to retain and reasonably rely upon the services of knowledgeable individuals or entities to assist in the performance of duties, it is the responsibility of the guardian to provide appropriate oversight and review, in order to preserve the guardianship estate. (Amended September 11, 2006).

## **407 Changes of Circumstances**

The guardian has an affirmative obligation to be alert to changes in the incapacitated person's condition or circumstances and report to the court when an increase or reduction in the authority of the guardian *should* be considered.

407.1 The guardian shall seek out information that will provide a basis for termination or limitation of the guardianship.

407.2 Upon indication that termination or limitation of the guardianship order is warranted, the guardian

shall request court action.

407.3 The guardian shall assist the incapacitated person to terminate or limit the guardianship and arrange for independent representation for the incapacitated person when necessary.

407.4 If the guardianship is a limited guardianship, the guardian shall report to the court when there are circumstances in which the incapacitated person appears to require assistance which exceeds the authority of the guardian.

407.5 If the guardianship is of the person only, the guardian shall report to the court when protection of the incapacitated person's estate may be necessary.

407.6 If the guardianship is of the estate only, the guardian shall report to the court when protection of the person may be necessary.

#### **408 Applicable Law**

The guardian shall perform duties and discharge obligations in accordance with current Washington law governing the certification of guardian. In each guardianship, the guardian shall comply with the requirements of the court that made the appointment.

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# CHAPTER 1

## Policies

### Purpose of Chapter

The purpose of this chapter is to provide basic policies and philosophy of the Aging and Long Term Care Network in Washington State. This set of policies and procedures provides an overall framework for Aging & Disability Services Administration (ADSA) and the Area Agencies on Aging (AAAs) to develop and implement their service delivery systems.

This chapter contains:

- Section I     Aging & Disability Services Administration Mission and Vision Statements
- Section II    Description of Area Agencies on Aging
- Section III   Listing of Local Area Agencies on Aging
- Section IV    Guiding Principles and Values to Implement the Aging and Disability Services Administration Mission and Vision Statements
- Section V     Policy Assumptions and System Building Strategies for the Aging, Disability, and Long Term Care Network
- Section VI    Targeting of Older Americans Act Funding
- Section VII   Funding Formula
- Section VIII  Confidentiality
- Section IX   Use of Area Agency on Aging (AAA) Funds to Serve Residents of Long Term Care (LTC) Facilities
- Section X    Code of Ethics

## **SECTION I. Aging & Disability Services Administration Mission and Vision Statements**

ADSA updates its mission and vision statement every four years in concert with publication of the administration's four year strategic plan. The mission and vision statements are available on the ADSA internet and intranet sites. The 2009-2013 ADSA Mission and Vision Statements are as follows:

## **MISSION STATEMENT:**

*The Aging and Disability Services Administration (ADSA) assists adults with disabling conditions due to aging, disease or accident and children and adults with developmental disabilities to gain access to the high quality, cost effective supports they need.*

## **VISION STATEMENT:**

*ADSA helps individuals and their families improve quality of life, develop and maintain self-sufficiency, and remain contributing members of their community. We guide a system of services that are high quality, responsive to individual needs and preferences, and cost effective.*

*We achieve success by supporting individuals, families and caregivers, expanding service options, and continuously improving quality of care and support in all settings. The supports and services we deliver are based on each individual's unique strengths and needs.*

*We contain overall costs by promoting prevention and self-reliance, reducing unnecessary use of more expensive services, and preventing or reducing the need for future services or resources.*

*Within Medicaid programs we are developing an increasingly integrated social and health care program. Our objective is a system that delivers seamless medical, habilitative, mental health, long-term care, employment and supportive services in the person's own community.*

*ADSA programs are accountable for high standards of preventative care. We use chronic care management practices that are outcome oriented and evidence based. In addition, ADSA's programs demonstrate superior service quality, community integration, continuity of care and support, economic value, and consumer satisfaction.*

Aging and Disability Services Administration (ADSA), Home and Community Services Division works with advocates and consumers from the aging and disability arena, including the State Council on Aging and Area Agencies on Aging to assure a client-focused service delivery system.

Unlike many other states, ADSA brings together under one administrative organization the major long-term care programs targeted to adults and children with disabilities (Home-based Care, Community-Residential Care, Developmental Disability, and Nursing Facilities). The ADSA organization includes:

Statewide network of Home and Community Services Offices providing:

- Financial eligibility for state/federal long-term care benefits
  - Functional needs assessment for adults 18 years and older with disabilities
  - Case management for adults 18 years and older in residential care settings
  - Adult protective services investigation and response
  - Relocation and transition assistance for individuals in nursing homes who would like to live in community settings
- Statewide network of contracted Area Agencies on Aging providing:
    - Specialized senior information and assistance (or Aging & Disability Resource Center) program
    - Family caregiver support program for unpaid family and other informal caregivers
    - Kinship caregiver support for relatives responsible for raising children not their own without the help of the child welfare system
    - Local contracting and quality assurance for home care and other home and community-based services
    - Case management for adults 18 years and older receiving Medicaid care in their homes
    - Nursing expertise to assist in assessment, care planning and working with paid and unpaid caregivers for vulnerable adults 18 years and older receiving care in their homes
    - Planning, development and administration of programs and services funded wholly or in part by monies available under the Older Americans Act, Senior Citizens Services Act (SCSA), State Family Caregiver Support (SFCSP), Kinship Caregiver Support (KCSP) and state and United States Department of Agriculture (USDA) Senior Farmers Market Nutrition Program (SFMNP).
  - Statewide network of Developmental Disability Offices providing:
    - Infant/Toddler Early Intervention services for children with disabilities and their families
    - Support to family caregivers of individuals with developmental disabilities
    - Functional needs assessment and service authorizations for individuals with developmental disabilities
    - Case management for persons with developmental disabilities
  - Statewide Residential Care Quality Assurance for:
    - Nursing facilities
    - Boarding homes/assisted living facilities
    - Adult family homes
    - Intermediate care facilities/mental retardation (ICF/MR)
    - Supported Living
    - Group and Group Training Homes
    - Investigation and response for abuse and exploitation in licensed settings

- Aging and Long-Term Care Payment Administration
  - Home care and other community-based programs
  - Community-based residential care and institutional care

## **SECTION II. Description of Area Agencies on Aging**

The United States Congress enacted The Older Americans Act in 1965. The purpose of the act is to provide assistance in the development of new or improved programs to assure the dignity and worth of older persons. Area Agencies on Aging are responsible to plan, coordinate and advocate for the development of a comprehensive service delivery system at local levels to meet both the short and long term needs of older persons in their planning and service area (PSA).

Aging and Disability Services Administration has designated thirteen Planning and Service Areas, also referred to as Area Agencies on Aging. A list of these agencies is listed in Section III of this chapter.

Area Agencies on Aging utilize Older Americans Act (OAA) funding to provide the types of services listed below. The specific services funded by each AAA are determined through local planning activities and delineated in an Area Plan document that is developed every four years with the budget updated annually. These services are available to older individuals (defined in most cases as ages 60 years of age or older). More detailed definitions of these services can be found in this manual under the topic "Service Definitions and Guidelines".

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| <ul style="list-style-type: none"> <li>• Information &amp; Assistance</li> <li>• Transportation</li> <li>• Case Management</li> <li>• Legal Assistance</li> <li>• Health Maintenance</li> <li>• Family Caregiver Support Services</li> <li>• Respite Care</li> <li>• Adult Day Care</li> <li>• Adult Day Health</li> <li>• Grandparents Raising Grandchildren</li> <li>• Geriatric Health Screening</li> <li>• In-home Personal Care Services</li> <li>• Minor Home Repair</li> <li>• Multipurpose Senior Centers</li> <li>• Long Term Care Ombudsman</li> </ul> | <ul style="list-style-type: none"> <li>• Home Delivered Nutrition Services</li> <li>• Congregate Nutrition Services</li> <li>• Senior Companion Program</li> <li>• Nutrition Outreach &amp; Education</li> <li>• Newsletters</li> <li>• Senior Community Service Employment</li> <li>• Home Health</li> <li>• Evidenced-based Health Promotion</li> <li>• Mental Health</li> <li>• Visiting &amp; Telephone Reassurance</li> <li>• Elder Abuse Prevention</li> <li>• Volunteer Chore</li> <li>• Medication Management</li> </ul> |
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Area Agencies on Aging also utilize Senior Citizens Services Act (SCSA) funding to provide the types of services listed below or to provide a local match for services provided under the Older Americans Act. Eligible persons under SCSA are low-income older individuals who are: a) sixty-five years of age or more; or b) sixty years of age or more and are either (i) non-employed, or (ii) employed for twenty hours per week or less; and c) in need of services to enable them to remain in their customary homes because of physical, mental, or other debilitating impairments. Refer to RCW 74.38 and WACs 388-106-1100 - 388-106-1120 for more detailed information on SCSA.

