Nursing Facility Case Management and Relocation

The purpose of this chapter is to ensure that:

- Nursing facility residents who have the desire to move to another setting are assisted by the Nursing Facility Case Manager (NFCM) in assessing barriers to relocation. This may include:
  - Ensuring residents and their informal supports have information about community long-term care options.
  - Ensuring the desire for community transition and any barriers to relocation are identified early.
  - Working with the client, their formal decision maker, their family, NF staff, and others to remove or address any barriers to discharge (transition planning).
  - Assessing, care planning, authorizing services, and making referrals and coordinating care with other community and informal resources.
  - In coordination with the nursing facility, authorizing and arranging transition resources.
- Individuals (Medicaid and Non-Medicaid), who have an intellectual disability or related condition and/or serious mental illness, are assessed for their need for specialized services per the Pre-Admission Screening and Resident Review (PASRR) process (see *PASRR section* for more information).
- Medicaid clients are determined/ confirmed to meet nursing facility eligibility.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Julie Cope RCL/NFCM Policy Unit Manager
360.725.2529 julie.cope@dshs.wa.gov

TABLE OF CONTENTS

Nursing Facility Case Management and Relocation 1
Table of Contents 1
Nursing Facility Case Management and Relocation Purpose, History and Philosophy 4
Philosophy of Nursing Facility Case Management 4
The Role of the Nursing Facility Social Worker 4
Providing Nursing Facility Case Management and Relocation Activities 5
What is the NFCM's Role with Hospital Swing Beds? 6
What is the NFCM's role with a Hospital's Bed Readiness arrangement with their assigned Nursing Facility? 7
NFCM Work Performance & Relocation Standards 7

Nursing Facility Admission: From the Community Setting (HCS/AAA/DDA Responsibilities) 9
Nursing Facility Admission: From the Hospital (NFCM/ DDA CRM Responsibilities) 12
Nursing Facility Admission or Approval of Expanded Behavior Support Services in a Nursing Facility (HCS coordination of Behavior Support Case Management and NFCM) 15
How is the Payment Begin Date Determined? 23
Nursing facility admits for Apple Health (AH) Managed Care clients (Classic and MAGI) 23
PRE-ADMISSION SCREENING & RESIDENT REVIEW (PASRR) 27
What is PASRR? 27
Who should be screened under PASRR? 27
What happens if someone meets the PASRR criteria for PASRR Level 2? 28
Clients that do not meet Nursing Facility Level of Care (NFLOC) 31
To facilitate payment to the NF using state funds: 33
Determining and Documenting Transition Goals 34
Ready for Relocation 34
No Current Transition Plan/Goal 36
Case Transfer Protocol for Institutional Settings (Hospital, Nursing Facility, or ICF-ID) 36
Transition Resources 37
Home Maintenance Allowance (HMA) 37
Community Transition Services (CTS) & Transition Support Services 39
Community Transition or Sustainability Services (CTSS) 43
Assistive Technology (AT) 46
Social/ Therapeutic Leave 46
Roads to Community Living (RCL) 47
HCS Housing Resources 48
State Funded Community Transition and Sustainability Services & Washington Roads 48
Resident Rights 48
Out of State Nursing Facility admissions 51
Admission of DDA Clients 52
State Funded Long-Term Care for Non-Citizens 53
Home & Community Services Private Health Insurance and Good Cause Determinations 53
Rules and Policy 54
Revision History 55
Appendix 59

Example of NFCM Weekly Tasks Schedule 59
HCS Decision Making for Transitions/Authorized Representative 60
Amazon Authorization Process (NFCM Only) 60
Client Services Purchasing Card Process-HCS Only 60
Documenting NFLOC in CARE - YouTube 60
Nursing Facility Expanded Behavior Supports Service Eligibility & Description 61
Transitional Care Center of Seattle 61
What Program to Use: Transition and Sustainability Goods and Services 61
Supporting Client Transitions to the Community - YouTube 61
MedStar Non-Medical Transportation Referral Process 61
Sample Letters: 62

NURSING FACILITY CASE MANAGEMENT AND RELOCATION PURPOSE, HISTORY AND PHILOSOPHY

Philosophy of Nursing Facility Case Management

The State of Washington is among the nation's leaders in rebalancing institutional and community-based long-term care services. The Washington State legislature recognized the desire of most people to maintain as much independence as possible in lesser cost settings and as a result passed legislation directing the department to expand the options available to long-term care clients beyond nursing facility care (Chapter 74.39 RCW, Chapter 74.39A RCW, and Chapter 70.41 RCW). This legislation also directed that the department provide transition planning for individuals to assist them in moving to the least restrictive setting of their choice.

The Home and Community Living Administration (HCLA) continues to work actively with individuals from the point of admission to a nursing facility to achieve the client's community transition goals and potential. This includes meeting face-to-face with clients early in their admission and working with families and staff at the facility to advocate that therapies, treatments and training is provided in a timely fashion. The goal is for clients to receive services in the least restrictive, most appropriate setting that meets the client's care needs while honoring client choice and preference.

HCLA embraces the belief that individuals with very high care needs can be cared for and supported in a variety of settings through the implementation of waivers and state plan services which provide alternatives to nursing facility long term care. HCLA's mission has been, and continues to be, to provide an array of long-term services and supports options from which clients and their families can choose.

The Role of the Nursing Facility Social Worker

The discharge planning responsibilities of nursing facility staff are governed by WAC 388-97-0080, WAC 388-97-0120, 42 Code of Federal Regulations (CFR) 483.15, and 42 CFR 483.20, and 42 CFR 483.25:

- 42 CFR 483.15 requires that when a resident's health improves sufficiently, the resident can be discharged with appropriate notice. Facilities are required to provide sufficient preparation to the resident to ensure safe and orderly transfer.
- 42 CFR 483.20 requires that the facility conduct initial and periodic comprehensive assessments (there are timeframes established in federal rule).
- 42 CFR 483.25 requires the assessment include the services needed to attain the resident's highest physical, mental and psychosocial well-being possible.

The care plan must include a summary of the resident's stay and final status, and a post discharge plan of care. The nursing facility staff should work collaboratively with the Nursing Facility Case Manager (NFCM) to provide and ensure a smooth transition from institutional long-term services and supports to community long term services and supports.

Providing Nursing Facility Case Management and Relocation Activities

Home and Community Services (HCS) provides nursing facility case management by working with HCS/Area Agency on Aging (AAA)/Developmental Disability Administration (DDA) staff, the client, family members/informal supports, formal decision makers, nursing facility staff, the client's physician, and community providers to assist clients in accessing services in the community.

NFCMs are responsible for transition planning and case management for:

1. Dual eligible clients (Medicare clients who also have Medicaid as a secondary payment source).
2. Medicaid applicants/recipients who need nursing facility payment to cover the cost of their care.
3. Private pay clients, when requested and as time allows.

NFCMs are **not** responsible for transition planning and case management for:

1. Program of All-Inclusive Care for the Elderly (PACE) enrolled clients. These cases should not be transferred/worked by NFCMs because the PACE organization is responsible for the transition planning and case management responsibility for these clients. HCS does not need to determine NFLOC for PACE enrolled clients as they already meet LOC, inherent to PACE enrollment and PACE organizations authorize NF admits prior to admit. These cases should remain assigned to their current HCS/AAA worker who coordinates with the PACE organization as needed. Please refer to Chapter 22c Program of All-Inclusive Care for the Elderly (PACE) for additional information.

A NFCM should not wait for communication from the nursing facility informing them that a client is ready for discharge. Instead, the NFCM should be actively involved with the resident at the earliest possible time to work with them, their formal decision maker, their family, the SNF, and community providers to remove/address barriers to a transition to a community setting.

Note: For more information on case transfer timeframes for when an in-home client enters an institutional setting, see the Case Transfer section of LTC Manual Chapter 5: Case Management.

NFCMs:

1. Are familiar with the nursing facility administrator, the Director of Nursing, the social services worker(s), and the discharge planner(s) in their assigned facilities.
2. Conduct a face-to-face visit for each newly admitted **Medicaid and dual eligible** client within 30 calendar days to begin to dialog about community options and their steps/desire for community transition. This action may be combined with the Nursing Facility Level of Care determination for the Medicaid resident.
3. Meet with the client, monitor health conditions and physical status for stability and predictability and document all work and progress towards the client's transition goals in CARE. Document your person-centered planning discussions with the client in a SER at a minimum of every 60 days.

4. Give information to nursing facility staff and residents on the services and supports provided by HCLA. This includes meeting with residents, their formal decision maker, and families to revisit LTSS options and reconsider community transition on a regular basis.

What is the NFCM's Role with Hospital Swing Beds?

The Social Security Act allows certain small, rural hospitals and critical access hospitals to use their beds for both acute care and post-acute skilled nursing facility care with Department of Health approval. These swing bed residents' conversions require physician orders from acute care to swing bed status and ongoing progress notes in the hospital's medical record system.

Rural Hospitals with approved swing beds must comply with SNF participation requirements under 42 CFR 482.58(b)(1–7):

1. Resident rights
2. Admission, transfer, and discharge rights
3. Freedom of abuse, neglect, and exploitation
4. Social Services
5. Discharge Summary
6. Specialized rehabilitation services
7. Dental Services.

Critical Access Hospitals must comply with SNF participation requirements under 42 CFR 485.645(d)(1-8):

1. Residents' rights
2. Admission, transfer, and discharge rights
3. Freedom from abuse, neglect, and exploitation
4. Social Services
5. Comprehensive care plan and discharge planning requirements
6. Specialized rehabilitative services
7. Dental Services
8. Nutrition Services

NFCMs are assigned to swing bed residents after admission for nursing facility case management activities and to support relocation activities to community settings. Any NFCM tasks performed on behalf of a Hospital Swing Bed resident should be captured in the NFCM's performance standards.

As Hospital Swing Beds are licensed and approved by the Department of Health, mandatory reporting requirements related to quality of care or transition planning practices will be filed with the Department of Health as a complaint by email or online.

For more detailed Swing Bed information, review the CMS Fact Sheet on Swing Bed Services.

Note about the use of Restraints in the Hospital: The use of restraints for the prevention of falls should not be considered a routine part of falls prevention. The use of restraints for staff convenience is prohibited and should be reported to the Department of Health. For additional information on restraint use in Hospitals, see the Resource section in Chapter 9: Inpatient Hospital Assessments and Transitions

What is the NFCM's role with a Hospital's Bed Readiness arrangement with their assigned Nursing Facility?

Many Hospitals have strong relationships with local nursing facilities in their communities and will invest in efficiencies with transferring patients from their acute care hospitals to these nursing facilities. The NFCM's role in these nursing facilities remains consistent with what is outlined in the Nursing Facility Case Management and Relocation activities section. The assigned NFCM to these facilities will likely see a larger volume of interdisciplinary meetings and resident care conferences to discuss transition barriers and planning progress. NFCMs should review the tips box above to maximize efficiency and meet with their supervisors to discuss workload volume when the number of care assessments required for these facilities exceeds 12 per month.

NFCM Tips:

- Obtain a copy of the nursing facility census on a weekly basis to confirm the number of newly admitted/discharged Medicaid only and dual eligible (Medicaid/Medicare) clients.
- Ask the Facility Administrator for read only permissions/access to their electronic medical record.
- Bring HCLA informational pamphlets to nursing facilities as resource materials for residents and families.
- Attend client care conferences with nursing facility staff to keep apprised of progress towards transition goals.
- Organize your schedule to ensure completion of 2-3 full CARE assessments a week.

NFCM WORK PERFORMANCE & RELOCATION STANDARDS

HCS Nursing Facility Case Managers perform a wide variety of activities relating to NF admission, Medicaid resident case management and NF transitions. One measurement of work performance standards relates specifically to actively assisting a client to relocate to a community setting. "Relocation" for this purpose is defined as a transition to a community setting in which all the following is true:

1. The individual is an active HCS client and is assigned to an HCS RU in CARE
2. There is a discharge date on the NFCM screen in CARE (and the RCL screen if utilizing RCL)

3. The case manager has completed a full face to face CARE assessment with the client, that was created after the date of admission (during the nursing facility stay) and was:
    a. Moved to Current (either before or after transition); OR
    b. Completed and moved to History (indicated by all green progress bars in CARE Web)
4. Has a program chosen in the Care Plan screen that is not Nursing Home Services (for clients that do not meet NFLOC this field may be blank).
5. Has a planned setting chosen in the Care Plan screen that is not Nursing Facility, including when the client is not functionally eligible
6. Has an address in the Contact Details Screen that is not designated as a Nursing Facility, but instead is an HCBS Setting with a start date to correlate with the discharge date on the NFCM screen.
7. Is not discharging to jail, hospital, or another institution. (see *Case Transfer Protocol for Institutional (Hospital, Nursing Facility, or ICF-MR) Settings*)
8. Has not died while in the nursing facility.

The expectation is that NFCMs will complete an average of five relocations per month which meet these criteria. The Regional Administrator or designee may identify circumstances beyond the control of an employee that could affect his or her ability to meet this minimum standard. As it is understood that not all full CARE assessments result with a community transition, NFCMs are expected to create a minimum of eight face to face full CARE assessments each month. This may be accomplished by setting up your weekly calendar as described in the appendix section of this chapter.

NFCM Tips:

- Meet with nursing facility staff and residents on a regular basis to assist with prioritizing and reprioritizing weekly scheduled CARE assessments. Weekly in person visits at the Nursing Facility is an efficient practice which ensures all NFLOC determinations are met timely and supports person-centered transition goal monitoring.
- Use the MDS Acuity Report to identify Medicaid residents with low acuity who should be approached/reapproached with community LTSS options.
- Consider using RCL or WA Roads services to authorize a Community Choice Guide &/or Client Training Services to support a resident's transition planning.
- Request a resident care conference with the nursing facility staff, the resident, formal decision makers, and family members to keep apprised of progress towards transition goals, and to discuss barriers to transition planning.
- Discuss all services or supports available to a resident which may be helpful for community living, such as affordable housing, PERS, Assistive Technology, Durable Medical Equipment, and Community Transition Goods and Services. Not all clients want personal care.

NFCMs are **not** responsible for transition planning and case management for:

- Program of All-Inclusive Care for the Elderly (PACE) enrolled clients. These cases should not be transferred/worked by NFCMs because the PACE organization is responsible for the transition planning and case management responsibility for these clients. The NFLOC determination will be completed by the PACE Case Manager. These cases should remain assigned to their current HCS/AAA worker who coordinates with the PACE organization as needed. Please refer to Chapter 22c Program of All-Inclusive Care for the Elderly (PACE) for additional information.

NURSING FACILITY ADMISSION: FROM THE COMMUNITY SETTING (HCS/AAA/DDA RESPONSIBILITIES)

***Note**: for individuals admitting from the community and whose PASRR Level I screening indicates that a Level 2 assessment is required, DDA PASRR Assessors will determine the client is appropriate for nursing facility care as defined in PASRR prior to admission to the nursing facility (see *PASRR Section* for more information.) DDA PASRR Assessors who identify that there is no HCS Case Manager assigned to a Medicaid Nursing Facility resident will escalate this to their DDA PASRR Program Manager for resolution.

Before a client admits to a nursing facility from a community setting the AAA/HCS/DDA case worker must:

1. Make sure the client meets nursing facility level of care (NFLOC) per the NFLOC assessment in CARE:
    a. NFLOC eligibility questions are located in the Pre-Transition & Sustainability folder on the NF Case Management screen. The questions are accessed by clicking on the "+" button when a record doesn't exist for the Nursing Facility stay or the "Edit/View" button if a record does exist for the NF stay on the Nursing Facility Case Management History table. A new window will be displayed which will enable access to the NFLOC questions. Click on the NFLOC tab at the top of the screen. For each new NFLOC generated, six (6) EBS questions will be displayed in the lower half of the screen. CMs cannot exit the Nursing Facility (NF) Case Management screen unless all questions are answered. Click on the save icon at the top left of the screen once the questions are complete before exiting.
        i. All clients who are eligible for a LTC waiver or state plan, such as CFC or CFC+ COPES, are eligible for admission to a nursing facility and do not need to be re-assessed prior to completing the NFLOC questions on the NFLOC tab (a NFCM can use a DDA assessment to complete the NFLOC assessment in CARE, when needed).
        ii. Client's medical chart, nursing assistant notes, and staff interviews and other records can be used to supplement interviews with the client to assess activities of daily living, cognition, etc. to perform the NFLOC assessment for clients on state plan services such as Medicaid Personal Care (MPC), as well as for Medicaid recipients/applicants (clients who are receiving Medicaid, but not home and community program services and supports).
        iii. For clients who are case managed by DDA, the DDA Case Resource Manager (CRM) completes this NFLOC determination process based on the current DDA assessment. For cases that are co-assigned to a HCS NFCM, the DDA CRM or co-assigned NFCM completes this NFLOC determination process, in consultation with the DDA CRM.