- Access Services
- Long Term Care Ombudsman
- In-home assistance with health or household activities
- Adult Day Care
- Adult Day Health
- Health Services
- Counseling
- Congregate Nutrition
- Home Delivered Nutrition
- Nutrition Services Incentive Program
- Legal Assistance
- Home repair & maintenance

Funding from the United States Department of Agriculture supports the Senior Farmers Market Nutrition Program.

Area Agencies on Aging use special-purpose state funding, authorized by the legislature, to provide the following programs:

- Family Caregiver Support
- ADSA Chronic Care Management\*
- Kinship Caregiver Support
- Kinship Navigator\*
- Senior Farmers Market Nutrition
- Senior Drug Education

\*Available only in some areas of the state.

#### Expansion of AAA services to individuals ages 18 and older:

Washington State's approach to long-term care has been to build a robust statewide home and community based system of care for individuals with functional disabilities. Since 1983, the 1915(c) Home & Community Based Services (HCBS) Waiver under Title XIX of the Social Security Act has allowed clients eligible for nursing facility care to be served in home and community residential settings.

In 1989, the State's Respite Program was funded statewide through the Area Agencies on Aging. The purpose of the program is to provide relief for families or other primary caregivers of people, ages 18 and over with disabilities. Under this program the AAAs determine eligibility, assess needs and authorize respite services. In 2000, services to

unpaid caregivers were expanded under the state's Family Caregiver Support Program, and serve caregivers of any age. In addition, the legislature approved the Medicaid Personal Care option as an entitlement to home and community-based services and effectively reducing the demand for nursing home care.

In 1993 the State Legislature established an expanded vision of reduced nursing home usage and increased access to home and community-based long-term care options: *"The legislature finds that the public interest would best be served by a broad array of long-term care services that support persons who need such services at home or in the community whenever practicable and that promote individual autonomy dignity, and choice. The legislature finds that as other long-term care options become more available, the relative need for nursing home beds is likely to decline. The legislature recognizes, however, that nursing home care will continue to be a critical part of the state's long-term care options, and that such services should promote individual dignity, autonomy, and a homelike environment."* (HB 2098, codified in RCW 74.39A)

In 1995, the Washington State Legislature continued this work by enhancing the goals of the 1915 (c) HCBS Medicaid Waiver: *"By June 30, 1997, the department shall undertake to reduce the nursing home Medicaid census by at least one thousand six hundred by assisting individuals who would otherwise require nursing facility services to obtain services of their choice, including assisted living services, enhanced adult residential care, and other home and community services."* (HB 1908, codified in RCW 74.39A)

To meet the legislature's intent and better manage the LTC Medicaid expenditures in Washington State, ADSA worked with stakeholders, including AAAs, to facilitate increased development of home & community based long-term care settings and options, which included better rates. Home & Community Services field social workers were deployed to work with nursing home residents and facilities to improve discharge processes so that more individuals could return, or transition, to home and community-based settings. In addition, the services provided by the Area Agencies on Aging expanded to include case management of individuals ages 18 and older receiving in-home services under the 1915 (c) waiver, Medicaid Personal Care Services and Chore programs. Individuals receiving these services must meet both financial and functional eligibility criteria.

With these additional responsibilities, the scope of the AAAs mission and service delivery expanded to coordinating and assisting low-income adults eighteen years of age and older with functional disabilities to maximize their independence, dignity and quality of life. AAAs are also responsible for monitoring and procurement of home and community based service providers. In providing case management under these programs, AAAs must follow federal and state regulations; and act in place of the State Medicaid agency. They work closely with Home and Community Services who is responsible for determining initial functional eligibility, initial and on-going financial eligibility, case management of clients in residential community and nursing home

settings and investigation of reports of abuse, neglect, abandonment or exploitation of vulnerable adults. Because of the AAA acting for the state and the strict federal and state regulations surrounding Title XIX-funded services, AAAs must approach the work differently than is done with OAA and SCSA-funded services.

Area Agencies on Aging utilize funding under Title XIX of the Social Security Act to provide the services listed below to eligible clients ages 18 and over. More detailed information regarding eligibility criteria and descriptions of services can be found in the Long Term Care Manual.

- Information and Assistance for individuals eligible for Title XIX services
- Case Management of clients receiving in-home care including assessment, service planning and implementation, and case management termination planning
- Nursing expertise with assessment and care planning under case management services
- Contracting and monitoring of home care agencies
- Authorization, contracting and monitoring of additional waived services under the 1915 (c) waiver programs to include
  - Environmental Modification
  - Home Delivered Meals
  - Home Health Aide Service
  - Personal Emergency Response Systems
  - Skilled Nursing
  - Adult Day Care
  - Adult Day Health
  - Specialized Medical Equipment
  - Client Transportation
  - Client Training

### SECTION III. Listing of Local Area Agencies on Aging

PLANNING AND SERVICE AREA	AREA AGENCY ON AGING	COUNTIES SERVED	HCS REGION
1	<b>Olympic Area Agency on Aging</b> 11700 Rhody Drive Port Hadlock, WA 98339 Phone: (360) 379-5064	Clallam, Jefferson, Grays Harbor, Pacific	Region 6
2	<b>Northwest Regional Council</b> 600 Lakeway Drive, Suite 100 Bellingham, WA 98225 Phone (360) 676-6749	Island, San Juan, Skagit, Whatcom	Region 3

3	<b>Snohomish County Long Term Care &amp; Aging Division</b> 3000 Rockefeller Ave. M/S 305 Everett, WA 98201 Phone (425) 388-7200	Snohomish	Region 3
4	<b>Aging &amp; Disability Services</b> Seattle Municipal Tower 700 - 5th Ave., 51st Floor Seattle, WA. 98124 Phone: (206) 684-0660	King	Region 4
5	<b>Pierce County Aging &amp; Long Term Care</b> 3580 Pacific Avenue Lakewood, WA 98418 Phone (253) 798-7236	Pierce	Region 5
6	<b>Lewis/Mason/Thurston Area Agency on Aging</b> 3603 Mud Bay Road Olympia, WA 98502 Phone (360) 664-2168	Lewis, Mason, Thurston	Region 6
7	<b>Southwest Washington Agency on Aging and Disabilities</b> 201 NE 73 <sup>rd</sup> St., Suite 201 Vancouver, WA 98665 Phone (360) 735-5720	Clark, Cowlitz, Klickitat, Skamania, Wahkiakum	Region 6
8	<b>Aging &amp; Adult Care of Central Washington</b> 50 Simon St. SE East Wenatchee, WA 98802 Phone (509) 884-6943	Adams, Chelan, Douglas, Grant, Lincoln, Okanogan	Region 1
9	<b>Southeast Washington Aging &amp; Long Term Care</b> 7200 W. Nob Hill Blvd Ste. 12 (Office) P.O. Box 8349 (Mail) Yakima, WA 98908-0349 Phone (509) 965-0105	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Yakima, Walla Walla	Region 2
10	<b>Yakama Nation Area Agency on Aging</b> 91 Wishpoosh (Office) P.O. Box 151 (Mail) Toppenish, WA 98948 Phone (509) 865-5121	Yakama Reservation	Region 2

11	<b>Aging &amp; Long Term Care of Eastern Washington</b> 1222 North Post Spokane, WA 99201 Phone (509) 458-2509	Ferry, Pend Oreille, Spokane, Stevens, Whitman	Region 1
12	<b>Colville Indian Area Agency on Aging</b> P.O. Box 150 Nespelem, WA 99155 Phone (509) 634-2759	Colville Reservation	Region 1
13	<b>Kitsap County Division of Aging &amp; Long Term Care</b> 1026 Sidney Avenue (Office) 614 Division, MS-5 (Mail) Port Orchard, WA 98366 Phone (360) 337-7068	Kitsap	Region 5

#### **SECTION IV. Guiding Principles and Values to Implement the Aging and Disability Services Administration Mission and Vision Statements**

The ADSA mission and vision statement are implemented through the Aging and Disability Long Term Care Network, a partnership of the Aging and Disability Services Administration, Area Agencies on Aging and their services providers; Home and Community Services regional offices; and Developmental Disabilities Division regional offices. Each partner is guided by the following values and guiding principles when carrying out its responsibilities to effectively serve older adults, persons with disabilities, and their families. Area Agencies on Aging are responsible for ensuring quality performance by all partners in their provider networks as well as understanding of, and adherence to, these guidelines.

#### **GUIDING PRINCIPLES AND VALUES**

ADSA Values:

- Individual worth, dignity, respect, self-direction, self-reliance, choice, and ability to accept responsibility and risk.
- Right to be free from abuse, neglect, abandonment, financial exploitation, and discrimination.
- An individual's social and health needs are strongly linked.
- Family caregivers have a critical role in providing support.

- Prudent management of state and federal resources including use of outcome-oriented, accountable, efficient, research-based practices for maximum public benefit.

#### ADSA Guiding Principles:

- Individual choice and self-direction are supported by professionals – not replaced by them.
- Services and supports enable people to remain in their own home and community whenever possible.
- Support for families and caregivers that improve client outcomes.
- Appropriate prevention, health management, and intervention services and policies to help alleviate future crises, improve individual and family capacity for independence, and reduce the need for future, more expensive and less preferred services.
- A cost-effective array of services to respond to diverse needs and preferences. Note: this includes how those needs evolve with changing demographics and needs of populations served.
- Monitoring quality, safety, and accountability of federal and state licensed/certified residential care programs in the interest of residents, regardless of payment source.
- Clear and consistent policies and procedures necessary to produce a reliable, accountable service system.
- Services and supports that are culturally and linguistically appropriate for both clients and employees.

The ADSA Home & Community Services Division (HCS) oversees the operations of Area Agencies on Aging.

*The mission of the Home and Community Services Division is to promote, plan, develop and provide long-term care services responsive to the needs of persons with disabilities and the elderly with priority attention to low-income individuals and families. We help people with disabilities and their families obtain appropriate quality services to maximize independence, dignity, and quality of life.*

### **SECTION V. Policy Assumptions and System Building Strategies for the Aging, Disability, and Long Term Care Network**

The services of the Aging and Long Term Care Network shall be client-centered and shall build upon, strengthen, and integrate the client's informal support network. It is through that effort, accomplished by planning, coordination, advocacy and accountability, that the dignity and rights of the individual are maintained.

The purpose of the policy assumptions that follow is to set in place broad, general aims of what the state Aging and Long Term Care Network is charged with accomplishing. The Network's underlying assumption is that all older persons and adults with disabilities in the state of Washington have a right to live independent and dignified lives. It is the purpose of the Aging and Long Term Care Network to work towards that end.

Because of the finite resources available to the Aging and Long Term Care Network and other social/health services systems and agencies, goals must be pursued within the confines of available resources. And while scarce resources must be targeted to the vulnerable and those in greatest economic and social need, the system recognizes the need to work with and advocate for all older persons and adults with disabilities.

The following sections describe Aging and Disability Services Administration (ADSA) expectations and assumptions regarding the Aging and Long Term Care Network.

#### POLICY ASSUMPTIONS:

A. Individuals have a right to live an independent and dignified existence.

Requirements for Area Agencies on Aging (AAAs) include:

1. Providing or assuring efficient, coordinated and accessible levels of care needed by the individual to maintain his/her independence and dignity.
2. Providing a system that is client-centered, culturally competent, and one in which persons shall have a voice in shaping.
3. Providing and assuring a continuum of care using a broad range and variety of services to enable older persons to live and function in the least restrictive environment.

B. The informal support system is the primary resource for meeting the needs of older persons and adults with functional disabilities.

Requirements for the AAAs include a primary responsibility for building a comprehensive, coordinated service delivery system that integrates, augments and supports the informal system.

C. Services must take into account participants' views about the services they receive.

Requirements for AAAs include:

1. Implementing client response systems, including grievance procedures and client satisfaction surveys.
2. Providing outreach activities to identify older persons in need (the target population) and informing them of and assisting them in accessing appropriate services.
3. Devising targeted strategies to optimize health and reach the most vulnerable older persons.

4. Establishing advisory councils that include older adults, adults with disabilities, and service recipients from diverse communities.
- D. The AAA shall perform accurate assessments of community needs and prioritize them.

Requirements for AAAs include:

1. Involving a large and diverse number of local persons in annual needs assessments to assure the planning process has a broad viewpoint. This includes but is not limited to persons from the target population (see Section VII), unpaid caregivers, members of Indian tribes, and adults with mental and functional disabilities.
  2. Planning for all areas and communities within the PSA, including those of low-income, low-income minority and limited English proficiency groups, those living in rural areas, those with disabilities, those at risk of institutionalization, and those with dementia or related disorders.
  3. Developing the capacity of service providers to serve individuals both above and below the poverty threshold through client cost-sharing opportunities.
  4. Operating services under standard guidelines for all recipients.
  5. Targeting the service delivery system to the most vulnerable which includes, but is not limited to:
    - a. low-income, minority, isolated, and age 75 years or older
    - b. limited English proficiency
    - c. having one or more functional disabilities and lacking an informal support system
- E. Services must cover a broad range of care that provides options to persons to enable them to remain in the least restrictive setting possible.

Requirements for AAAs include:

1. Developing stable, ongoing, well-publicized access to the system through a variety of means including, but not limited to:
2. information and assistance that may be part of an aging & disability resource center (ADRC)
3. case management
4. specialized information and assistance for unpaid relative caregivers
5. Cooperating with other planning, funding, and provider agencies to develop service responses that address identified needs within the community, not just those services or dollars administered by the AAA. This shall include local coordination with agencies providing services to adults with mental illness, functional and developmental disabilities, and substance abuse issues.
6. Strengthening and supporting informal support systems.
7. Implementing new program initiatives such as Aging & Disability Resource Centers, person-directed care, evidence-based health promotion, caregiver resources, chronic care, nursing home diversion, etc.

- F. To the extent possible, service delivery shall be decentralized to the regional or local level giving community identity to regional and/or local efforts.

Requirements for AAAs include:

1. Establishing and maintaining ongoing relationships with local governments (i.e. cities and counties), communities, and stakeholders to understand their diverse needs or circumstances; learn about potential resources; and to establish common goals for effective local service delivery.
2. Ensuring service provider procurement information is distributed widely throughout the Planning and Service Area.
3. Ensuring service providers establish a local presence in areas they serve.
4. Establishing advisory councils that represent a broad range of geographical areas and diverse communities within the Planning and Service Area.

- G. Services provided by, directed by, and/or funded by the AAA must be cost effective and efficient and meet the needs of its diverse clientele.

Requirements for AAAs include:

1. Establishing a fair and open competitive procurement process for purchasing services that emphasize quality as well as price.
2. Developing an effective service monitoring and evaluation procedure using clear, objective service standards.
3. Developing effective contracting and contract monitoring procedures.
4. Ensuring contractors meet contract standards.
5. Requiring contractors to conduct background checks for personnel who have unsupervised access to individuals served.
6. Developing a system of services by contracting for, coordinating or integrating services.
7. Seeking out and/or developing potential providers of services in the service delivery community in order to maximize service availability and competition where needed.
8. Providing technical assistance to service providers.
9. Establishing fiscal accountability through fiscal and program monitoring.
10. Ensuring prudent management of fiscal resources.

- H. Effective, involved, and representative advisory councils and bodies shall be formed at the state and Area Agency levels, involving as many older persons and adults with functional disabilities as possible who represent the target and disability population mix in the PSA. More detailed information regarding AAA Advisory Councils can be found in Chapter 2 of this manual.

Requirements for AAAs include:

1. Securing representation on advisory councils which reflects the diversity of the population within the PSA, including geographic and racial diversity.

2. Securing representation on advisory councils that includes adults with functional disabilities.
  3. Securing representation on advisory councils that includes a predominance of older persons.
  4. Securing participation by local elected officials.
  5. Establishing continuous planning involving the advisory council and other constituencies.
- I. Planning, coordination, and advocacy on behalf of older persons are a broad public responsibility.

Requirements for AAAs include:

1. Getting input from local elected officials regarding the activities of the AAA
2. Coordinating planning with local elected officials

- J. Area Agencies on Aging receive funding and act on behalf of the state Medicaid agency to deliver Aging and Long Term Care in-home Services under Title XIX of the Social Security Act.

Requirements for AAAs include:

1. Developing a broad array of services to assure access and free choice of providers
2. Managing AAA personnel to assure compliance and quality of care.
3. Contracting and monitoring of service providers to assure compliance and quality of care

Refer to the Long Term Care Manual and Chapter 6 in this manual for additional requirements.

- K. Aging and Long Term Care Services for adults are a public responsibility and must receive sufficient public financing.

Requirements for AAAs include:

1. Advocating with federal, state and local elected officials to support programs for older persons and adults with functional disabilities.
2. Advocating with public and private institutions to initiate, maintain, or increase funding of aging and long term care services.
3. Increasing other dollars to aging services by giving providers "seed money" to initiate more services paid for by participants and/or other sources.