See the recorded training *Documenting NFLOC in CARE* for instructions on updating the NFCM screen.

2. Notify HCS management of admission, per local policy, and assist the client with the admission process as needed.
3. Document in the SER note:
    a. The reason for admission to the nursing facility.
    b. A discussion with the client/representative of attempts to explore other setting and support service options.
    c. Notification of admission to regional HCS management, following local policy.

***Note:** If eligible, clients may choose nursing facility care regardless of the alternatives available, but the case manager must explain and offer all options and document the discussion in the SER note. Because the Nursing Facility is a medical setting, the facility will likely request support with obtaining a History & Physical, Physician Orders with Medication List and the PASRR as part of their admission consideration.

4. Assist the client in finding a Medicaid-certified nursing facility by using NF Compare or Nursing Home Locator, if necessary.

a. Medicaid-certified nursing facilities may not discriminate against Medicaid clients per WAC 388-97-0040.
b. A nursing facility may request a full CARE assessment and CARE Assessment Details for Admission consideration.
c. Do not facilitate client admission to a facility that has a "Stop Placement". Residential Care Services (RCS) Division may issue a "Stop Placement" when a nursing facility is in violation of its contract. Do not admit new clients until the "Stop Placement" has been rescinded by RCS. The RCS district manager may approve readmission for clients on a case-by-case basis while a stop placement is in effect.

5. Verify that a PASRR Level I Screening Form was completed prior to admit. For more information, read the *PASRR section or visit the PASRR Program Website*.
   a. If the PASRR Level I was not performed prior to admission, the case manager should complete the form, including making referrals for a Level 2 if indicated.
      i. Inform the nursing facility Admission Coordinator that the admission should not have occurred without the PASRR process being followed.
      ii. Make a report to the Complaint Resolution Unit (CRU) regarding the admission without the PASRR being completed.
   b. If a Level 2 PASRR evaluation was indicated on the Level 1 PASRR form, verify the PASRR Level 2 was completed, and the NF has a copy of the results. Make a note in the SER note to indicate the evaluation was performed.
6. For clients with Classic Medicaid: To begin payment and document nursing facility eligibility, submit the electronic DSHS 14-443 form to the Public Benefits Specialist (PBS) in Barcode, and include the following:
   a. The date of the request for NFLOC determination or CARE assessment.
   b. If the client is functionally eligible or if the level of impairment does not meet nursing facility eligibility.
   c. Date of admission.
   d. Name of the facility.
   e. If the client is likely to meet/exceed 30 days. *(This indicates the NFCM's good faith belief that the client will be residing in the facility for less or more than 30 days based on the information they have available. The PBS uses this information to determine which program rules to apply for the facility stay and to create an award letter which allows the facility to claim and be paid.)*
   f. Date of discharge, if applicable. Complete this box if the client has already been discharged from the facility at the time that you determine NFLOC. Also include the setting to which the client discharged, and which program was used, if services were authorized. The nursing facility also has a responsibility to submit a Notice of Action with this information, which the NFCM may retrieve or corroborate.
   g. Click here for more information on how the "payment begin date" is determined.
7. For MAGI or State Funded Medical Care Services (MCS) clients: Communicate the NFLOC determination directly in ProviderOne under the NFLOC Screen to include the following:
   a. The date of the request for assessment (this is the date the SNF submitted the Intake and Referral form to determine NFLOC).
   b. The date of admission.

c. The date NFLOC was determined (this is the date of the NFLOC assessment; it should match the date on the NFLOC tab in CARE).
d. See the section on Clients with Managed Medicaid for payment information regarding clients on an Apple Health managed care plan.

Note: Did you know there is an NFCM automated tickler in CARE that will generate 30 days after a client is determined "Yes" for NFLOC and "Yes" for Expected Discharge within 30 days?

8. Send a copy of the CARE Assessment Details to the nursing facility upon request. The service summary does not need to be signed for admission purposes.
9. End date all open authorizations effective the day prior to the admission. **Do not send a termination Planned Action Notice (PAN).** The client continues to be eligible for LTSS, they will be receiving services in another setting. Functional and Financial eligible for services remains in effect.
10. Transfer/assign the case to the NFCM per local transfer policy, when applicable (see *Case Transfer Protocol for Institutional (Hospital, Nursing Facility, or ICF-MR) Settings* for more information).
11. **Do not inactivate the client in CARE**; the NFCM will confirm NFLOC and monitor the case to facilitate transition planning.
12. The NFCM should conduct a face-to-face visit for each newly admitted **Medicaid** and dual eligible client within **30 calendar days** to begin to dialog about community options and the steps/desire to return to a community setting.

Note: For more information on case transfer timeframes for when an in-home client enters an institutional setting, see the Case Transfer section of LTC Manual Chapter 5: Case Management.

Note: The Veterans Affairs Registered Nurses (VARN) determines NFLOC eligibility for all state Veteran's home admissions.

NURSING FACILITY ADMISSION: FROM THE HOSPITAL (NFCM/ DDA CRM RESPONSIBILITIES)

Note: For individuals discharging from a hospital setting and whose PASRR Level 1 screening indicates that a Level 2 assessment is required, DDA PASRR Coordinators will determine the client is appropriate for nursing facility care as defined in PASRR prior to admission to the nursing facility (see *PASRR Section* for more information).

In the absence of delegated authority, for home and community-based clients who are admitted from the hospital, Medicaid-funded clients, or for residents who apply for Medicaid, within the first 10 calendar days of assignment, the NFCM or DDA Case Manager, must:

1. Ensure the client meets nursing facility level of care (NFLOC) per the NFLOC assessment in CARE:

a. NFLOC eligibility questions are located in the Pre-Transition & Sustainability folder on the NF Case Management screen. The questions are accessed by clicking on the "+" button when a record doesn't exist for the Nursing Facility stay or the "Edit/View" button if a record does exist for the NF stay on the Nursing Facility Case Management History table. A new window will be displayed which enables access to the NFLOC questions, click on the NFLOC tab at the top of the screen. For each new NFLOC generated, six (6) EBS questions will be displayed in the lower half of the screen. CMs cannot exit the Nursing Facility (NF) Case Management screen unless all questions are answered. Click on the save icon at the top left of the screen once the questions are complete before exiting.
   i. All clients who are eligible for a LTC waiver such as CFC + COPES are eligible for admission to a nursing facility and do not need to be re-assessed prior to completing the NFLOC questions on the NFLOC tab (a case manager can use a DDA assessment to complete the NFLOC assessment in CARE, when needed).
   ii. A client's medical chart, nursing assistant notes, and staff interviews and other records may be used to supplement interviews with the client to assess activities of daily living, cognition, etc. to perform the NFLOC assessment for clients on state plan services such as MPC, as well as for Medicaid recipients/applicants (clients who are receiving Medicaid, but not long-term services and supports). Consider including the date of admission and name of the hospital, in the comment field of the NFCM screen in CARE.
   iii. Explain and consider authorizing Home Maintenance Allowance (HMA) for clients likely to return home within 6 months of a physician's certification.
   iv. If the NFLOC determination assessment was not completed face-to-face, conduct a face-to-face visit for each newly admitted **Medicaid** and dual eligible client within 30 calendar days to begin to dialog about community options and the steps/desire for discharge.
   v. If the client was in a SNF resident prior to the hospitalization and is returning to the same facility where they resided prior to the hospital stay, a new NFLOC determination is not required.
   vi. If the client was a SNF resident prior to the hospitalization and is returning to a different facility than the one they resided in prior to the hospital stay, **a new NFLOC must be performed and documented in the NFCM screen in CARE.**
   vii. For clients who are case managed by DDA, consider including HCS assigned NFCM for transition support or consultation on the current DDA assessment. HCS cannot enter in the NFLOC or complete the NFCM screen if the case is not assigned to an HCS RU.
   viii. Tutorials on this process can also be accessed by NFCMs on the NFCM Workspace - Home

See the recorded training *Documenting NFLOC in CARE* for instructions on updating the NFCM screen.

2. Verify that a PASRR Level I Screening Form is completed. For more information, read the PASRR section.
   a. If the PASRR Level 1 was not performed prior to admission:

- Inform the nursing facility Admission Coordinator that the admission should not have occurred without the PASRR process being followed.
- Make a report to CRU regarding the admission without the PASRR being completed.

b. Level 2Level 2The facility must ensure that when a Level I PASRR screening identifies the need for a Level 2 evaluation, the PASRR Level 2 evaluation is obtained and uploaded into PCC. The Level 2 evaluation must clearly identify all specialized services and recommendations. The nursing facility is responsible for reviewing these recommendations and incorporating all required specialized services into the resident's individualized care plan.

Note: Unless other agreements have been made, if the case is being retained by the AAA, the NFLOC assessment may be completed by the AAA case manager, coordinating with the NFCM as necessary. All required steps regarding the NFLOC process must be followed, including completion of the necessary documentation.

3. For Classic Medicaid clients, complete and submit the electronic DSHS 14-443 form in Barcode to the PBS (unless already sent by Residential Care Case Manager (RCCM)/AAA/DDA) and complete the Nursing Facility Admission section by checking/filling in the appropriate boxes, including each of the following:
   a. The date of the request for assessment. This is the date the Nursing Facility requested the Intake and Referral from HCS. This is not the date of assignment in CARE.
   b. If the client is functionally eligible or whether the resident does not meet nursing facility eligibility.
   c. Date of admit.
   d. Name of the facility.
   e. If the client is likely to meet/exceed 30 days. This is the case manager's good faith belief regarding the anticipated length of time the client will be residing in the facility (indicating either less or more than 30 days). The Public Benefits Specialist uses this information to determine which program rules to apply for the facility stay and to complete the award letter which allows the facility to be paid.
      - If it was initially anticipated the client's stay would not exceed 30 days, however the client's stay ends up exceeding 30 days, the NFCM must inform the PBS using the electronic DSHS 14-443 form.
   f. Date of discharge, if applicable. Complete this box if the client has already been discharged from the facility at the time you determine NFLOC. Also, include the setting the client discharged to and which program was used if services were authorized.

4. Click here for more information on how the "payment begin date" is determined for Classic Medicaid clients.

5. For MAGI clients: Communicate the NFLOC determination directly in ProviderOne under the NFLOC Screen to include the following:
   a. The date of the request for assessment (this is the date the SNF submitted the Intake and Referral form to determine NFLOC).

b. The date of admission.
c. The date NFLOC was determined (this should match the date reflected on the NFLOC tab in CARE).
d. See the section on Clients with MAGI for payment information regarding clients on an Apple Health managed care plan.
e. Documenting this NFLOC determination directly in Provider One requires permissions awarded to your ProviderOne profile. For AAA/DDA and HCS Case Managers who are not primarily assigned to Nursing Facilities, you can reach out to NFLOCResolution@dshs.wa.gov for support in this process.

Monitor and document each client's transition-planning progress in SER within CARE. SER face-to-face conversations with each active client at least every 60 days. These conversations should capture the client's current preferences for care planning, behaviors, and any progress toward transition goals. When any changes in ADLs are identified, update the NFLOC and EBS eligibility determination.

6. Coordinate with nursing facility staff and other case managers. Do not rely on nursing facility staff to call when the client is ready to discharge. The work of an NFCM begins when the client is admitted to the nursing facility.

7. Attend care conferences as needed or requested. The NFCM may request a Care Conference at any time.

8. Work with the AAA, DDA and/or other HCS staff regarding clients who are returning home within 30 days.

Note: Did you know there is an NFCM automated tickler in CARE that will generate 30 days after a client is determined "Yes" for NFLOC and "Yes" for Expected Discharge within 30 days?

Note: If a client on a LTC waiver was admitted into the nursing home from the hospital, there is no need to have them sign an Acknowledgment of Services form.

NURSING FACILITY ADMISSION OR APPROVAL OF EXPANDED BEHAVIOR SUPPORT SERVICES IN A NURSING FACILITY (HCS COORDINATION OF BEHAVIOR SUPPORT CASE MANAGEMENT AND NFCM)

Before a client admits to a nursing facility with Expanded Behavior Supports (EBS) or receives approval for Expanded Behavior Support (EBS) services in this setting:

1. Ensure the client meets nursing facility level of care (NFLOC) per the NFLOC assessment in CARE:
   a. NFLOC eligibility questions are in the Pre-Transition & Sustainability folder on the NF Case Management screen. The questions are accessed by clicking on the "+" button if a record doesn't exist for the Nursing Facility stay or the "Edit/View" button if a record does exist

for the NF stay on the Nursing Facility Case Management History table. A new window will be displayed which enables access to the NFLOC questions; click on the NFLOC tab at the top of the screen.

i. All clients who are eligible for a LTC waiver such as the Residential Support Waiver are eligible for admission to a nursing facility and do not need to be re-assessed prior to completing the NFLOC questions on the NFLOC tab (when cases are co-assigned a case manager can use a DDA assessment to complete the NFLOC assessment in CARE, when needed).

ii. Client's medical chart, nursing assistant notes, staff interviews and other records can be used *to supplement interviews with the client* to assess activities of daily living, cognition, etc. to perform the NFLOC assessment for clients on state plan services such as MPC or Chore, as well as for Medicaid recipients/applications (clients who are receiving Medicaid, but not home and community programs).

iii. For clients who are case managed by DDA, the NFCM completes this NFLOC determination process based on the current DDA assessment or in consultation with the DDA CRM.

See the recorded training *Documenting NFLOC in CARE* for instructions on updating the NFCM screen.

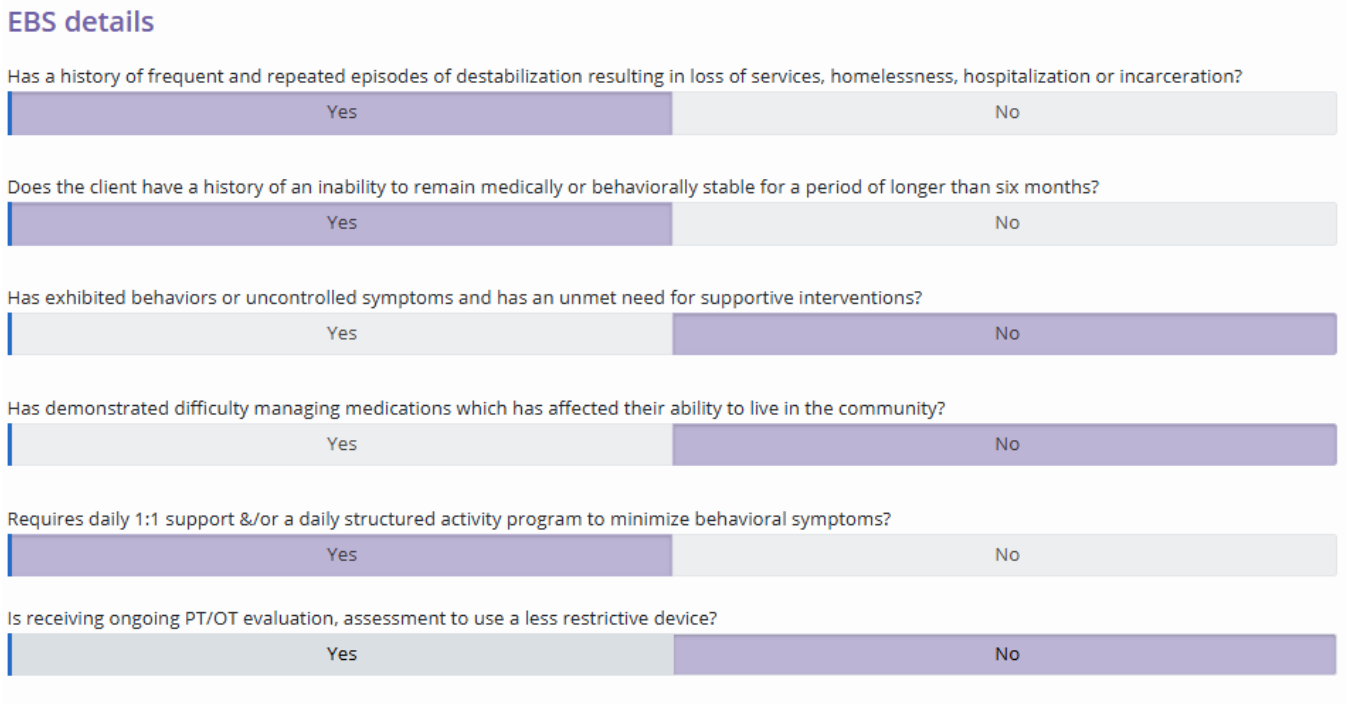
2. For acute hospital clients seeking EBS please refer to Chapter 7f: Residential Support Waiver referral process.

Expanded Behavior Supports referrals will be reviewed by the RSW Committee, the Case Manager sends the CARE Assessment and the 11-130 documenting the EBS Eligibility approval to the prospective SNF for EBS admission or EBS conversion consideration. A full CARE assessment is not a requirement for admission into a SNF, however, if one is completed, include this information as part of an admission packet.

a. The Case Manager coordinates admit date/EBS Start date with the SNF and regional delegate.
b. The regional delegate will notify HCLA HQ, NFCM Supervisor and the NFCM assigned to the facility.
    i. This communication allows HCLA HQ to generate a letter to the Nursing Facility outlining billing claim codes, the exceptional care rate, and provides a start date for these specialized nursing facility services.
    ii. This communication alerts the NFCM of this new Medicaid resident's admission or start date in their assigned facility.

3. **Communication to HQ must occur within 60 days of approval start or end date to ensure timely claims.**
4. For each new NFLOC generated, six (6) EBS questions will be displayed in the lower half of the screen. CMs cannot exit the Nursing Facility (NF) Case Management screen unless all questions are answered. Click on the save icon at the top left of the screen once the questions are complete before exiting.
    a. For existing admission records generated prior to October 1, 2025, EBS questions will not generate. EBS eligibility should be reviewed throughout the SNF stay.
    b. To enter a new EBS record, click on the "+" button in the EBS history table. After completing all the questions, the client's EBS eligibility level (EBS, EBS Plus, EBS Plus

Specialized Services, ECS Respite) will appear to the right of the questions, along with a determination date displayed to the right and in the EBS history table.



Note: See the Nursing Facility Expanded Behavior Support Service Level Descriptions for detailed information.

5. When a client is determined Expanded Behavior Supports eligible *and* resides in a contracted Skilled Nursing Facility (SNF):
    a. The determination date becomes the start date for EBS services.
    b. Within 2 working days of EBS eligibility determination the case manager must:
        i. Notify the SNF of the eligibility determination.
        ii. Send an email to ebsreferrals@dshs.wa.gov including:
            1. Client's full name
            2. ACES ID or ProviderOne ID
            3. Date of determination
            4. Facility name and location
            5. EBS eligibility level
            6. Cc supervisor, NFCM PM, or regional EBS delegate, and SNF staff contact information.
    c. Upon receiving the email, HQ will:
        i. Forward the information to the NF Rates Coordinator
    d. The NF Rates Coordinator will:
        i. Load the new EBS add-on rate into ProviderOne for reimbursement
        ii. Generate an approval letter with claiming instructions
        iii. "Reply all" to the original notification email with the approval letter attached

e. HQ will retain copies of all EBS approval letters in case the original communication is not received by the case manager or SNF contact.

6. When a client is determined eligible for Expanded Behavior Supports and the SNF is *not* contracted for EBS:
   a. The case manager may share a list of contracted EBS SNFs with the client, client representative, formal or informal decision maker, and SNF staff.
      i. The list can be found in the appendix.
   b. If the client chooses to transition to an EBS contracted SNF, the NFCM will provide the client and the SNF the EBS contracted Facilities list to assist the SNF with facilitating a SNF to SNF transition, if preferred.

Note: A *list of facilities contracted for Expanded Behavior Supports* is provided in the appendix. It includes each facility's contracted scope, region, and county.

7. When a client does not meet Expanded Behavior Supports eligibility:
   a. Once all questions are complete and the client is determined not to be eligible for EBS services:
   b. No further action is required.
   c. Save and Exit
8. When a client initially eligible for Expanded Behavior Supports is no longer eligible:
   a. If a client is determined eligible for EBS upon admission but later becomes ineligible during their Skilled Nursing Facility (SNF) stay, follow these steps:
   b. Update the EBS determination
      i. Navigate to the NF Case Management screen.
      ii. Click the "+" icon in the EBS History table to create a new EBS Determination.
      iii. Answer all questions.
      iv. The system will automatically:
         1. Generate an End Date for the previous EBS determination.
         2. Create a new entry indicating the client is "Not eligible."
   c. Within 2 working days of EBS eligibility determination the case manager must:
      i. Inform the SNF of the updated EBS determination.
      ii. Send an email to ebsreferrals@dshs.wa.gov including:
         1. Client's full name
         2. ACES ID or ProviderOne ID
         3. End date of EBS eligibility
         4. Facility name and location
         5. Cc supervisor, NFCM PM, or regional EBS delegate, and SNF staff contact information.
   d. Next Steps by HQ
      i. HQ will forward the information to the NF Rates Coordinator.
      ii. The EBS add-on rate will be end dated in ProviderOne prohibiting future SNF claims for this service.
9. When a client eligible for Expanded Behavior Supports on admission has a change in condition requiring a new determination:

a. If a client was initially determined eligible for EBS upon admission and later experiences a change in condition during their Skilled Nursing Facility (SNF) stay that requires redetermination and a change in EBS service level:
b. Update the EBS Determination in CARE
    i. Go to the NF Case Management screen.
    ii. Click the "+" icon in the EBS History table to create a new EBS Determination.
    iii. Answer all questions based on the client's current condition.
    iv. The system will:
        1. Automatically generate an End Date for the previous determination.
        2. Create a new entry with a Start Date and updated EBS service level.
c. Within 2 working days of EBS eligibility determination the case manager must:
    i. Inform the SNF of the updated EBS determination.
    ii. Send an email to ebsreferrals@dshs.wa.gov including:
        1. Client's full name
        2. ACES ID or ProviderOne ID
        3. Date of new determination
        4. Facility name and location
        5. Updated EBS eligibility level
        6. Cc supervisor, NFCM PM, or regional EBS delegate, and SNF staff contact information.
d. Next Steps by HQ
    i. HQ will forward the updated information to the NF Rates Coordinator.
    ii. The NF Rates Coordinator will:
        1. Load the new EBS add-on rate into ProviderOne for reimbursement.
        2. Generate an approval letter with claiming instructions.
        3. "Reply all" to the original notification email with the approval letter attached.
        4. Cc the case manager and SNF contact.
e. Recordkeeping
    i. HQ will maintain copies of all EBS approval letters in case the original communication is not received.

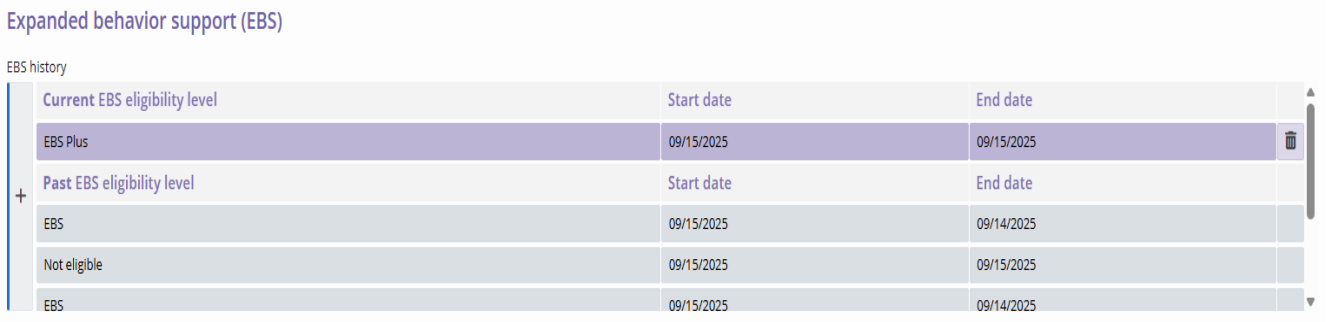
10. When a client receiving EBS services no longer meets NFLOC, transfers to other nursing homes, chooses to receive Hospice services, passes away, or is discharged from the SNF:
    a. Client no longer meets NFLOC criteria
        i. The case manager should update the NFLOC questions as needed to accurately reflect the client's functional status.
        ii. This action will automatically generate an EBS end date in the EBS History details table.
    b. Client transfers to other nursing homes
        i. The case manager should update the current NFLOC with a discharge date and location.
        ii. This action will automatically generate an EBS end date in the EBS History details table.
        iii. Generate an NFLOC for the new SNF stay and answer the EBS eligibility questions.

c. Client elects to receive Hospice services
    i. A client may remain eligible for EBS services.
    ii. The SNF may not claim for both Hospice and EBS services during the same period.
    iii. EBS services may be paused or discontinued for the duration of Hospice billing.
d. Client passes away or discharges from the SNF
    i. When a discharge date is entered in the NFLOC section, the system will automatically generate an EBS end date in the EBS History details table.
e. Within 2 working days of EBS eligibility determination the case manager must:
    i. Inform the SNF of the updated EBS determination.
    ii. Send an email to ebsreferrals@dshs.wa.gov including:
        1. Client's full name
        2. ACES ID or ProviderOne ID
        3. End date of EBS eligibility
        4. For Transitions, indicate which setting the EBS recipient transitioned
        5. Facility name and location
        6. Cc supervisor, NFCM PM, or regional EBS delegate, and SNF staff contact information.
f. Next Steps by HQ
    i. HQ will forward the information to the NF Rates Coordinator.
    ii. The EBS add-on rate will be end dated in ProviderOne prohibiting future SNF claims for this service.

11. EBS History Table Overview
    a. The EBS History Table displays the client's current EBS eligibility level, including associated start and end dates.
        i. The top section allows users to delete the current determination if it was entered in error.
        ii. The lower section lists past EBS determinations in descending order. These entries are view-only and cannot be modified or deleted.

EBS History Table – Additional Information

1. EBS history is linked to each individual NFLOC.
2. A comprehensive history across all NFLOCs is not shown.
3. To view EBS determinations from a specific SNF stay, users must click into each NFLOC entry individually.



12. EBS Referrals Inbox
    a. The ebsreferrals@dshs.wa.gov inbox will continue to serve as a resource for case managers and Skilled Nursing Facilities (SNFs).
    b. When a referral for EBS eligibility determination is received in the inbox from the SNF, the information will be forwarded to the assigned case manager with a Cc to their supervisor.
13. The assigned case manager will be responsible for reviewing the referral and entering the determination into the NF Case Management screen. The case manager should verify that a PASRR Level I Screening Form was completed prior to admit. For more information, read the *PASRR section*.
    a. When a Level 2 PASRR evaluation is indicated on the Level 1 PASRR form, verify the PASRR Level 2 was completed, and the NF has a copy of the results. Make a note in the SER to indicate the evaluation was performed.
    It is anticipated that most of the recipients of Expanded Behavior Support services in nursing facilities will have PASRR Level 2 recommendations. Consider including these approaches in the client's care plan.
        - If the PASRR Level 2 was not performed prior to admission, the case manager should Inform the nursing facility Admission Coordinator that the admission should not have occurred without the PASRR process being followed.
        - Make a report to CRU regarding the admission without the PASRR being completed.
14. Coordinated Case Management:
    a. The assigned case manager will complete the NFLOC and EBS determination and document this in the NF Case Management Screen in CARE (if not already completed) and then transfer primary case management in CARE to the regional delegate.
        i. For clients with Classic Medicaid: To begin payment and document nursing facility eligibility, submit the electronic DSHS 14-443 form to the Public Benefits Specialist (PBS), and include the following:
            - The date of the request for assessment.
            - If the client is functionally eligible or if the level of impairment does not meet nursing facility eligibility.
            - Date of admit.
            - Name of the facility.
            - If the client is likely to meet/exceed 30 days. *(This indicates the CM's good faith belief that the client will be residing in the facility for less or more than 30 days based on the information they have available. The Public Benefits Specialist uses*

this information to determine which program rules to apply for the facility stay and to complete the award letter which allows the facility to be paid.)

- Date of discharge, if applicable. Complete this box if the client has already been discharged from the facility at the time you determine NFLOC. Also include the setting to which the client discharged, and which program was used, if Home and Community Based Services (HCBS) were authorized.

ii. Click here for more information on how the "payment begin date" is determined.

iii. For MAGI or State Funded Medical Care Services (MCS) clients: Communicate the NFLOC determination directly in ProviderOne under the NFLOC Screen, including the following:

- The date of the request for assessment (this is the date the SNF submitted the Intake and Referral form to determine NFLOC).
- The date of admission.
- The date NFLOC was determined (this is the date of the NFLOC assessment; it should match the date on the NFLOC tab in CARE)
- See the section on Clients with MAGI for payment information regarding clients on an Apple Health managed care plan.

The assigned case manager will provide ongoing EBS case management for the client.

- Complete SERs in CARE to document continued eligibility every three (3) months..
- Documentation of continued eligibility must include confirmation of the client's status through one of the following:
  - Review of the client's nursing facility medical record, *or*
  - Communication with the nursing facility social work team, *or*
  - Attend an EBS or interdisciplinary team meeting with the SNF.

b. The case remains active and co-assigned to the EBS CM and NFCM for the duration of EBS eligibility.

c. When the EBS participant is ready for transition planning to a lesser level of care, the EBS CM coordinates with the NFCM and transfers primary case management to the NFCM in CARE.

d. The NFCM completes the CARE assessment and works on transition planning. When intensive behavior support services are needed in the community, the CM will make an RSW referral per Chapter 7f: Residential Support Waiver.

Note: Expanded Behavior Support services in a Nursing Facility is considered a Specialized Nursing Facility Program. There are other Specialized Nursing Facility Programs: Exceptional Care Rate, Community Home Project, Ventilator/Tracheotomy Weaning Program, and the Non-Citizen's Long Term Care Program. More information is available in the HCA Nursing Facility Billing Guide. There is also a Specialized Nursing Facility named the Transitional Care Center of Seattle. Information on how to make a referral for admission into Transitional Care Center of Seattle & Nursing Facilities which hold an Expanded Behavior Supports contract can be found in the Appendix.

Exceptional Care Rate requests per WAC 388-96-781 should be forwarded to Jevahly.Wark@dshs.wa.gov.

Many of these Specialized Nursing Facility Programs will require coordination &/or a prior authorization before utilization. Please direct questions regarding this process to: TCCSAdmissionRequest@dshs.wa.gov

How is the Payment Begin Date Determined?

For Medicaid Recipients: To ensure timely hospital discharge of Medicaid-eligible individuals, Medicaid payment begins on the date of the request for a NFLOC assessment or the date of admission to the NF, whichever is later (including swing beds). The nursing facility requests a NFLOC through the intake process for clients on Classic Medicaid and MAGI. Nursing facilities must request NFLOC assessments before or on the same day of admit to be guaranteed payment (this includes weekends).

For Medicaid Applicants: NFs must request assessments for Medicare/private-pay NF residents converting to Medicaid as soon as it is determined that the resident will likely need Medicaid funding. Medicaid payment will begin on the date:

a. The financial application for NF care was received; or
b. Nursing facility admission; or
c. When the client is functionally and financially eligible.

Payment can begin no more than three months prior to the first day of the month in which the financial application is received.

NURSING FACILITY ADMITS FOR APPLE HEALTH (AH) MANAGED CARE CLIENTS (CLASSIC AND MAGI)

The Apple Health (AH) managed care program is a managed medical care program that serves over 1 million Medicaid clients statewide. This program is administered by the Health Care Authority (HCA)

which contracts with managed care health plans to provide comprehensive medical care including preventative, primary, specialty and ancillary health services to all eligible clients in the state.