## **SECTION VI. Targeting of Older Americans Act Funding**

Older Americans Act funding is intended to identify and serve the entire community of older individuals, with particular focus on the following categories:

- A. Older individuals residing in rural areas.
- B. Older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas). The term “greatest economic need” means the need resulting from an income level at or below the federal poverty guidelines.
- C. Older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas). The term “greatest social need” means the need caused by non-economic factors, which include:
  - 1. Older individuals with limited English proficiency (LEP)
  - 2. Cultural, social, or geographical isolation, including isolation caused by racial, ethnic, and/or sexual orientation status that results in any one or more of the following:
    - a. restricted ability of an individual to access services
    - b. restricted ability of an individual to live independently
    - c. threatened capacity of the individual to live independently
  - 3. Older individuals with severe disabilities
  - 4. Older individuals with dementia and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals)
  - 5. Older individual at risk for institutional placement, which means the individual is unable to perform at least 2 activities of daily living without substantial assistance (including verbal reminding, physical cuing, or supervision); and/or meets institutional level of care criteria
  - 6. Older individuals providing care to individuals with severe disabilities, including children with severe disabilities

**POLICY:** AAAs and their subcontractors must provide all services to minority and limited English proficient clients in at least the same proportion as the population of minority and limited-English proficient individuals in the PSA without exception in: Information and Assistance, Family Caregiver Support Program, Transportation, Congregate Nutrition and In-home Nutrition programs. AAAs and their subcontractors should attempt to provide these services to the low-income minority, rural, and limited-English proficient populations within their PSA.

Case Management services will be provided at twice the percentage levels of minorities and limited-English proficient older individuals in the PSA.

**POLICY:** AAAs and their subcontractors must provide all other services to minority and limited-English proficient older individuals in at least the same proportion as the population of minority and limited-English proficient older individuals bear to the population of older individuals of the PSA.

**POLICY:** AAAs shall include in their subcontracts references as to how providers will emphasize provision of service to the targeted populations listed above and identify and serve target populations for specific programs.

**PROCEDURE:**

- A. If the service is available in a single county, then the service need only be provided in the same proportion as the population of minority and limited-English speaking older people bear to the over 60 population in that county.
- B. A waiver may be justified and granted by ADSA in the following cases:
  - 1. In a multiple county PSA where the service is provided in one county only and that county has a lower percentage of minorities than the PSA as a whole.
  - 2. A program is funded by another service provider and that provider is focused on serving minorities and/or the limited-English speaking and the service need is considered to be adequately met.
  - 3. A program provides service to less than 50 older individuals.
  - 4. There are several service providers providing the same service in a single county and their combined efforts meet the service delivery requirements of that county.

**POLICY:** A substantial number of older Native Americans or minority and/or limited-English speaking older individuals residing in a single county of a PSA shall be defined as 100 or more older individuals, of a single ethnic group, or with a common primary language.

**PROCEDURE:**

- A. Title XIX Case Management/Nursing Services - if in a single county there are a substantial number (100 or more) case management clients of a single ethnic group or with a common primary language, the AAA or Case Management provider shall employ or contract for an individual fluent in the language or of the ethnic background of that group.

If a AAA is unable to hire or contract for qualified language specific staff, the AAA may request a waiver from ADSA. The waiver request must describe the recruitment efforts made by the AAA.

- B. Other AAA Services - if in a single county there are a substantial number (100 or more) of minority and/or limited-English speaking older individuals of a single ethnic group, or with a common primary language, the AAA or service provider shall implement a defined strategy for reaching/serving these populations. Acceptable strategies include:
  - 1. Employ or contract for an individual fluent in the language or of the ethnic background of that group, whose responsibilities shall include:

- i. Taking action to assure that assistance is made available to older individuals of limited-English speaking ability in order to assure access to and receive assistance from available services.
  - ii. Providing guidance to individuals engaged in the delivery of supportive services under the area plan to enable them to be aware of cultural sensitivities and to take into account linguistic and cultural differences.
2. Implementation of an outreach plan that targets the identified populations in an effort to ensure that these communities are aware of available services, assisted to access services and supports, and provided with cultural appropriate training and educational materials as is necessary. At a minimum, the outreach plan must:
- i. be written and incorporated into the AAAs internal policies and procedures
  - ii. clearly delineate roles and responsibilities
  - iii. include a schedule of planned outreach activities/events
  - iv. identify how translation and interpreter services will be provided
  - v. include a method for evaluating the effectiveness of outreach activities

## **SECTION VII. Funding Formula**

**POLICY:** A formula (effective January 1, 1993), which takes into account indicators of vulnerability, is used to distribute Older Americans Act (except for Title V), Senior Citizens Services Act (SCSA), State Family Caregiver Support Program (SFCSP), state and United States Department of Agriculture (USDA) Senior Farmers Market Nutrition (SFMNP) and Volunteer Chore funding to AAAs. The formula components and weights assigned to each are:

<u>Factor</u>	<u>Weight</u>
Age 60+ Populations	25%
Age 60+ at or below poverty	30%
Age 60+ minorities	12%
Square Miles in AAA Service Area	10%
Age 60+ Limited English Speaking	05%
Age 60+ Needing Asst. w/ ADL's	18%

## **SECTION VIII. Confidentiality**

**POLICY:** Personal information may not be disclosed by any person or organization without the informed consent of the individual who is the subject of the information.

**PROCEDURE:** Additional information regarding the confidentiality policy and releases of information can be found in the LTC Manual.

## **SECTION IX. Use of Area Agency on Aging (AAA) Funds to Serve Residents of Long-Term Care (LTC) Facilities**

**POLICY:** AAA funds may not be used to provide services to individuals living in long term care residential settings with the following exceptions:

- A. When services are designed specifically to benefit LTC residents, e.g., ombudsman services; and
- B. When it is documented that the provision of such services will enable the resident to move to a lower level of care within a specific time period.
- C. Contracting and oversight of Medicaid waiver services.

**PROCEDURE:** Each AAA may establish its own procedures consistent with the above policy regarding the use of aging funds to provide services to residents of a LTC facility. Whether or not the LTC facility is being paid by the state to provide the service in question should be taken into consideration when establishing local procedures.

## **SECTION X. Code of Ethics**

**POLICY:** Each AAA and their subcontracted service providers must have on file written policies containing ethical standards of behavior. Such policies must be distributed to all employees, and each employee must receive training that will enable the employee to apply those policies into practice

### **PROCEDURE:**

The purpose of the Code of Ethics policies is to provide guidelines and clear directions to employees as they provide services to vulnerable, frail adults.

These policies should, at a minimum, address the following:

- A. Acceptance or usage of a client's money or property (i.e. sharing living expenses or purchasing bulk items or accepting gifts)
- B. Purchase of client's property, real and otherwise
- C. Selling services, property, investments or anything of value to clients
- D. Setting parameters of time and relationships (i.e. employee off-time and employees' friends or relatives performing activities or services for clients)
- E. Issues regarding the roles of the employee related to protection of the client with regard to financial interests, health care decisions, living arrangements (i.e.

guardianship, power of attorney or protective payee and limits on who may be such a fiduciary)

F. Consequences of breaching ethical conduct

To see the policies used by ADSA, please refer to DSHS Administrative Policy 18.64 (*Standards of Ethical Conduct for Employees*), Chapter 42.52 RCW, and RCW 9A.80.010 .

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IN THE SUPERIOR COURT IN AND FOR THE COUNTY OF PIERCE  
STATE OF WASHINGTON

RESA RAVEN, )  
 )  
 Plaintiff, )  
 )  
 vs. ) No. 09-2-10119-7  
 )  
 STATE OF WASHINGTON )  
 DEAPRTMENT OF SOCIAL AND )  
 HEALTH SERVICES, )  
 )  
 Respondent. )

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VERBATIM REPORT OF PARTIAL PROCEEDINGS  
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BE IT REMEMBERED that on the 26th day of  
March, 2010, the above-mentioned cause came on duly for  
hearing before the HONORABLE KITTY-ANN vanDOORNINCK,  
Superior Court Judge in and for the County of Pierce, State  
of Washington; the following proceedings were had, to-wit:

APPEARANCES

FOR THE PLAINTIFF: JEFF B. CROLLARD  
Attorney at Law  
  
FOR THE RESPONDENT: CATHERINE ROUBAL HOOVER  
Assistant Attorney General  
  
Reported by,  
Carla J. Higgins, CSR

1 MARCH 26, 2010

2 (Excerpt begins.)

3 THE COURT: I think you're jumping too far ahead.  
4 Let me interrupt you. Do you have any other topics you  
5 want to talk about, because I have some questions?

6 MS. HOOVER: Okay.

7 THE COURT: Mr. Crollard can jump in, as well.

8 In the Order of Guardianship that ordered Ms. Raven  
9 to be the guardian, it's a limited guardianship and there's  
10 two things that she's required to do, is my understanding  
11 -- correct me if I'm wrong -- consent or refuse medical  
12 treatment and to decide who shall provide care and  
13 assistance.

14 MS. HOOVER: There's actually three things, Your  
15 Honor. She also was required to comply with the personal  
16 care plan statute, 11.92, I think it's 043.

17 THE COURT: Do you have the actual order?

18 MS. HOOVER: I did not bring it with me. I do  
19 recall it's an actual order, Exhibit 25.

20 MR. CROLLARD: I have the order. I can pull it out.  
21 I think what Ms. Hoover is referring to, it essentially  
22 says to comply with the guardianship laws.

23 MS. HOOVER: No. It says the personal care plan  
24 statute, it specifically cites to that Exhibit 25.

25 THE COURT: I looked at it before. Hang on.

1 MS. HOOVER: And is her -- her expert Tom O'Brien  
2 said that she had all the duties of a medical guardian, and  
3 let me just touch on that, Your Honor.