The AH contract with the managed care organizations (MCOs) includes a rehabilitative and skilled nursing facility benefit as part of the medical benefits covered by HCA. The MCO is responsible for paying for rehabilitative or skilled nursing days in a nursing facility if the MCO authorized the stay. The contract requires the MCO to provide a written authorization approval or denial to the nursing facility for any stay. The facility will use this authorization to bill the MCO for services or use a denial to bill fee for service. HCA's Nursing Facility Billing Guide provides detailed instructions regarding the responsibilities of the nursing facility.

How do I know if the resident is enrolled in an AH MCO?

Staff can verify real time enrollment in an AH MCO in ACES Online. From the client summary screen select 'Medical Information' under the Details tab. You will see the ProviderOne ID for the client and AH MCO the client is enrolled in.


Client >> Medical Information

New Search: Client ID

Benefit Month: December 2021

Client

Client ID: [redacted] Name: [redacted]

Primary Language: English (EN) Extra Help Needed: Yes (Y) Equal Access

Client Medical Information

ProviderOne ID: [redacted]WA Hospice Indicator: No (N)

Medicare: Restriction Indicator: No (N)

TPL Insurance: DDD Client Indicator: No (N)

Placement Code:

Managed Care Information

Health Plan	Program	Start Date	End Date
Amerigroup Washington Inc	Fully Integrated Managed Care	10/01/2021	12/31/2999

AU Medical Information

AU ID	Coverage Group	Eligibility Start Date	Retro Medical	Delayed Certification
[redacted]	SSI Long Term Care (L01)	06/01/2020	No (N)	No (N)

Can an AH MCO enrollee transfer to another facility?

Yes, but the transfer must be coordinated with the MCO responsible for payment of the stay. The facility needs to contact the MCO to authorize and coordinate services.

When does a NFLOC need to be completed for an AH MCO enrolled resident?

1. If the client is covered by the AH MCO rehab or skilled nursing benefit, then no NFLOC is required. Always refer the nursing facility to the AH MCO if there are questions regarding the client's MCO benefit.
2. The facility must notify HCS of a need for NFLOC assessment by requesting a social service intake and the NFCM must determine NFLOC when any of the following occurs:
    a. The client is not admitting to the nursing facility under a benefit covered by the MCO;
    b. The client enrolls in an AH MCO after date of admit; or
    c. The client's rehab or skilled nursing benefit is ending (or has ended) with the AH MCO.

3. The NFCM must notify HCA whether or not the client meets NFLOC by communicating the NFLOC determination directly in ProviderOne under the NFLOC Screen. The record is available for HCA and the NF to review in the ProviderOne system. Include the following in your communication:
    a. The date of the request for assessment (this is the date the SNF submitted the Intake and Referral form to determine NFLOC);
    b. The date of admission;
    c. The date NFLOC was determined (this is the date of the NFLOC assessment; it should match the date on the NFLOC screen in CARE); and
    d. Whether or not the client meets NFLOC.

It is important the NFCM completes the form with accurate dates. Based on the dates provided, HCA's NH Payment Unit will determine SNF payment date discrepancies and forward these to HCS HQ. Payment dates are managed directly by HCS HQ and HCA.

If the client meets NFLOC, the payment begin date for the NF is based on the following:

For Medicaid Recipients:
To be guaranteed payment, nursing facilities must request a NFLOC assessment for a client not admitting with coverage from an MCO, enrolls in an AH MCO after date of admit or as soon as it is determined the client's skilled nursing or rehab benefit will be ending to be guaranteed payment (this includes weekends). **Medicaid payment begins on whichever is later:** the date of the request for a NFLOC assessment or the date of admission to the NF.

For Medicaid Applicants:
For applicants, the department may back date the institutional date up to three months prior to the date of application as long as the client is otherwise eligible. To determine financial and functional eligibility, NFs must request a NFLOC assessment and assist the client in applying for Medicaid on Washington HealthPlanFinder as soon as it is determined a resident will likely need Medicaid funding.

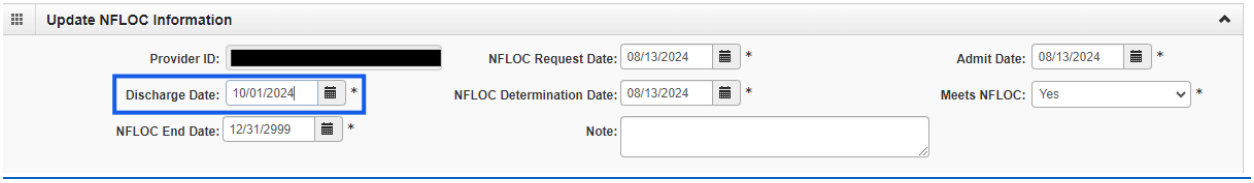
See ***Clients that Do Not Meet Nursing Facility Level of Care*** for more information regarding a client who does not meet NFLOC.

Do we need to send a 14-443 on MAGI or MCS clients?

If the client is MAGI or State Funded Medical Care Services (A01, A05, A24), do not send a 14-443 to the PBS unless the client can only be served under an HCBS Waiver and not MPC or CFC upon discharge. Public Benefit Specialists will not make eligibility changes for individuals eligible for MAGI even if the client is in a NF for 30 days or more. For Managed Medicaid recipients, NFLOC is communicated to the Health Care Authority directly via ProviderOne. This ability to enter/edit the NFLOC screen in ProviderOne requires a profile update via a Non-HCA Employee Access Request form to be submitted to hcaitsecurity@hca.wa.gov. For AAA/DDA and HCS Case Managers who are not primarily assigned to Nursing Facilities, you can reach out to NFLOCResolution@dshs.wa.gov for support in this process.

Do we update the NFLOC Communication in ProviderOne at the time of discharge?

The NFLOC determination in ProviderOne is completed at the time of admit, application or conversion and is updated when a MAGI or MCS client discharges. Refer to ***NFLOC Communication in ProviderOne*** section for additional P1 documentation instructions for this scenario.



Will Managed Care Assist with Care Coordination and Transition Planning?

When a client enrolled in managed care needs assistance to coordinate their health care services and access to appropriate treatment, the NFCM must assist the client and their guardian, if applicable, to request "care coordination" from the client's Apple Health MCO (including clients who have managed care only for behavioral health services).

The Medicaid and Medicare Managed Care Coordination Contact information can be found on the HCS/AAA intranet website on the right side of the webpage, under Contractors. Alternatively, this contact information and other resources are available on the Cross System Care Coordination | DSHS website. To request care coordination, the CM may send a secure email* to the client's MCO to request care coordination and assistance to address barriers the client is experiencing to access medically necessary care covered by Apple Health.

Note: Requests for Exceptional Care Rate requests from SNFs for clients enrolled in MCOs must be submitted directly to the assigned MCO. HCS cannot process these requests on behalf of an MCO.

*Emails from the DSHS URL (@dshs.wa.gov) identifies the requestor as a DSHS employee and meets HIPAA requirements to request care coordination on behalf of a HCS/AAA client.

1. When making a care coordination request include the following in your email:
   a. In the Email "Subject" line, provide the reason for care coordination request. For example:
      i. Mental health treatment
      ii. Durable medical equipment
      iii. Needs Primary Care Provider
   b. In the body of the email, provide the following information:
      i. Client Name
      ii. Client ProviderOne ID: (9-digit number ending in WA)
      iii. Date of Birth
      iv. Residence Type
      v. CM Name and Contact Information

vi. Summary of client barrier/issue/need

2. If you do not receive a response or assistance with your request timely, the CM should discuss the case with their supervisor to determine if escalation is needed. Sent a second email to the MCO with 'escalation' in the title of the email.

3. If the CM and supervisor do not receive a response, they may determine escalation to HCS HQ is needed when issues are not resolved.

    a. If the CM supervisor determines that escalation to HQ is appropriate, the CM supervisor will submit the original email communication and escalation with the MCO to Ethan.Leon@dshs.wa.gov

Once the request for escalation is received, HCS HQ will outreach with HCA to discuss the identified barrier to access. Based upon the type of request, the case manager and supervisor will be notified regarding next steps. You can find more detailed information on Managed Care in Chapter 22 of the LTC Manual.

PRE-ADMISSION SCREENING & RESIDENT REVIEW (PASRR)

What is PASRR?

Federal regulations (42 CFR §483.100 – 138) require that ***all*** individuals applying for or residing in a Medicaid-certified nursing facility be screened to determine whether they:

1. Haveserious mental illness or an intellectual disability or related condition; and if so,
2. Require the level of services provided by a nursing facility; and if so
3. Require specialized services beyond what the nursing facility may provide.

The Level I Pre-Admission Screening and Resident Review Form documents the first level of screening. If serious mental illness or intellectual disability or a related condition is identified or credibly suspected, a Level 2 evaluation is required to confirm or exclude identification, determine whether the individual requires nursing facility level of care, and determine whether specialized services are required.

Who should be screened under PASRR?

Anyone seeking nursing facility admission to a Medicaid-certified nursing facility, whether funded by Medicaid or a non-Medicaid source, must be screened ***prior*** to admission.

Who completes the Level I pre-admission screening for people coming from a hospital?

Any professional who is referring an individual for admission to a nursing facility may complete the Level 1 PASRR form. The form may also be completed by designated HCS or DDA staff who are facilitating the referral.

The nursing facility is responsible for ensuring that the form is complete and accurate **before** admission. After admission, the NF must retain the Level 1 form (and the Level 2, if applicable) as part of the resident record. In the event the resident experiences a significant change in condition, or if an inaccuracy in the current Level 1 is discovered, the NF must complete a new PASRR Level 1 and make referrals to the appropriate entities if a serious mental illness and/or intellectual disability or related condition is identified or suspected.

Who completes the Level 1 pre-admission screening for individuals coming from their own homes or from a residential setting?

- The referring physician or ARNP should complete the form.
- For Medicaid funded clients, the HCS, AAA, or DDA worker should verify that the screenings are complete for current clients being admittedin a NF.
    - DDA may complete the Level I screening for DDA clients who are being admitted to a nursing facility directly from home.

Are there exceptions to a Level I being completed?

Level I screens are not required for individuals who are:

- Transferring from one NF to another NF; or
- Being readmitted to the same NF following hospitalization (applies only if a Level I PASRR screen had previously been completed and is still applicable to the individual's status).

What happens if someone meets the PASRR criteria for PASRR Level 2?

The referral source will contact DDA and/or the Behavioral health (BH) contractor for an evaluation. (*See DDA PASRR and the BH PASRR Internet sites for a list of evaluators.*)

1. Unless the individual meets criteria for an exempted hospital discharge or Categorical Determination, a DDA assessor or MH contractor must perform a Level 2 evaluation to verify the diagnosis prior to admission to the nursing facility, determine whether nursing facility admission is appropriate, and determine whether the person needs specialized services. If the person has both a serious mental illness and an intellectual disability or related condition, the individual must receive a Level 2 evaluation from both DDA and Behavioral Health.
2. It is the nursing facility's responsibility to ensure that a potential resident has a completed PASRR Level 1 screening and, if necessary, a Level 2 evaluation ***prior*** to admission into the facility.

Are there exceptions to a Level 2 evaluation being completed?

Per 42 CFR §483.104, a person may be admitted to a NF without a PASRR Level 2 when:

1. The person is readmitted to the NF directly from a hospital after receiving acute inpatient care at the hospital;
2. The NF admission is to treat the condition for which the person was hospitalized; and

3. The person's attending physician, ARNP, or physician's assistant certifies that the person requires fewer than 30 days of nursing facility services *(Level2 required by Day 31 if stay unexpectedly exceeds 30 days*).

Is an NFLOC needed for a client who meets the PASRR level I screen?

Yes, NFLOC is a requirement for Medicaid recipients in nursing facility settings. For individuals who have a positive Level 1 screening and require a Level 2 evaluation, the assigned DDA or HCS CM completes the NFLOC assessment following all regular policies. DDA PASRR Assessors will determine the client is appropriate for nursing facility care as defined in the PASRR determination process prior to admission to the nursing facility. DDA PASRR Assessors document this information within their PASRR Data System (PDS). In the event a DDA PASRR Assessor identifies that an HCS Case Manager is not assigned to the DDA Client in CARE, this will be escalated to the DDA PASRR Program Manager for resolution.

What are "specialized services"?

"Specialized services" is a term used in federal PASRR regulations (42 CFR §483.120) to describe any services or equipment that are (1) recommended in a Level 2 evaluation to meet the needs of individuals with serious mental illness or an intellectual disability or related condition, and (2) exceed the scope of services normally provided by the nursing facility.

What if a Nursing Facility finds that a person's condition has changed after admission?

The NF must complete a new PASRR Level 1 and make referrals to the appropriate entities if a serious mental illness and/or intellectual disability or related condition is identified or suspected. The NF should promptly refer residents to *DDA PASRR* or the local *BH PASRR* evaluator when either of the following occur:

- Already have a mental illness or developmental disability and show a significant change in condition (improving or declining).
- Develop a serious mental illness and may need a Level 2 evaluation.
- If the resident has had a significant improvement, the facility must request a new NFLOC from HCS to verify functional eligibility.

What if there is not a PASRR contracted evaluator in my area or if I have questions about a PASRR contracted evaluator?

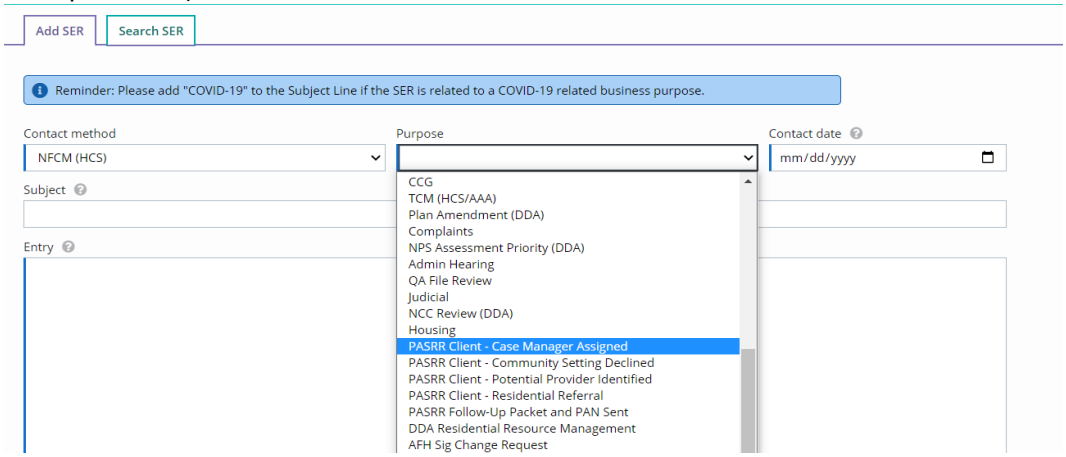
HCA is responsible for contracting with all Level 2 PASRR contractors who conduct evaluations related to mental illness. For questions about HCA contracted PASRR evaluators, please contact Elizabeth Loska beth.loska@hca.wa.gov or call 360-725-1478 and review the website: PASRR Program Contacts by County.

DDA is responsible for conducting Level 2 evaluations related to intellectual disability or related conditions. For questions about the DDA Assessors, please contact your local *DDA PASRR* Coordinator.

How should I document case activities when the client is receiving PASRR services (For DDA PASRR Assessors only)?

Complete SERs for activities related to community transition for clients in PASRR RUs using the SER subject lines in **bold type** below:

- **PASRR Client – Case Manager Assigned:** Enter a SER with this Purpose code when a current NF resident desiring community transition is assigned a DDA or HCS case manager (see example below).



- **PASRR Client – Community Setting Declined:** Enter a SER with this Purpose code when a PASRR client is offered a viable community setting that meets their needs, but the individual or guardian does not accept the setting.
- **PASRR Client – Potential Provider Identified:** Enter a SER with this Purpose code when a potential community-based provider is identified.
- **PASRR Client – Residential Referral:** Enter a SER with this subject when referral information is shared with a potential provider for community transition (adult family home, supported living agency, assisted living, etc.).