4 THE COURT: That why I want to get to the order. To  
5 me, that's critical.

6 MS. HOOVER: If she didn't have all the authority  
7 she needed to authorize the care that Ida needed, under  
8 11.92.043, she had a duty to the court to inform the court  
9 that the scope of her guardianship needed to be expanded,  
10 and she never did that. Her personal care plans --

11 THE COURT: Just a second. I want to read it into  
12 the record to make sure we all understand what it says.

13 MS. HOOVER: Yes.

14 THE COURT: So she's appointed limited guardian of  
15 the person of Ida, shall be specifically stated in this  
16 order as required, letters of guardianship, do a report,  
17 annual reports, who all is going to be advised...

18 MS. HOOVER: Right. And the annual reports, I think  
19 it specifically says complies with RCW 11.92.043.

20 THE COURT: Where did I come up with these two...  
21 Ida shall lose the following rights unless exercised by her  
22 limited guardian of the person: To appoint someone to act  
23 on her behalf, to consent to or refuse medical treatment  
24 consistent with 7.70.065, and to decide who shall provide  
25 care and assistance. And she has duties to report to the

1 court. But we're talking basically about two main things.

2 MS. HOOVER: I'm sorry. I didn't bring it with me.  
3 She was ordered --

4 THE COURT: Let me hand it to you.

5 MS. HOOVER: -- to comply with the personal care  
6 plan statute, Your Honor.

7 THE COURT: Right. But as to the order itself,  
8 there are two -- it wasn't a full guardianship.

9 MS. HOOVER: That's correct.

10 THE COURT: I mean, I deal with them every week so  
11 the distinction to me is important. It may not make a  
12 difference, but I think it's important. She has the  
13 regular duties of reporting to the court all of those kind  
14 of things and giving notice to everybody else. But those  
15 specific things I think on the second to last page there,  
16 Ida has the right to do all sorts of things but these are  
17 the two main things she can't do and Ms. Raven is going to  
18 do for her now.

19 MS. HOOVER: And Ms. Raven is required to develop  
20 her personal care plan.

21 THE COURT: And that's specified in the order, as  
22 well.

23 MS. HOOVER: Right. Let's say it was limited and  
24 all she did was consent when asked. Under 11.92.043(2)(g)  
25 if she needed more authority she absolutely had to petition

1 the court for that, if the guardianship needed more  
2 authority. She didn't have to stay in as guardian. But  
3 the statute says that the guardian needs to make  
4 recommendations about the scope of the guardianship. And  
5 so she knows she's the only one reporting to the court. As  
6 she saw everything falling through the cracks, did she  
7 truly lack the authority to give Ida the care, authorize  
8 the care that she needed? She needed to inform the court  
9 and she never did. Her personal care plans are at Exhibits  
10 27 and 30 and they specifically tell the Court, it says,  
11 "Recommended changes to the scope of guardian: None." So  
12 either way, she messed up. Either she had all the  
13 authority she needed to authorize the services that Ida  
14 needed, and I think she did, I think she was correct  
15 actually in telling the court I don't need more authority,  
16 because I think under her appointment order and the order  
17 requiring her to develop the personal care plan, I think  
18 she had the authority that she needed. But if she didn't,  
19 she had a duty to tell the court the scope of this  
20 guardianship needs to be expanded, and she didn't do that.

21 THE COURT: Right. In the hearing in front of Judge  
22 Strophy one of his suggestions was to change caregivers and  
23 she already had the authority to do that. That's clear  
24 under the previous order. That sort of, to decide who  
25 shall provide care and assistance, the second prong, she

1 more than once had consented to medical treatment by having  
2 her brought to the doctor or having her go to the hospital.  
3 So clearly that was done a couple of times. Then she  
4 clearly made decisions about who the caregivers were going  
5 to be. Continue with SCCS, get this nurse practitioner for  
6 a little tiny period of time, get the Providence Hospital  
7 hospice folks on board, so other caregivers were involved.

8 So my question then -- and I'm not going to  
9 articulate it very clearly -- so it's the pattern of  
10 conduct that fails to provide the goods and services. So  
11 it's the Department's position that this pattern over a  
12 year or two of not re-positioning her every two hours, not  
13 having consistent medication and not having personal  
14 hygiene -- let's call it that -- that's the pattern of not  
15 making sure that those things happened?

16 MS. HOOVER: That's correct. I think it's clear  
17 from the Conclusion of Law, both 56 and 46, that Ida needed  
18 pain management, re-positioning and personal bath care.  
19 And then Conclusion of Law 56 says that for many months, if  
20 not longer, these three basic medical care needs were  
21 critical to Ida's well-being. And as Ida's court-appointed  
22 guardian for medical decisions, Ms. Raven was ultimately  
23 responsible -- as Ida's court appointed guardian -- for  
24 medical decisions. Ms. Raven was ultimately responsible  
25 for ensuring these basic needs were met. Ms. Raven's

1 failure to ensure these critical care needs were met did  
2 constitute a pattern of conduct or inaction that failed to  
3 provide the services to maintain Ida's physical health and  
4 failed to avoid and prevent physical harm to her.

5 So I think that the final order is finding neglect  
6 under both of those prongs in sub A.

7 THE COURT: I don't think I have any other  
8 questions.

9 MS. HOOVER: I would like to conclude very briefly  
10 and recognize that we can all have sympathy for Ms. Raven  
11 and the evidence shows there was no malicious conduct and  
12 that she, in fact, cared for Ida and Richard and her  
13 daughter and everybody concerned very much. But it appears  
14 that she was in over her head. This was her first  
15 guardianship and Ida had a lot of behavioral challenges and  
16 Ms. Raven wasn't familiar with all of the resources out  
17 there. I can imagine that it must have feel terrible to  
18 have the State find that you neglected somebody that you  
19 cared about. But there is not an intent element or defense  
20 in the statute. Her good intentions and her lack of  
21 experience are not a defense. There is substantial  
22 evidence for the finding of neglect, and it's not in there.  
23 It should be upheld.

24 THE COURT: I know you want to briefly reply. I'm  
25 going to rule, and then I'm going to ask sort of how we do

1 it.

2 I am going to reverse the Department and I, unlike  
3 -- I don't want to give a 170-page written decision like  
4 the review judge did. I don't know if I have to go through  
5 specifically which Finding of Fact I disagree with or which  
6 Conclusions of Law.

7 Let me tell you the Conclusions of Law I do disagree  
8 with. Primarily I'm looking at this limited guardianship,  
9 the two elements that was Ms. Raven's responsibility. Now,  
10 this is an incredibly difficult case. There's no question  
11 that a lot of time and energy and resources went into  
12 taking care of Ida. Sure, some things, in 20/20 hindsight,  
13 could have been done differently and I'm not condoning the  
14 practice, but I'm not finding it reaches the level of  
15 neglect under RCW 74.34.

16 Where I specifically have problems with the review  
17 judge's finding are his Conclusion 52. He indicates,  
18 "Appellate had a duty to have meaningful, in-person  
19 contacts with Ida as needed to observe her circumstances."  
20 I agree with that. And that's where I do think that Ms.  
21 Raven, if there was a problem, that was a problem.

22 But from there it goes 53, where it says, "If the  
23 Appellant had made meaningful, in-person visits to Ida in  
24 the later part of 2006, the Appellant could have  
25 re-evaluated her decision not to place Ida in some form of

1 full-time residential facility." I think that's just  
2 absolute speculation. I mean could, would, should, that's  
3 not a Conclusion of Law that I think falls from the facts.

4 I think that the record is clear that Ms. Raven  
5 deferred to the medical providers and said to them, you  
6 certainly can take her to the hospital if it gets that bad.  
7 I will authorize it; I will authorize it if she needs  
8 medical assistance. I think the record is clear that that  
9 conversation went on regularly and she was in regular  
10 contact with the care providers. That's the speculation  
11 part.

12 Still on number 53 he says, "At the very least,  
13 meaningful in-person visits would have stressed upon the  
14 Appellant the need to immediately retain adequate staffing  
15 in the home, notwithstanding the Appellant's reluctance to  
16 be responsible for their supervision."

17 I don't think Ms. Raven ever didn't understand that  
18 there needed to be more care. What happens is you have a  
19 person who's indigent, Ida, who can't pay for medical care  
20 and is only allotted a certain amount of hours by the  
21 Department. And you have Catholic Community Services  
22 unable to fill those hours. I don't have any problem with  
23 Ms. Raven not hiring somebody independent. I don't think  
24 she would have been capable of training them and that was  
25 not her job. I think the agency supervisor, in terms of

1 being able to be tell the caregivers, train the caregiver  
2 when you have somebody -- when you have somebody in such  
3 dire medical need, I find that Conclusion of Law to be  
4 wrong.