For DDA and HCS Case Managers: Contact the DDA Regional PASRR Team prior to inactivating a case in CARE when the client is assigned to a PASRR RU. When transferring a shared PASRR case:

1. On the Transfer Form, note that the case is shared with a DDA PASRR worker; document the office and name of the worker on the form.
2. Contact the regional PASSR Team (see below) to let them know the case is being transferred.
3. In the SER documenting the transfer, the transferring worker should note that the client has a DDA PASRR case worker that should be notified once the case is assigned.
4. The assigned worker in the receiving RU should email the Regional PASRR Team to let them know the case has been transferred and is now assigned.
5. Upon notification, the Regional DDA PASRR Team can add the PASRR information back into the CARE Overview screen.

DDA PASRR distribution lists:

- DSHS DL DDA R1 PASRR Team: ddar1pasrrteam@dshs.wa.gov

- DSHS DL DDA R2 PASRR Team: ddar2pasrrteam@dshs.wa.gov
- DSHS DL DDA R3 PASRR Team: ddar3pasrrteam@dshs.wa.gov

What if I have other questions about this process?

For other questions about PASRR, please refer to your regional HCS or DDA office or your local RCS field manager.

CLIENTS THAT DO NOT MEET NURSING FACILITY LEVEL OF CARE (NFLOC)

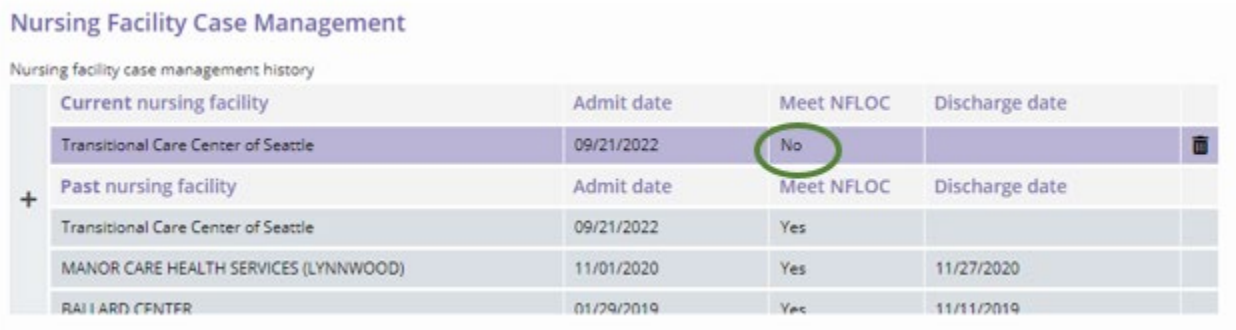
The nursing facility should submit a Intake and Referral Form (DSHS Form 10-570) when:

1. A new Medicaid client has been admitted from the hospital.
2. A current resident is converting from Medicare to Medicaid.
3. A current resident's rehab or skilled nursing benefit has ended with the AH MCO.
4. A resident is applying for Medicaid.
    - Financial eligibility may be retroactively determined for up to 3 months.
    - Functional eligibility must be requested at the time the Medicaid application is submitted.
5. A client has expressed interest in transitioning to the community.
6. The resident's health has improved to the extent that they may no longer meet nursing facility level of care. .

If the client does not meet nursing facility eligibility 1) at time of admission to the nursing facility or 2) at any time during their nursing facility stay, a full CARE assessment should be completed as soon as possible to verify functional eligibility. Follow steps as outlined in the CARE Web Help file when a client does not meet functional eligibility for HCBS programs. Document any changes in NFLOC status by completing the following:

1. A new line will need to be created on the Nursing Facility Case Management Screen in the NFCM history table in CARE to document the change in determination.
    a. Create a new line on the NFCM Main screen by clicking on the "+" sign on the NF Case Management screen history table.
    b. Select the SNF where the client resides (it will likely be the same as the previous line).
    c. On the NFLOC tab, answer questions 1 through 5. If the client does not meet NFLOC (All "no" answers to questions 1-5), the system will auto-populate "Does the client meet NFLOC?" with "No".
    d. Select "Yes" from the drop-down for "Expected to discharge within 30 days?"
    e. Expanded Behavior Supports (EBS) eligibility questions (6) will generate on the lower half of the screen.
        - These questions must be completed prior to exiting the screen.
        - If the client *is not* determined to be eligible for EBS, no further action is required.
        - If the client *is* determined to be eligible for EBS, once a CARE assessment is complete:

- Discuss Residential Support Waiver (RSW) services and settings with the client.
- Consider submitting Form 11-130 RSW and EBS Eligibility to RSW Committee for eligibility determination.


Nursing Facility Case Management

Nursing facility case management history

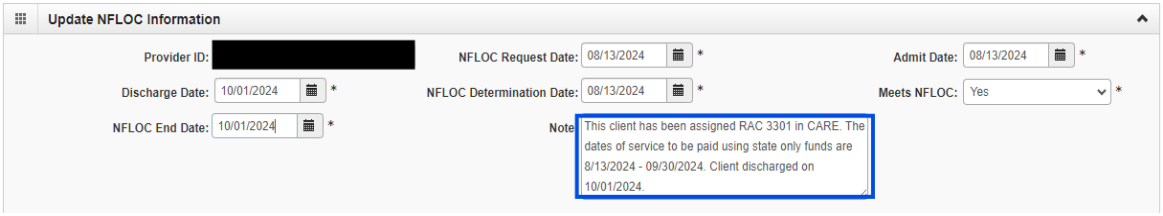
	Current nursing facility	Admit date	Meet NFLOC	Discharge date
	Transitional Care Center of Seattle	09/21/2022	No	
+	Past nursing facility	Admit date	Meet NFLOC	Discharge date
	Transitional Care Center of Seattle	09/21/2022	Yes	
	MANOR CARE HEALTH SERVICES (LYNNWOOD)	11/01/2020	Yes	11/27/2020
	BALLARD CENTER	01/29/2019	Yes	11/11/2019

2. The NFCM will send written notice to the nursing facility that the client no longer meets NFLOC and that payment will end in 30 days (*see sample letter in* Resources).
    a. A copy of the letter saying payment to the facility will end must be provided to the client.
3. The facility must initiate discharge of a resident who does not require nursing facility care (WAC 388-97-0100).
    a. The facility must send a 30-day notice to the client, the client's surrogate decision maker and, if appropriate, a family member or the client's representative.
    b. Notice of a resident-initiated discharge must also be provided to the LTC Ombudsman office.
    c. The notice to the client and representative(s) must include the reason for denial and their right to a fair hearing, per RCW 74.42.450.
    d. If the client requests a fair hearing and prevails based on the NFCM re-determining NFLOC, send a letter to the client and SNF describing continuous eligibility (see sample letter in Resources).
    e. ***For Classic Medicaid only:*** When an NFCM is aware that a fair hearing has been requested, they must notify the public benefits specialist of this via a 14-443 communication.
4. HCLA's policy is to authorize payment for up to 30 days or until the client is discharged, whichever is earlier:
    a. ***For Classic Medicaid only***: Notify Financial via a 14-443 communication that the client no longer meets NFLOC.
    b. Client must meet financial eligibility in order for the facility to be paid.
    c. Payment will be made from state funds to the nursing facility.
5. Continue to work with the client on transition planning options and document all efforts in CARE.
6. If the case manager observes that a facility has a pattern of admitting clients who do not meet NFLOC or that does not initiate determination of level of care for residents whose health has improved, notify your supervisor, and call the Complaint Resolution Unit (CRU) hotline with specific concerns.

Note: When a Medicaid resident declines to participate in a full CARE assessment to verify NFLOC, indicate this in the Reason for Assessment field. Keep in mind that the client should always be the primary source of information, so notify the resident that an assessment will be completed without their participation. To receive services funded by Medicaid in a nursing facility setting, the client must remain Nursing Facility Level of Care. A video tutorial on this process can be found on the NFCM Workspace.

To facilitate payment to the NF using state funds:

1. Upon completing the NFLOC assessment and determining NF level of care is not met:
   a. The case worker indicates on the NFLOC tab that the client does not meet NFLOC with the date of the determination.
   b. If the client has been a resident and this is a change in status, follow the instructions above to create a new line on the NFCM history table.
   c. The case worker assigns RAC 3301 in CARE, but no authorization is created.
2. ***After the client discharges from the SNF,*** the case worker completes Barcode form 14-443 (Financial/Social Services Communication) or Updates the NFLOC Communication in ProviderOne (NFLOC for MAGI or MCS) indicating that NFLOC is not met and includes the following statements in the Comment box of the 14-443 or NFLOC Screen in P1 (see sample below):
   a. The client has been assigned RAC 3301
   b. The RAC was added in CARE by the case manager and sent to P1.
   c. The dates of service to be paid using state only funds.
   d. The date of discharge (date of discharge is not paid, per the NH billing guide).



3. The SNF bills as usual:
   a. HCA's NH Payment unit will look for the 14-443 in Barcode or NFLOC Screen in P1 and process claims when NFLOC is not met, and the RAC and discharge information is provided.
   b. If NFLOC is not met per the 14-443 or NFLOC screen in P1, but RAC and discharge information is not provided, payment is "on-hold" until clarification is received (not denied, but not paid).
   c. If there is no 14-443 or NFLOC Determination in P1, the claim is denied per usual procedure and facility must contact their assigned NFCM to get it completed.

DETERMINING AND DOCUMENTING TRANSITION GOALS

The NFCM will:

1. Visit the client and inform the client and/or family/representative, as appropriate, of case management services and inquire about the resident's transition goals. Informed consent is always obtained directly from the person unless he/she/they is legally not competent to consent. In that event, State statute (RCW 7.70.065) allows the following in order of priority to give informed consent for adults: legal guardian, Durable Power of Attorney, spouse or State registered domestic partner, adult children, parents and adult siblings. Additional resources can be found at: Consent, Capacity, Legal Decision Makers, and Guardianship Topics
2. When appropriate, work with the client, nursing facility staff, and family to help the client relocate to a community-based setting.
3. Offer support to the client, the family and/or representative by addressing concerns regarding care in the nursing facility or other quality of life issues.
4. Monitor progress towards transition goals and encourage progress towards the highest level of functioning possible. **All cases must remain active for a minimum of 6 months to monitor progress and address transition barriers.** There is no maximum length of time a case may remain active while a Medicaid funded resident is residing in a nursing facility.
5. If it is not feasible for the client to return to their own home, talk to the client, their family/representative, and/or their case manager about other living situations such as adult family homes or assisted living facilities. In coordination with the nursing facility staff, contact AFHs and ALFs to determine if they have openings and discuss the client's care needs to learn if they would be interested in meeting the client.
6. Encourage the education of clients so that they may address their own care needs, such as self-medication programs, nutritional programs, or home evaluations.
7. Document progress towards community transition in the SER and update applicable screens in CARE.

> The client's preferences should be the primary influence regarding transition planning; family desires should be considered in transition planning but should not be the sole source. See HCS Decision Making for Transition Planning in the Appendix Section of this Chapter.

Ready for Relocation

When the client chooses to live in a less restrictive setting, the NFCM will:

1. Perform a CARE assessment (initial, significant change, or reapply) with the client.
    a. For clients on DDA services, contact the DDA CRM/PASRR Coordinator to initiate the completion of a DDA assessment and to coordinate any discharge resources that may be needed.

b. The assessment to prepare a client for community transition while they are in a SNF or hospital setting does not require the assessor to assess the community setting prior to moving the assessment to current (see Chapter 3 regarding if an assessment is in a setting other than the client's home or residence where services are being provided). The 30 day face-to-face visit required by the receiving case worker meets the requirement to identify any safety or other concerns regarding the living environment (See Chapter 5 for details).

Note: CARE assessments may be initiated or completed at any point of the client's nursing facility stay. It may be necessary to complete more than one CARE assessment to accurately reflect the client's long-term service and support needs in the community. To ensure accuracy and reduce unnecessary administrative work, CARE assessments may be moved to current as close as possible to the anticipated date of discharge. Finalizing the assessment near the discharge date minimizes the likelihood that multiple Interim Assessments will be required.

2. Develop an individualized plan that reflects client choice and the person's specific care needs. Document in a SER the client's informed decision regarding setting and care.
3. If appropriate, authorize Transition Resources and request care coordination with the resident's managed care organization.
4. Create an approval Planned Action Notice (PAN) for all services the client is authorized to receive as outlined in CARE (With the exception of any services provided through WA Roads.)
5. Within 7 days of discharge, update the following in CARE (whether or not the assessment is ready to move to Current or History):
   a. Discharge date on the NFCM main tab by highlighting the line in the table and clicking on the "Edit/View" button (if the client discharged on RCL after a reinstitutionalization, update the Discharge Date on both the NFCM **and** the RCL screens.)
   b. Update information in CARE on the Contact Details screen in CARE Web.
   c. Choose the appropriate Residence Type in addition to updating other residence information. The dropdown options under Residence Type include Correctional Facility, Homeless, Medical Hospital, Psychiatric Hospital, as well as every residential and in-home setting, including if the individual is living with a relative; use "Other" only when there is no appropriate option.
   d. The residence Start Date should be the same as the Discharge Date (the Start Date field can be manually corrected on the Contact Details screen in CARE.)
6. On the CARE Plan:
   a. Indicate Program (only choose RCL if the client has been enrolled on the RCL Enrollment Screen). If the program choices do not reflect CFC, then refer to Client does not meet NFLOC section of this chapter.
   b. Client chosen/planned living Situation.
7. For the relocation to be included on the monthly NFCM Transition report, move the assessment to Current/ History:
   a. Do not delay assisting a client with their transition while waiting for the assessment to be moved to current. **If the client is making an informed decision to decline personal care or**

Note to CM: A video tutorial detailing how to make your discharges count with relocation standards can be found on the NFCM Workspace.

other long-term services and supports, the assessment can be moved to History but must have all "Green progress bars" and Care Plan Screen completed to be included in the report.

No Current Transition Plan/Goal

Some individuals or designated decision maker may not be interested in discussing a return to the community immediately upon admission. For clients who do not have a current discharge plan or do not currently expect to return to a community setting, offer ongoing support to the client, family and/or representative by addressing concerns regarding care in the nursing facility or other quality of life issues and continue to support all efforts towards reducing or eliminating transition barriers to a less restrictive setting. If, **after a minimum of 6 months,** the client has not made any progress towards their transition goals, you *may* Inactivate the client in CARE using the "No Current Discharge Plan" code. Case inactivation *is not* required if there is no transition plan, cases may remain active if no transitions goals are identified. **For those residents receiving specialized nursing facility services** or Guardianship & Conservatorship Assistance Program (GCAP)**, these clients must remain active with nursing facility case management.** Please see Chapter 9 for specific actions related to GCAP Cases.

Follow up with clients at least annually to determine if interest/motivation to return to the community has changed, or whether the client's informal supports have changed. Document these discussions of offering alternative setting choice and sharing information on community resources and services in a SER.

Note: For DDA co-assigned clients, move the LTC assessment to history and remove yourself from the CARE team on the Overview screen. **Do not inactivate the client in CARE.** If the client is receiving PASRR services, follow all protocols in the PASRR section.

CASE TRANSFER PROTOCOL FOR INSTITUTIONAL SETTINGS (HOSPITAL, NURSING FACILITY, OR ICF-ID)

The intent of this case transfer policy is to encourage coordinated transition/treatment planning in the best interest of the client. The AAA CM, RCCM or DDA CRM/ PASRR Coordinator should collaborate with the facility's assigned NFCM to determine when a case transfer is appropriate for a client who intends to return to a community setting. For those nursing facility residents who are already on an HCS NFCM's active caseload the following also applies when a client transitions to another institutional setting:
In that regard, AAA, DDA and/or HCS staff may:

- Assess client in the NF or hospital.
- Determine NFLOC in the NFCM tab of CARE.
- Attend care conferences at the hospital, NF, or ICF-IDs
- Access transition resources for clients
- Review medical records and/or files.
- Request Housing Maintenance Allowance (HMA)

Timeline Benchmarks

The client may remain with the RCCM or AAA CM for 30 days from initial admission to Nursing Facility regardless of subsequent changes in institutional setting (hospital, SNF, ICF-ID). The client case may be kept longer than 30 days if a return to community setting is imminent. If the client does not intend to return to their previous setting, the NFCM/RCCM/CM/AAA may transfer client to the NFCM unit immediately (earlier than 30 days). DDA CRMs/PASRR Coordinators will co-carry the case with the NFCM assigned to the nursing facility where the client resides.