5           Then on 54 is the same basic thing. "Having made  
6 the decision that Ida was to remain in her home, the  
7 Appellant cannot excuse herself from the duty of procuring  
8 independent caregivers to provide necessary bi-hourly  
9 re-positioning and timely personal bath care by claiming  
10 she was not experienced in supervising such staff."

11 There's no question it would have been better to have  
12 somebody come in and do that more regularly. But, again, I  
13 just don't think there are resources available. If wealthy  
14 people can hire private nurses, poor people don't have  
15 access to that.

16           So was it ideal? No. Was Ida difficult? Yes.  
17 Were there lots of people who were trying to help her?  
18 Yes. Did Ms. Raven have some responsibility? Yes. But,  
19 again, I don't think it rises to the level of neglect.

20           In 55 he says, "Attempts at remedying Ida's  
21 untenable situation were not enough, effective results or  
22 turning the responsibility over to others who could obtain  
23 the necessary result was required." And I disagree with  
24 that in terms of -- there was constant communication  
25 between the people who were trying to help, and I think

1 this is not an uncommon scenario. Unfortunately, as  
2 people's medical care doesn't get met in home but they want  
3 to stay at home for a variety of reasons, and I think that  
4 Ms. Raven was trying to respect that wish of Ida's.

5           There's more in Conclusion of Law No. 55 that I have  
6 a problem with. That's why I don't know exactly how much I  
7 should talk. In that Finding, in that Conclusion -- I'm  
8 sorry -- he talks about duty to let the court know of her  
9 need to be released from the guardianship duties. I think  
10 that she demonstrated, you know, that she understood the  
11 court was in charge by having the motion in May of 2006  
12 and, you know, the one -- having sat in that position and  
13 having a guardian say, gee, what should I do, I don't know  
14 -- I'm the guardian and I don't know what resources are  
15 available and I don't have any options either and I don't  
16 think that would have been necessarily helpful in the  
17 timing of when things got critical, was clearly that  
18 December 15, 16 whenever the power outage was and then  
19 December 30 going to the hospital, those two weeks were  
20 critical. There wasn't necessarily time to go to court to  
21 find some other intervention. I don't think that's kind of  
22 a reasonable Conclusion of Law.

23           He ends that Conclusion of Law by saying, "Such  
24 action would have forced the court and the Department to  
25 take alternate and possibly more aggressive action in

1 providing care for Ida rather than allowing her condition  
2 to spiral into a situation where she was lying with open  
3 wounds in her own excrement for hours at a time." I just  
4 think that's unrealistic and not a Conclusion of Law.

5           Number 56, "The Appellant's lack of attention and  
6 remedial action as Ida's court appointed guardian for  
7 medical decisions contributed to Ida's inadequate pain  
8 management, inadequate re-positioning and inadequate  
9 personal bath care for at least several months, if not  
10 longer." Again, I think there was a critical period of  
11 time in December. I think she was doing the best she could  
12 with the resources that were available. And the court put  
13 her in an untenable position to begin with.

14           Having said that, I do think that the better  
15 practice -- and I'm sure everybody has learned from this  
16 case -- would be more in-person visits and more attempts to  
17 determine if Ida would change her mind about anything. I'm  
18 not speculating whether the result would be different. I'm  
19 just indicating the better practice would be more visits.  
20 I have become more diligent with the guardianships I  
21 oversee about their in-person visits, how regular they need  
22 to be, after reading the transcripts and realizing how it  
23 does make a difference if you see somebody, so the court  
24 knows there's face-to-face. Doesn't change anything, it  
25 just feels better.

1           So I think that, like I said, if there's something  
2 to be learned from this, I think that's the most important  
3 thing, to continue to reassess and re-engage the person to  
4 see if there's anything that they want to do differently.

5           So I don't know where we go from here. I want to  
6 thank both attorneys for really excellent brief writing. I  
7 know that you both put a lot of work into it, as did I.  
8 It's a huge undertaking so I want to thank you both for  
9 that.

10           Suggestions what to do now? If I'm required to go  
11 through every finding that the review judge made I will,  
12 but it's going to take me forever.

13           MS. HOOVER: I think I can order the transcript and  
14 then draft an order and have you review it to see if it  
15 captured the oral ruling.

16           THE COURT: I will say in reviewing it all, most of  
17 the Findings of Fact, most of them I don't have any issue  
18 with them. I know there were several of them that the  
19 Appellant criticized and would like me to reverse but I'm  
20 not tempted to do that. It's really the Conclusions of  
21 Law, that's what I talked about in the beginning, what is  
22 my job, is the application of law with the facts. I pretty  
23 much agree with the review judge's facts that have been  
24 presented, I just think the application of law is wrong.  
25 That's one more person's decision.

1 MR. CROLLARD: Your Honor, in the APA there is a  
2 provision that says if the Court, you know, reverses or  
3 remands, that it should set the, you know, the basis for  
4 its decision. That's actually one reason why the proposed  
5 order that we offered has a fair amount of detail. But I'm  
6 not aware of any case law that would say you have to go  
7 through every Finding of Fact or every Conclusion of Law.

8 With regard to your last statement, for consistency  
9 sake, sometimes there's Findings of Fact that are  
10 designated Findings of Fact that are actually sort of  
11 Conclusions of Law in there. At least this is my  
12 interpretation of some of them. Occasionally there's an  
13 instance where it says, you know, she had a duty to, you  
14 know, to obtain, you know, an individual provider, that  
15 kind of thing. So sometimes they are linked. It may make  
16 sense to not just categorically say none of the Findings of  
17 Fact would be set aside.

18 THE COURT: There are several Findings of Fact that  
19 have Conclusions of Law interspersed in the facts. I don't  
20 know if we can parse that out or if I can make another  
21 blanket statement.

22 MR. CROLLARD: I think Ms. Hoover and I can make a  
23 proposed order based on the transcript and your oral  
24 ruling.

25 THE COURT: I'd like to set a presentation date for

1 that. It's going to take time to get the transcript.  
2 Maybe a month down the road, not too far down, so I don't  
3 forget everything.

4 Anything else for the record?

5 MR. CROLLARD: We should -- should we have you sign  
6 the order allowing for the reply brief to be submitted, two  
7 days late or is your oral --

8 THE COURT: It's your record, however you want to do  
9 it. And the order striking the other material.

10 MR. CROLLARD: I think we each probably brought  
11 orders.

12 THE COURT: Why don't you work on that. I'm not  
13 going anywhere.

14 (Adjourned.)  
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## **Agency Plan for 6.287 Percent GF-S Allotment Reduction**

**Agency Name: Medicaid Purchasing Administration**

**Name of Service Being Eliminated: Pharmacy benefits for adults**

**Description of Reduction:** The department will eliminate coverage for outpatient prescription drugs provided by a retail pharmacy. These prescriptions will continue to be covered for Long Term Care clients who are under the supervision of Aging and Disability Services Administration and coverage will still be provided for medications administered in the physician's office and the outpatient hospital setting.

**Dollar Amount (GF-S reduction in thousands):** Preliminary estimate is about \$39.4M. This includes estimated HO savings.

**Description of Client Impact and /or Effect on Service Outcomes:** Inpatient hospitalizations and emergency room visits may increase for treatment of infections that have reached a severity where they now require IV antibiotics. Hospitalization may also be the alternative care for clients who do not have access to insulin, mental health medications, respiratory and cardiac medications, anti-coagulants, and other life supporting medications. There will be a decline in health status and an increase in costs associated with more intensive services required to treat the more severely ill. This will impact about 277,000 users.

**Implementation Date:** March 1, 2011

**Name of Service Being Eliminated: Adult Dental Services**

**Description of Reduction:** Under this cut, only emergent dental services would be provided for adult clients. Dental services allow adult clients to maintain their oral health and to make sure they can chew their food sufficiently and without pain. Sixteen percent of the clients who receive these services are already disabled.

**Dollar Amount (GF-S reduction in thousands):** \$8.3M

**Description of Client Impact and /or Effect on Service Outcomes:** If adult dental were reduced to emergency service only, treatment would be limited to clients who come to an emergency room or a dental office complaining of pain. Treatment would be limited to

elimination of pain; the cause of the pain would not necessarily be addressed, and this may result in a cycle of treating pain only. The oral health of many clients will decline, and that will lead to a decline in physical health. Other health care conditions may develop and require costly treatment. Adequate oral health is also tied to improved pregnancy outcomes and better management of chronic diseases such as diabetes. This will impact about 105,000 users.

**Implementation Date:** January 1, 2011

**Name of Service Being Eliminated: Adult Hearing Services**

**Description of Reduction:** These adult hearing services are aimed at providing clients with corrective hearing devices to restore lost or impaired hearing. Three percent of the clients who use this benefit are already disabled. Their ability to regain an optimal level of hearing can have serious impacts on their ability to function within the family or outside the home.

**Dollar Amount (GF-S reduction in thousands):** \$300K. This includes estimated HO savings.

**Description of Client Impact and /or Effect on Service Outcomes:**

Inability to hear is also a safety risk and can result in accidental injury that requires costly treatment, or possible death. Clients can no longer participate in conversation; hear their children sing in the school play, or hold a job as before. They may withdraw from social interaction and avoid social gatherings, losing access to friends as well as other support systems. Depression is a likely consequence of these circumstances. This will impact about 2,400 users.

**Implementation Date:** January 1, 2011

**Name of Program and Service Being Eliminated: Adult Hospice Services**

**Description of Reduction:** Hospice services allow terminally ill clients to spend the last six months of life in comfort and surrounded by family and friends in their own homes. Professional nursing services are provided through the hospice benefit. The nurse can assess a change in the client's condition and work with the physician to make required modifications to the care plan -- e.g. adjustments in pain medication, controlling nausea, intake needs, skin care, etc. The nurse also works with the family and support persons to help them prepare for the end of life phase of the dying process.

**Dollar Amount (GF-S reduction in thousands):** \$4.6M

**Description of Client Impact and /or Effect on Service Outcomes:** Without hospice services, clients are likely to require increased use of emergency rooms and possible hospitalization to

manage symptoms such as pain control. Families will not have ready access to the support they need to cope with the decline in health, and they will not be prepared for their loved ones death. About 2,600 clients currently use this service.

**Implementation Date:** January 1, 2011

**Name of Service Being Eliminated:** Adult Podiatry

**Description of Reduction:** The reduction proposed will eliminate coverage of services by podiatric physicians. Most of these podiatry services will still be covered if performed by other types of physicians.

**Dollar Amount (GF-S reduction in thousands):** \$400K

**Description of Client Impact and /or Effect on Service Outcomes:** About 6,500 users will be affected by the elimination of this service which includes treatment of broken bones in the foot, deformities of the foot, bunions and hammer toes, and care of the toe nails and skin of the foot for diabetic clients. Lack of availability of these services may result in clients requiring durable medical equipment such as canes, walkers, potentially wheelchairs. Diabetic clients may develop foot infections resulting in the need for antibiotic therapy and if severe enough amputation of the limb. Since most of these same services are available from physician and nurse practitioners, care will still be available to those clients who seek care from these healthcare practitioners.

**Implementation Date:** January 1, 2011

**Name of Service Being Eliminated:** Adult Physical, Occupational, Speech Services

**Description of Reduction:** Physical and occupational therapies support our client's ability to restore lost functions -- e.g. the ability to walk or perform activities of daily living such as: brushing teeth, dressing, fixing meals.

Speech therapy is necessary to help clients regain the function of speech, which can be lost as a result of stroke, head injury, or brain cancer treatment.

**Dollar Amount (GF-S reduction in thousands):** \$2.9M. This includes estimated HO savings.

**Description of Client Impact and /or Effect on Service Outcomes:** Occupational and physical therapy allows these clients to perform simple tasks such as packing lunches for spouses, or walking the kids to the park. For the client who was born with cerebral palsy and is now an adult, these therapies help them remain independent as well as avoid contractures or painful muscle spasms. Without speech therapy, clients may lose the ability to communicate, to express their

needs, have difficulty drinking or eating and may even be at risk of choking on his or her saliva. These conditions can also result in pneumonia. This will impact about 20,000 users.

**Implementation Date:** January 1, 2011

**Name of Service Being Eliminated: Adult Vision Services**

**Description of Reduction:** Adult vision services are aimed at providing clients with corrective lenses and frames to restore lost vision acuity. Two percent of the MPA clients who use this benefit are already disabled.

**Dollar Amount (GF-S reduction in thousands):** \$500K. This includes estimated HO savings.

**Description of Client Impact and /or Effect on Service Outcomes:** Without corrective vision services, both disabled and non-disabled clients will experience impaired eyesight, losing their independence and for some, the ability to hold a job. With impaired vision, they can no longer drive, complete ordinary household tasks or even help their children with homework. They may become wholly dependent on other family members, including their children. Impaired vision is a safety risk that can result in accidental injury, costly treatment, or possible death. This will impact about 67,000 users.

**Implementation Date:** January 1, 2011

**Name of Service Being Eliminated: Take Charge/Family Planning**

**Description of Reduction:** Family planning is part of basic health care for women; it is care that is central to their ability to complete an education, keep a job and provide care for their families. More than nine in 10 women who are eligible for publicly funded family planning services are also eligible for prenatal, delivery and post partum care if they become pregnant. Every dollar invested in helping men and women avoid unintended pregnancies saves four dollars in federal and state Medicaid expenditures. Medicaid family planning services are matched by the federal government at 90%.

**Dollar Amount (GF-S reduction in thousands):** \$1.2M

**Description of Client Impact and /or Effect on Service Outcomes:** Family planning services are important at any time, but especially in a turbulent economy. Washington may see an increase in economic problems associated with unintended pregnancy. These include: premature births, infant mortality, teen pregnancy, abortions, and the spread of sexually transmitted diseases and increased incidence of some cancers.

Approximately 43,000 women are receiving these services. It is likely these women will continue to use birth control; the methods they choose may not be as effective as those available through Take Charge. It is anticipated there may be a rise in the number of Medicaid births over time.

**Implementation Date:** March 1, 2011

**Name of Service Being Eliminated: School Based Medical**

**Description of Reduction:** This program reimburses school districts for special education related services delivered to Medicaid-enrolled children in special education in accordance with the Individuals with Disabilities Education Act (IDEA). These school-based health care services include audiology, counseling, nursing, occupational therapy, physical therapy, psychological assessments, speech therapy and evaluations.

**Dollar Amount (GF-S reduction in thousands):** \$3.3M

**Description of Client Impact and /or Effect on Service Outcomes:** Pulling state and federal funds will have an impact on the amount of resources available to these children for the healthcare related services they require to benefit from their free appropriate public education. Schools use these dollars to help fund professional healthcare positions. While they are obligated to provide the services, some will have insufficient resources to do so without this additional money. MPA estimates that approximately 20,000 clients will be impacted per year due to this reduction.

**Implementation Date:** January 1, 2011

**Name of Service Being Eliminated: Medicare Part D co-Pays**

**Description of Reduction:** Medicare has offered a pharmacy benefit through the Medicare Part D program since 2006. Each drug dispensed through the Medicare Part D program carries a co-pay requirement. Washington State covers this Part D co-pay requirement for clients who are eligible for both Medicare and Medicaid. These “dual-eligible clients” are usually very low income senior citizens.

**Dollar Amount (GF-S reduction in thousands):** \$3.2M. There is a projected savings offset for this item as this elimination will increase the spend-down requirements for long-term care clients of about \$1.3M.

**Description of Client Impact and /or Effect on Service Outcomes:**

Eliminating the co-pay coverage will shift this expense back to clients – many of whom have multiple prescriptions. For many, it will force them to choose between essential needs such as food and medicine. When the client is unable to cover the cost of the co-pays, some will do without the medicine, with adverse impacts on chronic health conditions and their quality of life. About 49,000 dual eligible users will be impacted by this elimination.

**Implementation Date:** January 1, 2011

**Name of Service Being Eliminated: First Steps/Maternity Support Services/Infant Case Management**

**Description of Reduction:** These programs help women access prenatal care. They include medical, social, education and other services and provide case management services to high risk families/infants for the first year of life. Access to prenatal care across the state is very fragile.

**Dollar Amount (GF-S reduction in thousands):** \$6.4M.

**Description of Client Impact and /or Effect on Service Outcomes:** Reducing or eliminating existing funding may result in a number of Medicaid providers closing their doors to low-income women and infants. Poor birth outcomes and infant mortality may increase which can lead to increased medical expenditures. Some groups, such as African Americans and Native Americans, have a disproportionately higher rate of poor birth outcomes than the rest of the low income population. Approximately 65,000 women currently receive these services, and eliminating these programs will leave many young pregnant mothers with little or no resources to help ensure healthy birth outcomes.

**Implementation Date:** March 1, 2011

**Name of Service Being Eliminated: Interpreter Services**

**Description of Reduction:** Interpreter services provide medical and/or social interpreter services for Medicaid clients. Although these costs are a provider's responsibility under federal law, Washington State has chosen to subsidize that expenditure in the past.

**Dollar Amount (GF-S reduction in thousands):** \$3.3M

**Description of Client Impact and /or Effect on Service Outcomes:** If these services are eliminated, providers will have to absorb the additional cost of interpreters or stop accepting Medicaid covered clients. In some cases, family members, including children or other unqualified individuals, will be recruited to relay complex medical information to clients and providers. They may have to interpret for clients who may result in poor communication and

negative healthcare outcomes for non-English speaking or limited English proficiency clients. Costly FQHC and emergency room visits may increase due to lack of providers and health emergencies. Currently, about 70,000 clients use the interpreter service.