When a hospital stay goes beyond 30 days, the NFCM/RCCM/CM/AAA may coordinate with the Hospital unit regarding the transfer of the case. When an NFCM is unclear whether the client will return to the nursing facility, retain case management of the client until the 30-day timeline, or until the client transitions to another nursing facility. Upon admission into another nursing facility, the NFCM will transfer the case to the assigned NFCM of that center. NFCMs are required, to staff the client case with the ongoing Hospital Case Manager/RCCM/AAA/DDA case manager at transfer.
The NF case manager Supervisor will:

1. Immediately staff the case with the hospital supervisor unit,
2. Create a hospitalization transfer SER with the following information
    1. Hospital Name
    2. Admission date
    3. Current hospital social worker
    4. Barriers to returning to SNF setting.
    5. Date of staffing with Hospital Supervisor
    6. Is the client decisional? (If not, who is the guardian/conservator or DPOA)?
    7. What steps have been taken to maintain or allow the client to return to previous setting?
3. Transfer the case to an HCS hospital case manager supervisor for case assignment.

See Chapter 5 Case Management of the Long-Term Care Manual.

TRANSITION RESOURCES

Home Maintenance Allowance (HMA)

Home Maintenance Allowance: The HMA is income, up to 100% of the Federal Poverty Level, which the client can keep maintaining their community home during a NF or institutional stay. WAC 182-513-1380

Who is eligible?	A **single** client applying for HMA must be: 1. A Medicaid recipient; and 2. Certified by a physician that the client will likely be institutionalized in a NF or Medical Institution for no more than six months. A **married** client may be eligible if: 1. Both members of the couple are residing in a NF or receiving Housing Maintenance Allowance; and 2. One of them is likely to return to their place of residence within six (6) consecutive months. A married client whose spouse is not institutionalized is not eligible for the HMA.
What is covered under the HMA?	The client is allowed to keep 100% of the federal poverty level of their income to maintain their community home.
How do I authorize HMA?	1. Consult with the client or Public Benefits Specialist to determine the first month that an HMA may be authorized. 2. Request written verification from the client's physician that the client is likely to return home within six consecutive months. This may be in the physician's orders at the Nursing Facility, or you may use the HMA DSHS Form 14-456 3. Document the verification of the written Physician's Certification in a SER or place the completed HMA in the client's electronic client record. 4. If the physician certifies the client is likely to return home within six months: a. In Barcode, indicate the home maintenance allowance exemption on DSHS form 14-443 (HCS/AAA staff) or on DSHS Form 15-345 (DDADDA staff) and provide the start date. 5. If the physician will not certify the individual is likely to return home within six months: a. Indicate on DSHS form 14-443 (HCS/AAA staff) or on DSHS Form 15-345 (DDADDA staff) there is no HMA and leave the HMA Start Date blank. b. List details of the HMA actions in the CARE SER using Contact Code "NFCM" 6. Send the client a letter indicating the HMA Action if denied. **Note:** If the AAA CM retains case management of the case, the completion of the HMA is their responsibility. For clients shared by HCS and DDADDA, the DDADDA CRM/PASRR Coordinator completes the HMA. Additional HMA completion resources can be found on the NFCM Workspace.
When do I authorize this service and for how long?	The HMA begins on the first of the start month (as stated on the) and ends when the client is discharged from the facility or at the end of six months, whichever comes first. HMA should not be requested for a month in which the client does not have participation (i.e. the first month of admission or when Medicare is the

	primary payment source). For non-SSI clients, circumstances must be reviewed after 90 days, and the Public Benefits Specialist must be informed of the need for an extension of an additional 90 days or termination of HMA. If a client transitions to their community home and is later re-admitted, you may reauthorize the HMA with a Physician's certification indicating the client will likely return to their community home within six months. If a client has HMA approved but does not owe participation during the approved allowance benefit period (for example, the client's stay is covered by a medical benefit or is private pay for an interrupting period of time such as after an acute hospitalization), the six consecutive month limit may be adjusted by notifying the Public Benefits Specialist via DSHS form 14-443. No new verification from the physician is required if the break is covered during the original verification period.
What if it is a Temporarily Institutionalized SSI Recipient?	• SSI only income: Upon NF admission, the client's SSI income is exempted; therefore, these clients are not eligible for a HMA. • SSI/SSA (or some other income): Authorize the HMA taking into consideration the client's SSI income for the first 3 months. • SSI income would need to be subtracted from the total need, since this income is available to the client for the first 3 months. If the client continues to need NF care following the first 3 months and has additional income such as SSA, pension, retirement, etc., authorize an income exemption for 3 additional months.
Are ETRs allowed for HMA?	• If the client has only SSI income and requires NF care following the first three months of institutional care, Emergency Rental Assistance may be authorized to maintain the client's residence see LTC Manual, Chapter 6B: Interim Housing Resources (Motel Interim Stay for Transitions & Emergency Rental Assistance). • No ETRs are allowed for HMAs longer than six months in duration. • No ETRs are allowed for amounts over the federal poverty level per month.

Community Transition Services (CTS) & Transition Support Services

Community Transition Services (CTS): CTS are used to purchase one-time, set-up expenses necessary to help relocate clients discharging from an institutional setting to a less restrictive setting (see WAC 388-106-0270). The Appendix includes a Supporting Client Transitions to the Community - YouTube video which describes some of these services. **See *Which Program to Use: Transition and Sustainability Goods and Services* in the Appendix as a reference guide.**

Who is eligible for Community Transition Services (CTS)?	HCS/AAA clients who are receiving Medicaid long-term services who: • Are discharging from a nursing facility, institution for mental disease (IMD) or intermediate care facility for individuals with intellectual disabilities (ICF-ID) to a home and community-based setting; and • Will be receiving Roads to Community Living (RCL), Community First Choice (CFC) or Residential Support Waiver (RSW) services upon discharge. CTS funds **must** be considered before you use CTSS state funds. For those on the Address Confidentiality Program, refer to Chapter 3: Assessment and Care Planning for additional information on service coordination. To ensure accuracy and reduce unnecessary administrative work, CARE assessments may be moved to current as close as possible to the anticipated date of discharge. Finalizing the assessment near the discharge date minimizes the likelihood that multiple Interim Assessments will be required.
What is covered under Community Transition Services SA297? **CTS: Goods SA296?** HCS Only: You may utilize Amazon for purchasing Goods. See Amazon Authorization Desk Aid in Appendix section.	Services may include: 1. First month's rent, security deposits, safety deposits 2. Utility set-up fees or deposits 3. Health and safety assurances, such as pest eradication, allergen control, or non-recurring cleaning fees prior or upon return to the home. 4. Moving fees 5. Non-recurring rental insurance required for lease up. Goods may include: 1. Furniture, essential furnishings, and basic items essential for basic living outside the institution. For AFH Settings reference WAC 388-76-10685, and for Assisted Living Settings reference WAC 388-78A-3011 which outline resident unit furnishings in these settings. In the event a residential setting indicates they are unable to provide the required furnishings as outlined in WAC, notify the provider of their requirements as outlined in WAC, and also submit a referral to RCS to document the provider's inability to meet residential unit furnishings per WAC. 2. The provision of goods that increase independence or substitute for human assistance to the extent that expenditures would have been made for the human assistances, such as purchasing a microwave. CTS cannot be used to authorize environmental modifications. If a client transitioning from a congregate setting needs an environmental modification completed prior to discharge, that service must be accessed via COPES or CTSS depending on eligibility.
What is not covered under CTS?	• Federal rules require that services do not include recreational or diversional items such as television, cable or DVD players. • CTS does not pay for items or services paid for by Medicaid or other programs and resources, through the state plan or waiver such as

	groceries available under the Food Assistance benefit. Roads to Community Living will allow a one-time pantry stocking for enrolled participants. • Community Transition Services may not be used to furnish or set up living arrangements that are owned or leased by an AFH, ARC, EARC, ESF or AL facility. For eligible clients, state funded CTSS can be used in combination with federally matched CTS for items/services not covered under CTS.
How much can I spend?	The amount that can be used for CTS is $2500. **Note:** If both CTS and CTSS funds are being authorized, the "combined" costs cannot exceed $2500 without an approved ETR. CTSS ETRs are Local, CTS ETRs require a HQ approval by the CFC Program Manager.
Do I need to use a contracted provider?	If the DSHS payment system will pay directly for a service or item, a contract is required for all CTS providers. • Service providers such as pest eradicators, janitorial services and movers must be contracted with the CTSS contract and paid directly via ProviderOne. • Check to see if the provider has an existing contract for the service or goods that will be provided. • If there is not an existing contract, notify your local AAA Contracts Management team of the network capacity need. Providers must meet all other obligations associated with the contracting process such as background checks, Medicaid Provider Disclosure Statement and insurance requirements, when applicable. • For one-time payment for deposits or set up fees, the Special Considerations contract may be used. • NOTE: 1. A contract is not required if another payment mechanism is utilized. Options include: a. Using a client services P-Card (state issued credit card available to HCS HQ staff); or b. Authorizing a contracted provider to pay for rental deposits and community living set-up fees directly and be reimbursed. i. Compensation to the contracted provider for issuing payment does not count towards the CTS $2500 limit.
How do I authorize CTS?	1. Perform a CARE assessment to determine/document the need and plan of care for the CTS. CTS needs are often captured in the Treatment table as "Community Transition Goods or Items" or "Community Transition Services" Program and/or Client Safety. 2. The Sustainability Goals screen in CARE may be used as part of transition planning and as a communication tool with contracted providers.

	3. For CFC and COPES, move the assessment to *Current*. The CTS provider will be assigned the "Community Transition Goods or Items" or "Community Transition Services" Program treatment on the Supports screen as the paid provider. For RCL enrolled recipients, services may be initially authorized without a current assessment, though will need to be included and documented in a completed assessment. 4. Document the extent of services provided and the cost in the SER; for Nursing Facility discharges use Contact Code "NFCM." 5. Assign the applicable Program RAC and authorize the items or services using the appropriate code(s). For CFC recipients, the total cannot exceed $2500 without an HQ approved ETR. For RSW clients, add RAC 3056 "RSW-CFC ancillary services." 6. Submit a DSHS form 02-615 Invoice Coversheet to DMS with all invoices, receipts, etc. Include verification that the client received the goods or services. 7. Send the client a Planned Action Notice reflecting CTS.
When do I authorize this service?	This is solely for one-time payments to help a client establish a residence (no ongoing services/items). Only if the client has needs beyond what is covered under CTS may state funded CTSS also be used. Under CFC and RSW programs, CTS funds can be accessed up to 30 days after discharge if the item/service is needed for a successful transition and no other resource is available. When Community Transition Services are furnished to individuals returning to the community from an institutional setting, the service is not considered complete and may not be billed until the participant leaves the institution and is enrolled in the CFC or RSW program. You may use CTS each time the eligible client is discharged from a Nursing Facility or State Hospital. Additional information can be found in CFC Chapter 7b.
Are ETRs allowed for CTS?	All CFC CTS funds that exceed $2500 must have an ETR approval from the Community First Choice (CFC) Program Manager. Send CFC ETR requests by choosing "Pending HQ Approval" in processing status and Victoria Nuesca as the "Worker". Send a notification email to victoria.nuesca@dshs.wa.gov with CTS ETR in the subject line.
Community Choice Guiding: SA263 **Issuing Payment for AT Good present: SA266**	1. Community Choice Guiding (when leaving a Nursing Facility or State Hospital.) to include non-medical transportation services. 2. This service includes coordinating, educating, and linking the client to resources which will establish or return an individual to their community setting, including arrangements with pharmacies, primary care physicians, financial institutions, utility companies, housing providers,

	social networks, local transportation options, household budgeting, and other needs identified in the care plan. 3. Most clients receiving Community Choice Guiding services will benefit from **concurrent authorization of both** SA263 and SA266 service codes. See more information on Community Choice Guiding in Chapter 7b: COPES
Non-Medical Transportation T2003	Non-Medical Transportation can be used to support a client's non-medical transportation needs. Examples include supporting a client's reinstatement of benefits with Social Security or to visit Adult Family Homes for admission consideration. Non-Medical Transportation could also be used for other one-time transportation needs which will support a client's community living. For those AAAs which are not contracted with a local non-medical transportation provider, staff may utilize MedStar Transportation. The referral process for this Statewide contracted provider can be found in the appendix. To capture non-medical transportation in CARE, ensure that "Non-Medical Transportation" is reflected in the Treatment Screen and assigned to the paid provider in the Supports Screen. See more information on Transportation Services in Chapter 7b: COPES.

See *Which Program to Use: Transition and Sustainability Goods and Services* in the Appendix as a reference guide.

Community Transition or Sustainability Services (CTSS)

Community Transition or Sustainability Services (CTSS): CTSS are state funded non-recurring setup items or services necessary to assist individuals establish, resume or stabilize a home or community-based setting. WAC 388-106-0950; 388-106-0955; 388-106-0960.	
Who is eligible for CTSS?	A client is eligible for community transition or stabilization services if they: 1. Meet eligibility criteria to receive long-term services and supports from home and community services; 2. Are transitioning from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to their own home, or are living in the community and need stabilization services to remain there; and 3. Do not have other programs, services, or resources to assist them with these costs; and 4. Have needs beyond what is covered under the Community Transition Services (under CFC or RSW); or 5. Are not eligible for Community Transition Services (under CFC or RSW). 6. DDA clients who are being discharged from Nursing Facilities **only.**
What is covered under CTSS?	CTSS Goods may include:

CTSS Goods SA290 **CTSS Services SA291** **HCS ONLY: Amazon Desk Aid located in Appendix section.**	1. Furniture, essential furnishings, and basic items essential for basic living outside the institution. For AFH Settings reference WAC 388-76-10685, and for Assisted Living Settings reference WAC 388-78A-3011 which outline resident unit furnishings in these settings. In the event a residential setting indicates they are unable to provide the required furnishings as outlined in WAC, notify the provider of their requirements as outlined in WAC, and also submit a referral to RCS to document the provider's inability to meet residential unit furnishings per WAC. 2. The provision of goods that increase independence or substitute for human assistance to the extent that expenditures would have been made for the human assistances, such as purchasing a microwave. CTSS Services may include, but are not limited to: 1. Security deposits that are required to lease an apartment or home, including first month's rent. 2. Activities to assess need, arrange for, and procure necessary household furnishings. 3. Setup fees or deposits for utilities, including telephone, electricity, heating, water, and garbage. 4. Services necessary for your health and safety such as pest eradication and nonrecurring extreme cleaning.
What is not covered under CTSS?	CTSS does not pay for items or services paid for by other state programs or Community Transition Services. CTSS does not include recreational or diversional items such as television, cable, or gaming systems.
When do I need a provider contract?	If the DSHS payment system will pay directly for a service or item, a contract is required for all CTSS providers. • Check to see if the provider has an existing contract for the service or goods that will be provided. • If there is not an existing contract, notify your local AAA Contracts Management team of the network capacity need. Providers must also meet all other obligations associated with the contracting process such as background checks, Medicaid Provider Disclosure Statement, and insurance requirements, when applicable. • For one-time only payment for deposits or set up fees, the Special Considerations contract can be used. • NOTE: 1. A contract is not required if another payment mechanism is utilized. Options include: a. Using a client services P-Card (HCS Only State issued credit card); or b. Authorizing a contracted individual transition services provider to pay for deposits and set-up fees directly and be reimbursed. i. Compensation to the contracted provider for issuing payment does not count towards the CTSS $850 limit.