**Implementation Date:** January 1, 2011

**Name of Program Being Eliminated: Medical Care for Disability Lifeline**

**Description of Reduction:** The Disability Lifeline (DL) Program, previously known as General Assistance – Unemployable or GA-U serves vulnerable adults who are unable to work because of a physical condition, mental illness or chemical dependency, yet who don't qualify for Medicaid or disability services. The existing program provides both a health care safety net and is often the first step in a process that leads to federally funded care and Supplemental Security Income (SSI).

**Dollar Amount (GF-S reduction in thousands):** \$20.3M

**Description of Client Impact and /or Effect on Service Outcomes:** Without Disability Lifeline benefits, many of these clients will delay needed care or seek services in already burdened community health centers (CHCs) and costly emergency rooms. Significantly, clients with chronic disabling conditions may not improve with this type of episodic care. Without Disability Lifeline many of these clients will likely become further disabled. Their chronic conditions may worsen; leading to more expensive health care needs, and result in otherwise avoidable deaths. This will impact about 21,000 users.

**Implementation Date:** March 1, 2011

**Name of Program Being Eliminated: Children Health Program (CHP)**

**Description of Reduction:** Eliminate coverage for undocumented children

**Dollar Amount (GF-S reduction in thousands):** \$10.1M

**Description of Client Impact and /or Effect on Service Outcomes:** Elimination of health coverage for undocumented non-citizen children, effective March 1, 2011. The savings estimate assumes that any emergent medical care provided to such children will continue to be covered through the Alien Emergency Medical program. This change will affect health coverage for about 27,000 undocumented children currently served under the Apple Health for Kids program. This will impact about 27,000 users.

**Implementation Date:** March 1, 2011

**Name of Program Being Eliminated:** State-only component of Alien Emergency Medical (AEM) coverage.

**Description of Reduction:** In the original 2009-11 biennial budget, the AEM program was reduced to medically emergent services for undocumented and non-citizen residents of Washington State. A new state-funded program was then implemented (the State-Funded Alien Medical program) that provides coverage for undocumented or non-citizens who suffer from cancer and require chemotherapy or surgery, who have acute or end-stage renal disease, or who have had an organ transplant and require anti-rejection medication. This program also provides coverage for undocumented aliens authorized for placement in a nursing facility. Elimination of the State funded Alien Medical program, effective January 1, 2011, would not affect the mandatory Medicaid AEM program.

**Dollar Amount (GF-S reduction in thousands):** \$8.6M

**Description of Client Impact and /or Effect on Service Outcomes:** MPA estimates that approximately 1,300 clients per year will be impacted as a result of this reduction. Their qualifying conditions are all serious and likely to require additional, uncompensated health care at hospitals and clinics.

**Implementation Date:** January 1, 2011

## Medicaid Purchasing Administration

### Estimated State Fiscal Year 2011 Savings

(Dollars in millions)

Optional Services <sup>(1)</sup> :	Effective Date	State \$ <sup>(2)</sup>	Offsets	Net State \$	# Users Impacted <sup>(3)</sup>
Adult Drugs	Mar 1, 2011	(\$39.4)		(\$39.4)	277,000
<i>FFS Estimate (Net of Rebates)</i>		(\$29.4)		(\$29.4)	
<i>Managed Care (Preliminary Estimate)</i>		(\$10.0)		(\$10.0)	
Adult Dental (Incl FQHC/RHC Impact) <sup>(4)</sup>	Jan 1, 2011	(\$8.3)		(\$8.3)	104,900
Adult Hearing <sup>(5)</sup>	Jan 1, 2011	(\$0.3)		(\$0.3)	2,400
Adult Hospice	Jan 1, 2011	(\$4.6)		(\$4.6)	2,600
Adult Podiatry	Jan 1, 2011	(\$0.4)		(\$0.4)	6,400
Adult PT-OT-ST	Jan 1, 2011	(\$2.9)		(\$2.9)	19,600
Adult Vision <sup>(6)</sup>	Jan 1, 2011	(\$0.5)		(\$0.5)	66,800
Take Charge / Family Planning <sup>(7)</sup>	Mar 1, 2011	(\$1.2)		(\$1.2)	43,000
School-Based	Jan 1, 2011	(\$3.3)		(\$3.3)	20,000
Part D Copayments	Jan 1, 2011	(\$3.2)	\$1.3	(\$1.9)	48,600
Maternity Spprt / First Steps / Infant Case Mgt (Incl FQHC/RHC Impact)	Mar 1, 2011	(\$6.4)		(\$6.4)	65,000
Interpreters	Jan 1, 2011	(\$3.3)		(\$3.3)	70,000
<b>Total, Optional Services</b>		<b>(\$73.8)</b>	<b>\$1.3</b>	<b>(\$72.5)</b>	

**State-Only Programs:**

DL/ADATSA <sup>(8)</sup>	Mar 1, 2011	(\$20.3)		(\$20.3)	21,000
Children's Health Program (CHP)	Mar 1, 2011	(\$10.1)		(\$10.1)	27,000
AEM (Non-Emergent)	Jan 1, 2011	(\$8.6)		(\$8.6)	1,300
<b>Total, State-Only Programs</b>		<b>(\$39.0)</b>	<b>\$0.0</b>	<b>(\$39.0)</b>	
<b>Grand Total (may include minimal overlap)</b>		<b>(\$112.8)</b>	<b>\$1.3</b>	<b>(\$111.5)</b>	

			Surplus/ (Shortfall)		
<b>6.3% Target</b>		<b>(\$112.8)</b>	<b>\$0.0</b>		

1,789,973, -  
000 6.3%

**Assumptions:**

<sup>(1)</sup>Does not include DME. Includes managed care impacts.

<sup>(2)</sup>Baseline budget assumes ARRA extended through June 2011.

<sup>(3)</sup>Impacted users in any given reduction step might also be counted as an impacted user in other reduction steps.

<sup>(4)</sup>Assumes only emergency dental services are preserved. Coverage for DDD and disabled clients are eliminated.

<sup>(5)</sup>Includes hardware only; physician services are preserved; 3% of expenditures relate to DD clients.

<sup>(6)</sup>Includes hardware only; physician services are preserved; 2% of expenditures relate to DD clients.

<sup>(7)</sup>Includes Take Charge and 10 month family planning extension.

<sup>(8)</sup>Estimate assumes 4 months of savings and bridge waiver approval.





CHRISTINE O. GREGOIRE  
Governor



STATE OF WASHINGTON  
OFFICE OF THE GOVERNOR

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**EXECUTIVE ORDER 10-04**

**ORDERING EXPENDITURE REDUCTIONS IN ALLOTMENTS OF  
STATE GENERAL FUND APPROPRIATIONS**

**WHEREAS**, the national economic downturn continues and revenues have fallen short of projections; and

**WHEREAS**, the current official state economic and revenue forecast of general fund revenues is less than the official estimate upon which the state's 2009-2011 biennial operating budget and supplemental operating budget were enacted; and

**WHEREAS**, the anticipated revenues combined with the beginning cash balance of the general fund are insufficient to meet anticipated expenditures from this fund for the remainder of the current fiscal period; and

**WHEREAS**, a revised official economic and revenue forecast will be submitted in September pursuant to chapter 82.33 RCW which will reflect greater downturns in estimated receipts and revenues; and

**WHEREAS**, state law authorizes and directs the Governor to implement across-the-board reductions of allotments of appropriations to avoid a projected cash deficit; and

**WHEREAS**, under state law, an across-the-board reduction in allotments necessitated by a cash deficit applies to all agencies of state government, including agencies of the legislative and judicial branches and agencies headed by elected officials; and

**WHEREAS**, funding necessary for basic education, debt service on state bonds, state pension contributions and certain other purposes cannot be withheld;

**NOW, THEREFORE**, I, Christine O. Gregoire, Governor of the state of Washington, pursuant to chapter 43.88 RCW do hereby order:

The allotment of each appropriation from the State General Fund will be reduced effective October 1, 2010, by an amount necessary to avoid a cash deficit in the State General Fund. The reductions in allotments shall be based on the September 2010 official state economic and

revenue forecast. The amount of the reduction in allotted spending authority shall be assigned to reserve status as provided in RCW 43.88.110.

The Director of the Office of Financial Management shall calculate the amount by which the aggregate of planned expenditures and disbursements charged to the General Fund will exceed the aggregate of estimated receipts credited to such fund in the current fiscal period, less the beginning cash balance. In making this calculation, the Director shall use the estimated receipts and revenues contained in the September 2010 official state economic and revenue forecast. The Director shall enter across-the-board revisions to the allotment of each appropriation from the State General Fund effective October 1, 2010, by the amount calculated under this order. The Director shall not withhold approval of spending authority necessary to satisfy constitutional obligations such as basic education, debt service on state bonds, and state pension contributions.

Signed and sealed with the official seal of the state of Washington on this 13<sup>th</sup> day of September 2010 at Olympia, Washington.

By:

/s/

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Christine O. Gregoire  
Governor

BY THE GOVERNOR:

/s/

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Secretary of State