How do I authorize CTSS?	You must: 1. Perform a CARE assessment to determine/document the need and plan of care for the CTSS. CTSS needs are captured in the Treatment screen in CARE as "Community Transition Goods or Items" or "Community Transition Services" with a comment indicating the nature of the service in the comment box. Assign the "Community Transition Goods or Items" or "Community Transition Services" Treatment to the paid provider in the Care Plan Screen. 2. If the client will not be discharging with long-term care services, document the client's need and reason for the allowance in the SER. 3. The Sustainability Goals screen in the Client Details section of CARE may be used as part of transition planning and as a communication tool with contracted providers. 4. Complete the Housing Modification Property Release Statement (DSHS Form 27-147) for all environmental modification authorizations if the client has a rental agreement or does not own the residence. 5. Document all costs in the SER under Contact Code "NFCM", for non NFCM transitions, use "Admin" Activity Code. 6. Authorize services and/or items using the appropriate code(s). The total cannot exceed $850 without local ETR. 7. Submit a DSHS form 02-615 Social Services Invoice/Receipt Packet Cover Sheet to DMS with all invoices, receipts, housing modification property release statement, etc. Include verification that the client received the goods or services. 8. Send the client a Planned Action Notice for any CTSS. **Note:** To ensure accuracy and reduce unnecessary administrative work, CARE assessments may be moved to current as close as possible to the anticipated date of discharge. Finalizing the assessment near the discharge date minimizes the likelihood that multiple Interim Assessments will be required.
When do I authorize this service?	This is solely for one-time payments to help a client establish, resume, or stabilize a residence (no ongoing services/items). CTSS funds can be accessed if the item/service is needed for community living and no other resource is available. You may use the CTSS each time the eligible client transitions from an institution **or** for each occurrence of instability that threatens the loss of the client's continued living in the community.
Are ETRs allowed for the CTSS?	Yes, all CTSS requests that exceed $850 must have a local office ETR approval.

See *Which Program to Use: Transition and Sustainability Goods and Services* in the Appendix as a reference guide.

Assistive Technology (AT)

Assistive Technology (AT): These services should be considered for those clients who are eligible for assistive technology through RCL, RSW (known as CFC Ancillary Services) or CFC (see chapters for additional information). Assistive Technology funds may be used to purchase adaptive/assistive items and devices. Assistive technology is designed to:

1. Increase a person's functional independence &/or substitute for caregiver assistance with an ADL, IADL or health related task;
2. Maximize a person's health and safety;
3. Increase the likelihood that adults in institutional settings will transition to their own homes and communities.

For RCL Participants only:
Smart Care Device is an assistive technology option for in home clients on Roads to Community Living. The Smart Care Device is an AI device that interacts and engages with a client to provide support through proactive suggestions, cuing and reminders for ADL &/or IADL tasks or health-related activities, and accessing their community. This service would be captured as Technology Support Services in the Treatment screen and assigned to a paid provider in the Supports Screen. See Chapter 29: Roads to Community Living for additional details. For additional resources please see the Assistive Technology SharePoint, HCS SharePoint site.

Technology Support Consultation and Technical Assistance is available. This option provides individualized AT recommendations by an assistive technology professional as well as technical assistance to ensure the client can incorporate AT into their daily life. This service would be captured as Technology Support Services in the Treatment screen and assigned to a paid provider in the Supports Screen. See Chapter 29: Roads to Community Living for additional details. For additional resources please see the Assistive Technology SharePoint HCS SharePoint sites.

Please see *Chapter 7b: Community First Choice* from the LTC Manual for more information on CFC Ancillary services that are offered to CFC and RSW recipients.

Social/ Therapeutic Leave

Social/ Therapeutic Leave: The Department will pay the nursing facility for a Medicaid resident's social/ therapeutic leave up to 18 days per calendar year. See WAC 388-97-0160.	
What is covered under Social/ Therapeutic Leave?	Social/ Therapeutic leave gives NF residents an opportunity to participate in: • Social/ Therapeutic activities outside the NF and beyond the care of the NF staff. • Trial visits to less restrictive settings-more information below. Social/ Therapeutic leave **must not** be used for medical care leave in another medical institution.

How is the NF paid?	The department pays for **up to** 18 days (24 hr. periods) per calendar year for each Medicaid resident's social/ therapeutic leave. The nursing facility must track the number of days spent per year. NFs are required to notify the department of social/therapeutic leave in excess of 18 days per year through a Notice of Action (DSHS form 15-031).
How do I know if an ETR is needed?	NFs and/or the resident can request additional Social/ Therapeutic leave from the department in excess of 18 days per year.
Are ETRs allowed for Social/ Therapeutic Leave?	1. Requests for ETRs for social/ therapeutic leave exceeding 18 days per calendar year may be approved with a local ETR. ETR should be submitted via the electronic ETR process in CARE. ETRs that promote resident independence are appropriate. 2. Any requests for over 18 days of leave must be approved prior to the client taking the leave. 3. If an ETR for leave exceeding 18 days per calendar year is approved or denied you must: • Notify the HCS Financial Worker using a Social Service/Financial Services DSHS 14-443 form, making a note in the Comments section; • Document approval/denial in the SER; and • Send a letter notifying the client of the approval or denial **Note:** Frequent or excessive social/therapeutic leave may indicate the resident has potential for NF discharge.
Trial Visits	Many nursing facility residents may choose to consider moving to a new living arrangement or an Adult Family Home or Assisted Living Facility as their preferred community services setting and may wish to have a trial overnight period before finalizing their decision. The client may use their social/therapeutic leave for this purpose. A trial visit is often paired with CCG services to support the coordination of the visit. The CCG may pay for the trial residential services with state funded Community Transition and Sustainability Services (RAC 3105) at the daily rate as outlined in CARE. Any trial visit would be reimbursed to the CCG under SA291 or SA295 for RCL enrolled participants.

Roads to Community Living (RCL)

Roads to Community Living is a statewide, demonstration project funded by the "Money Follows the Person" grant. The purpose of the RCL demonstration project is to investigate what services and supports will successfully help people with complex, long-term care needs transition from institutional to community settings. For clients meeting eligibility criteria, additional transition services are available while the client is in the nursing facility and for one year after they have moved to the community. See the RCL chapter of the LTC Manual for more information regarding eligibility and services offered. Send any inquiries or referral requests directly to: dshsaltsarclreferrals@dshs.wa.gov.

HCS Housing Resources

Home and Community Services has resources to increase access to permanent and affordable housing for its clients and continuously strives to expand the availability and utilization of services that support tenancy in independent housing centering on the following beliefs and values:

- Affordable housing is the foundation for stability and growth.
- Housing improves health.
- Income, age, ability, lack of family and friends, or past or current conduct should not prevent anyone from having a home.
- Each tenant holds their lease or mortgage and is responsible for maintaining tenancy.

There are affordable housing vouchers and subsidies the HCS Housing Team can help you access, and Supportive Housing available to HCLA clients to support their tenancy.

See the Housing Resources for HCS Clients, Chapters 6a and 6b, of the LTC Manual for more information regarding eligibility and services offered.

State Funded Community Transition and Sustainability Services & Washington Roads

Community Transition and Sustainability Services (RAC 3105) and Washington Roads are additional state funded service packages created from the lessons learned and cost savings seen through the first year of the RCL project. In 2009, the Washington State legislature approved this additional funding to relocate adults from institutions and are available to assist with transition planning for clients who are not eligible through RCL and also as a resource for challenging or complex cases involving individuals who are currently living in the community, but who are at risk of losing their community setting.

See the CTSS/WA Roads, Chapter 5a, of the LTC Manual for more information regarding eligibility and services offered.

RESIDENT RIGHTS

NFCMs should be familiar with resident rights and report any significant or repeated resident rights violation to the RCS Complaint Resolution unit (CRU) for review and investigation.

Single incidents, not classified as abuse, neglect, abandonment, or financial exploitation, may be handled through consultation and education with the provider or by involving the Long-Term Care Ombudsman Program. The Ombudsman program is responsible for protecting the rights of all residents and handling complaints from facility residents. The Long-Term Care Ombudsman can be contacted at 1-800-422-1384.

Residents of nursing facilities have the same civil and legal rights of all US citizens, plus additional resident rights. These rights can be found in ***Chapter 70.129 RCW***. Resident rights include, but are not limited to:

- Right to a dignified existence
- Right to self-determination
- Right to be fully informed
- Right to raise grievances
- Rights of access
- Rights regarding financial affairs
- Right to privacy
- Rights during discharge/transfer:
  - A facility cannot use the following reasons to transfer/discharge a resident*:
    - Resident is disruptive, argumentative, and/or obnoxious.
    - Resident doesn't follow facility policies or their care plan.
    - Caring for the resident is too hard or costs too much.
    - The resident refuses treatment.
    - The resident's Medicare eligibility ended.
    - The resident's savings is gone and they are now Medicaid-eligible, as described in the facility's policy for accepting Medicaid

*Unless the actions jeopardize the health and safety of themselves and/or other resident(s).

Facility Initiated Discharges

The Centers for Medicare and Medicaid Services (CMS) began an initiative to examine and mitigate nursing facility-initiated discharges in violation of federal regulations. Per CMS, a facility-initiated transfer or discharge is one that the resident objects to, did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences.

Before a long-term care facility transfers or discharges a resident, the facility must first attempt through reasonable accommodations to avoid transfer or discharge, unless agreed to by the resident.

Discharge Criteria for Nursing Facilities

There are very specific and limited criteria under which a nursing facility can initiate the discharge of a resident without the resident's consent:

- The resident no longer requires nursing facility level of care (see ***NFLOC section***)*
- The facility can no longer meet the resident's level of care needs**
- Resident poses a health or safety risk to themselves or others*
- The resident has failed to pay.
- The facility ceases to operate/closes.

*Documentation by a full CARE assessment is required.
**Documentation by a medical doctor is required.

Residents who are sent to the emergency room or hospital must be permitted to return to the facility unless the resident meets one of the above criteria. The facility may not evaluate the resident's behavior based on the behavior at the time of the transfer to the hospital.

Notification

The facility must provide written notification to the resident, resident's representative and state LTC Ombuds 30 days in advance of the date of discharge*. DSHS Form 10-237 can be used by the SNF to provide notice, but the SNF can develop and use their own notice as long as it includes the following:

- The reason for transfer or discharge;
- The effective date of transfer or discharge;
- The location to which the resident is transferred or discharged;
- A statement of the resident's appeal rights,
- LTC Ombuds information
- For residents with intellectual disability or mental health disorder, information regarding Disability Rights WA

*Exceptions: Other residents' health or safety would be in danger, the resident has urgent medical needs requiring a transfer or discharge, or the resident has not lived in the facility for 30 days.

Appeals

The resident has up to 90 days to appeal the facility-initiated notice of transfer or discharge. If the individual appeals notice, the facility cannot discharge the resident during the appeal process and by law, must assist the person in helping the resident prepare and file an appeal request.

As a case manager/social worker, you may need to intervene by having a conversation(s) with a provider to determine if a provider is trying to discharge a client in conflict with Chapter 70.129 RCW.

As an employee of DSHS, you are a mandated reporter:

Call and report any issues of abuse, neglect, exploitation, and abandonment of any nursing facility resident. This report will remain confidential within the limits provided by law. For additional information regarding abuse, neglect, self-neglect, exploitation or abandonment, see the Adult Protective Services web page.*1-800-562-6078*

OUT OF STATE NURSING FACILITY ADMISSIONS

WA State Clients Admitted in Recognized Bordering City Nursing Facilities

Medicaid clients admitted in recognized bordering city nursing facilities for stays of 30 days or less, who intend to return to Washington, may receive coverage, if eligible. WAC 182-501-0175 lists the bordering cities as:

- Idaho: Coeur d'Alene, Moscow, Sandpoint, Priest River and Lewiston
- Oregon: Portland, The Dalles, Hermiston, Hood River, Rainier, Milton-Freewater and Astoria
- Per WAC 182-502-0120, stays of greater than 30 days may be approved by HCLA HQ when the resident's needs cannot be met within the state.

The bordering city nursing facility must be contracted with WA State to receive payment. Prior to admission, the assigned CM should:

- Ask the out of state facility if they have a nursing facility contract with Washington State; and
- Verify a fully executed contract is in the ACD.
- Notify the HCLA's NH Payment Coordinator of out of state admission by emailing: NFRPaymentCoord@dshs.wa.gov
- Information regarding the rate for the bordering city SNF is determined by the NH Rates unit (if there are questions, the contracted SNF can contact them using the same email as above).

Follow the procedures listed in the "DDA Nursing Facility Admission: From the Community Setting (HCS/AAA/DDA Responsibilities)" section of this chapter. If the stay extends beyond 30 days, the client must do one of the following:

1. Move to a Washington State nursing facility;
2. Apply for benefits from the bordering state; or
3. Supply the NFCM with information to demonstrate that there is a definite discharge date planned within the subsequent 30 days (e.g. a statement from the client's physician stating that the client needs an additional 20 days of rehabilitation after the first 30 days expires.)

If a Washington State client applies for Medicaid from the bordering state and is determined not to be eligible, the NFCM must assist the bordering city Nursing Facility and the client in moving back to Washington within 30 days. Continue payment authorization until the move is complete. Document your efforts in a SER and notify NFRPaymentCoord@dshs.wa.gov if the client's stay exceeds 60 days.

Clients who are placed in out-of-state nursing facilities for emergency purposes may also receive coverage for their short stay per WAC 182-502-0120. The NFCM must determine if the client meets nursing facility eligibility based on information available and notify financial.

Note: Children residing in the Providence Child Center are exempt from these requirements. Providence Child Center must comply with all PASRR requirements.

Clients Seeking Nursing Facility Care in Washington from Out of State

If a NFCM receives an inquiry regarding an individual seeking NF care in Washington and the individual is a resident of another state, encourage the individual or their representative to contact the facility to which the individual is interested in admitting. Individuals may not receive services in two states at the same time. If the individual is currently a resident of a NF in another state, staff at the discharging facility and staff at the admitting facility typically work together to arrange the transfer. If the individual is moving from another state and is not currently receiving nursing facility care out of state, the family and/or representative can work with the receiving NF to arrange the admission. If an admission date is known, the application process can be started on the Washington HealthPlanFinder website or through the local Home and Community Services office. However, the application for services cannot be finalized until the individual has made the move to the state.

ADMISSION OF DDA CLIENTS

From home/residential settings

The Case Manager must:

1. Work with the DDA to determine if nursing facility care is the most appropriate service for the client (see DDA Admission: From the Community Setting (HCS/AAA/DDA) Responsibilities for more information).
2. All clients entering the nursing facility must have a PASRR Level I screening completed prior to admission to the facility. If a PASRR Level 2 Assessment is required as a result of the PASRR Level I, verify that the Level 2 Assessment was performed prior to admission (see PASRR FAQs for more information). As part of the PASRR process, the DDA PASRR coordinator will determine if the client is appropriate for NF admission. This is not the functional eligibility determination. For those clients who only have a DDA PASRR RU assigned, the DDA PASRR coordinator will notify HCS for NFCM assignment. The assigned HCS NFCM will complete the NFLOC determination.
3. If a DDA assessment in CARE has been completed and moved to current, either the DDA assigned case manager or the NFCM may use this information to complete the NFLOC and EBS eligibility determination questions on the NFLOC Tab. See the section regarding NFLOC for more information). The NFCM should consult with the DDA for co-assigned cases when necessary to determine NFLOC.
4. Review and authorize the admission, if appropriate.
5. Follow all other protocols found in the section on Admission from Community settings.
6. If requested, participate in inter-disciplinary team staffing or provide consultation to the DDA or other case managers involved with the resident.
7. DDA retains case management responsibility for transition planning in coordination with the NFCM.

From the hospital

The assigned Case Manager must:

1. Determine NFLOC within the first 10 calendar days of assignment and inform the public benefits specialist per the DSHS 14-443 form.

a. For each new NFLOC generated, six (6) EBS questions will be displayed in the lower half of the screen. CMs cannot exit the Nursing Facility (NF) Case Management screen unless all questions are answered.
b. Click on the save icon at the top left of the screen once the questions are complete before exiting.

2. Follow all other protocols found in the section on Admission from the Hospital
3. If requested, participate in inter-disciplinary team staffing or provide consultation to the DDA or other case managers involved with the client.
4. DDA retains case management responsibility for reassessment and transition planning in coordination with the NFCM.

Note: Children residing in the Providence Child Center or Bridges to Home are exempt from these requirements. Providence Child Center and Bridges to Home must comply with all PASRR requirements. DDADDA will coordinate with the Department of Children, Youth and Families (DCYF) case manager for these residents admitted to Nursing Facilities for children as necessary.

STATE FUNDED LONG-TERM CARE FOR NON-CITIZENS

The Home and Community Living Administration has limited state funding available for non-citizens in need of long-term care services outside of a hospital, but who are not eligible for federally matched Medicaid, Aged, Blind and Disabled (ABD) cash or Medical Care Services (MCS). New admissions into nursing facilities or residential settings under the state-funded long-term care program must be pre-approved by Emily Watts, Home and Community Services HQ, via email at: emily.watts1@dshs.wa.gov . For these state funded long term care recipients, any transition planning and transition services are paid for with state funded service packages. Use of these funds must receive prior approval by Emily Watts or her delegate. For more information reference Chapter 5a: CTSS/WA Roads.

Further detail may be found at the Social Service Authorization Manual.

HOME & COMMUNITY SERVICES PRIVATE HEALTH INSURANCE AND GOOD CAUSE DETERMINATIONS

Medicaid clients are required to cooperate in the identification and use of third party liability (insurance carriers) that may be responsible for paying for nursing facility care and other long-term care services. Clients may object to the options offered by their private insurance for a variety of reasons, including the location of the facility. The Department is allowed to exempt the client from cooperation if we have determined that there is “good cause” for the exemption.

If a client has third party liability (TPL) and resides in a facility that is a non-participating/non-network/non-contracted provider of the plan, the following process will occur:

1. The nursing facility will contact the insurance carrier to determine if they will pay a non-participating/non-network/non-contracted provider, or can decide to become a participating/network/contracted provider, if possible.
2. If the TPL has denied coverage and the nursing facility believes good cause exists, the nursing home must contact the client's case manager (NFCM) through the local HCS office.
3. The local NFCM determines if a client should be exempted from using their TPL if there is no DSHS participating/network/contracted nursing facility within 25 miles or 45 minutes from the client's current residence.
4. If there is a DSHS participating/network/contracted nursing facility within 25 miles or 45 minutes of the client's current residence, the NFCM will talk with the client and/or the client's representative about the possibility of moving to a facility that is within the insurance carrier's network.
5. The local NFCM, in coordination with their supervisor, will determine if good cause exists.

The final decision regarding good cause is made by the local HCS office:

1. To determine good cause, the local NFCM will evaluate the reasons why the client does not want to transfer to a participating network provider. Good cause can include a variety of reasons such as location, physical or emotional harm, or that a move to a different NF will cause transfer trauma.
2. The NFCM will document in the SER if good cause is approved or denied.
3. If approved, the NFCM must inform the HCA-Coordination of Benefits at 1-800-562-3022
4. If the client is deceased, no longer a resident at the facility, or no longer has the insurance, a local exception to policy to WAC 182-501-0200 may be submitted by the nursing facility directly to Home and Community Services headquarters to the NFCM Program Manager.

Note: The Veterans Affairs Registered Nurses (VARN) or other designee of the Washington Department of Veterans Affairs shall complete all good cause determinations for all state Veteran's home admissions.

RULES AND POLICY

RCW 74.42.055	Discrimination against Medicaid recipients prohibited.
RCW 74.42.056	Department assessment of Medicaid eligible individuals – Requirements.
RCW 74.39.041	Community residential options—Nursing facility eligible clients
RCW 7.70.065	Informed consent-Persons authorized to provide for patients who do not have capacity while the person is in a hospital or skilled nursing facility setting

WAC 388-96-781	Exceptional care rate add-on – Covered Medicaid residents; please submit requests to Jevahly.Wark@dshs.wa.gov
WAC 388-97	Nursing Homes; Resident Rights, Care and Related Services
WAC 388-106-0355	Am I eligible for nursing facility care services?
WAC 388-106-0360	How do I pay for nursing facility care services?

REVISION HISTORY

Date	*Made By*	*Change(s)*	*MB #*
7/2026	Jevahly Wark Desiree Vallejo Rebecca Kaiser	• Removed monthly and twice monthly EBS eligibility review. • Removed reference for Kroger Authorization Process • Updated all references from DDCS to DDA	
4/2026	Julie Cope Jevahly Wark	• Clarified that nursing facilities residents who are receiving GCAP services must remain active. • Expanded Behavior Supports updated to remove the case management attendance at EBS meetings with SNFs. • Text box added to indicate Expanded Behavior Supports process for dual assigned DDCS clients • Language added to include contact for SNF exceptional rate requests • List of contracted EBS facilities added to appendix • CARE assessment moved to current guidelines	
11/2025	Jevahly Wark Cassie Pizano	• Expanded Behavior Supports eligibility updated throughout the chapter. • EBS Supports in SNF (Roles and Responsibilities) Document updated in Attachment Library Medstar forms added • Included Guardian & Conservatorship Assistance Program as part of the Specialized Nursing Facility programs which must remain active for case management.	
7/2025	Julie Cope	• Updated ALTSA references to reflect Administration name change to Home and Community Living Administration (HCLA)	

	Rebecca Kaiser Cassie Pizano	• Updated all DDA references to reflect their new divisional name of Developmental Disabilities Community Services (DDCS) • Added references to the SharePoint Site: NFCM Workspace for assigned Nursing Facility Case Managers. • Included a 60-day face-to-face discussion SER requirement for active NFCM cases. • Updated DSHS Form 14-456 Home Maintenance Allowance to include client ACES # • Updated Desk Aid for Amazon Business	
3/2025	Julie Cope Jevahly Wark Cassie Pizano	• Added clarification when a client no longer meets NFLOC, the chosen program in the Care Plan screen may remain blank. • Added additional clarification for DDA case manager's roles and responsibilities throughout the chapter. • Added clarification that HCS cannot enter an NFLOC in CARE if the case is not assigned to an HCS RU. • Removed the requirement for the case manager to complete PASRR Level 1 screening form. • Added link to NFCM Workspace within Client No Longer Meets NFLOC section. • Clarified transfer protocols for cases transferring from nursing facility settings to hospital case management. • Updated treatment name for CTS from "other" to "Community Transition Goods or Items" and "Community Transition Services" • Removed Bathroom Equipment from the transition resources table as this is a covered service under the Apple Health benefit. • Update to Expanded Behavior Supports referral, approval, and notification process. • Updated TCCS Referral Flow Document in Appendix and added TCCS Referral Email Template. • Updated Assistive Technology to include Smart Care Companion and Technology Support	H25-010

		Consultation and Technical Assistance service descriptions.	
10/2024	Julie Cope	• Added a Note Box with Expanded Behavioral Supports referral considerations • Provided the TCCSAdmissionRequest@dshs.wa.gov mailbox for coordination support related to Specialized Nursing Facilities. • Clarified that residents receiving specialized nursing facility services must remain active with nursing facility case management. • Added MedStar statewide non-medical transportation referral process to appendix. • Included Chapter 3 hyperlink for additional information on the Address confidentiality Program.	H24-062
7/2024	Julie Cope	• Updated hyperlinks and formatting. • Provided instruction that the discharge date is to be entered in ProviderOne for MAGI and MCS participants. Previous P1 procedure only documented the discharge date when a client no longer met NFLOC.	H24-044
4/2024	Julie Cope	• Provided minor clarifications surrounding Transitional Care Center of Seattle and Expanded Behavior Supports. • ProviderOne requires a profile change to enter/edit this functional eligibility directly into the system. The date of discharge will now be communicated in ProviderOne directly for MAGI and MCS recipients. • Included additional transfer clarification for NFCMs whose clients become hospitalized. • Updated EBS Support Level Eligibility & Description and EBS/RSW Referral Flow chart in Appendix to reflect updated RSW Committee language.	H24-018
12/2023	Julie Cope	• Amended EBS in SNF HCS Coordination instructions to be consistent with MB H23-076 • Added updated EBS Service Level Description to Appendix. • Clarified PASRR Level 2 evaluation information. • Clarified length of time a case may remain active with NFCM.	H23-090

		• Amended the Home Maintenance Allowance client letter. • Added Non-Medical Transportation (T2003) to the Community Transition & Transition Support Services section. • Included Trial Visit information under Social/Therapeutic Leave section.	
8/2023	Amanda Speck Julie Cope	• Added HCS Purchasing Card Process to Appendix • Added Hospital Swing Bed and Hospital Bed Readiness information. • Removed APS Funded Client Intervention Services from Transition Resources Section • Revised EBS approval and notification instructions to incorporate Eligibility form 11-130 & EBS Descriptions in the Appendix. • Clarified instruction for out-of-state Nursing Facility admissions in neighboring cities. • Clarified case coordination instruction for those cases shared with DDA.	H23-071
6/2023	Julie Cope	• NFLOC determination exclusion for PACE participants • Updated TCCS Referral Flow Chart to include Specialty Settings referral form	H23-039
11/2022	Julie Cope	• Updated NFLOC Documentation screen • HCS Decision Making for Transitions resources • Included RCL Referral mailbox • Updated TCCS Referral Form	H22-064
5/2022	Julie Cope	Included face to face assessments into NFCM Work Performance and Relocation Standards. Updated CTS Funding Limits. Incorporated DSHS Form 11-159 into EBS Eligibility, Added ALTSA Housing Resources to the Transition Resource section, updated hyperlinks and screenshots, added Transitional Care Center of Seattle Admission Referral Flow & Supporting Client Transitions to the Community YouTube video to Chapter Appendix	H22-028
12/2021	Julie Cope	Added additional information on coordinating with MCOs. Refined Specialty Nursing Facility Program Note to include the TCCS Referral Flow hyperlink added in the Appendix.	H22-005
05/2021	Julie Cope	Amended HMA instructions, added Sample Letter for Home Maintenance Allowance replacing PAN, added Residential Furnishings WACs	H21-050

2/2020	Julie Cope	Updated HMA PAN instructions in Transition Resources	H20-056
12/2019	Julie Cope	Updated MAGI Communication procedures with HCA to include direct entry of NFLOC determination in ProviderOne Added Kroger Authorization Process to Appendix	H19-066
9/2019	Julie Cope	Added Sample Letter for Social/Therapeutic Leave to Appendix	H19-048
7/2019	Julie Cope	Added Policy Regarding Case Management of SNF residents approved for Expanded Behavior Supports	H19-039

APPENDIX

Example of NFCM Weekly Tasks Schedule

NFCM Tasks	***Monday***	***Tuesday***	***Wednesday***	***Thursday***	***Friday***
Facility On Site Visits-2x a week		10a-4p		10a-4p	
NFLOC Determination/ Redetermination		During Visit		During Visit	
Weekly Transition Coordination Meetings (SNF & NFCM)		10a-12:00p			
PointClickCare Review -New Admissions/Transitions	9-10:00a		9-10:00a		
Face to Face CARE Assessment		During Visit		During Visit	
Supervisor on Site Visits each Quarter		10-12:00			
MCO Transition Coordination meetings *Every Other Week* (CCW, UHC, Molina, CHPW, Wellpoint, Humana)				1-3:00p	
DME Specialist referrals for Transition Coordination		11:30-12p			
Office/Desk Day for SERs, Referrals, Authorizations, Emails, Phone calls &					8-5:00pm

NFCM Tasks	*Monday*	*Tuesday*	*Wednesday*	*Thursday*	*Friday*
Paperwork to DMS for imaging, case transfers.					
MDS Acuity Report and compare to SNF Census	Monthly				

Every On-Site Visit should include:

1. Meeting with SNF staff to prioritize CARE assessment of the day, debrief after CARE Assessment is completed identifying SNF Roles and NFCM next steps, and prioritize next three scheduled CARE assessments. Share Pending CARE assessment with SSD, Obtain Plan approval with Resident, SER Actions
2. Introduce self to each new admit (Intake) where NFLOC is needed and document NFLOC in NFCM Screen, SER and enter 14-443/P1. Work with SNF staff and client to ensure HMA is requested, when eligible.
3. Complete required documentation with clients to include 14-225, Rights and Responsibilities, Release of Information, Signature on Service Summary etc.
4. Confirm that LTSS Brochures, RCL Brochures, and NFCM Brochures are available for the Social Services Department, Admissions and the Business Office.

HCS Decision Making for Transitions/Authorized Representative

ALTSA- How to Identify a Guardian
ALTSA Power of Attorney vs. Uniform Guardianship
HCS Decision Making for Transitions.pdf

Amazon Authorization Process (NFCM Only)

Desk Aid for Amazon Business

Client Services Purchasing Card Process-HCS Only

HCS Purchasing Card

02-615 Social Services Packet Coversheet

Documenting NFLOC in CARE - YouTube

Nursing Facility Expanded Behavior Supports Service Eligibility & Description

Expanded Behavior Supports Contracted Facilities

Expanded Behavior Supports in SNF-Support

Transitional Care Center of Seattle

TCCS Referral for (Client Initials).msg
TCCS Admission Request Flow Chart

What Program to Use: Transition and Sustainability Goods and Services

Which Program to Use Transition and Sustainability Goods and Services

Supporting Client Transitions to the Community - YouTube

MedStar Non-Medical Transportation Referral Process

Non-Medical Transportation Request Process

Medstar Trip Request Form

Medstar Stretcher Transport Form

Sample Letters:

SAMPLE LETTER
(Print on HCS letterhead)

Date:

To: <<Nursing Facility>>

Subject: Nursing Facility Level of Care Determination

This notification is to inform you that I recently performed a review of the nursing facility level of care for <<Resident's Name>>, a resident of your facility, and determined that <<he/she>> does not meet nursing facility level of care and therefore is not eligible for Medicaid payment. Nursing facility level of care criteria is determined in WAC 388-106-0355.

You are required per RCW 74.42.450 to send the client a 30 day discharge notice following all notification requirements. Medicaid payment through ProviderOne will end 30 days from the date of this letter.

If you have any questions or assistance with discharge planning, please feel free to contact me directly.

Sincerely,

<<CM Name>>
Home and Community Services

SAMPLE LETTER
(Print on HCS letterhead)

Date:

To: <<Nursing Facility>>

Subject: Nursing Facility Level of Care Re-Determination

This notification is to inform you that, based on a request for a Fair Hearing, I recently performed another assessment of the nursing facility level of care for <<Resident's Name>>, a resident of your facility, and determined that with additional information regarding care, <<he/she>> <<does>> meet nursing facility level of care and continues to be eligible for Medicaid coverage in the facility. Nursing facility level of care criteria is determined in WAC 388-106-0355. Medicaid payment through ProviderOne will continue.

All notices can be rescinded and the LTC Ombuds office should be notified of this change in determination.

If you have any questions or assistance with discharge planning, please feel free to contact me directly.

Sincerely,

<<CM Name>>
Home and Community Services

cc: <<Nursing Facility Resident>>
SAMPLE LETTER
(Print on DSHS Letterhead)

Date:

To: <<NF Resident Name>>

Subject: Social and Therapeutic Leave

We received your request for an Exception to Rule, WAC 388-97-0160. You have requested additional social and therapeutic leave days.

The exception to rule (ETR) has been <<approved/denied>> for <<amount>> of days.

If you do not agree with the ETR decision, you may call your case manager with your concern. You also have the right to present your complaint in writing to your case manager's supervisor.

- Address your written complaint to "NFCM Supervisor of (Case Manager's Name)", or
- Ask your Nursing Facility Case Manager for the name of their supervisor.

Upon receipt of your written complaint, the Supervisor will review the ETR decision on your complaint and notify you in writing within ten (10) days of their decision.

If you are not satisfied with the Supervisor's decision, you have the right to send your written complaint to the Home and Community Services Regional Administrator for your region.

The Home and Community Services Regional Administrator or designee will review your written complaint and send you a written notice of his/her decision within ten (10) working days of receipt of the complaint. <u>This notice terminates the complaint procedure.</u>

If you have any questions or would like assistance with transition planning to another setting, please feel free to contact me directly.

Sincerely,

<<CM Name>>
Home and Community Services

cc: <<Nursing Facility>>

SAMPLE LETTER
(Print on DSHS Letterhead)

Date:

To: <<NF Resident Name>>

Subject: Home Maintenance Allowance Income Exemption

This notification is to inform you that you have not been approved the Home Maintenance Allowance income exemption. Home Maintenance Allowance (HMA) eligibility criteria is outlined in WAC 182-513-1380. You are not eligible for HMA due to:

☐ The HMA income exemption is allowed for a single institutionalized client or institutionalized couple. A married client whose spouse is not institutionalized is not eligible for the HMA.

☐ HMA is limited to a maximum six-month period; and requires a physician certification that the client or couple is likely to return to their community home within the six-month period. The physician will not certify the likelihood of your return to a community home.

☐ SSI only income. Upon Nursing Facility admission, your SSI income is exempted for three months; therefore, you are not eligible for a HMA.

If you have any questions and would like assistance with transition planning to another setting, please feel free to contact me directly.

Sincerely,

<<CM Name>>
Home and Community Services

cc: <<Nursing Facility>>