Long-Term Services and Supports Presumptive Eligibility (LTSS PE)

Chapter 30e describes LTSS PE as part of the 1115 Medicaid Transformation Project waiver. LTSS PE will establish presumptive eligibility for individuals in need of long-term services and supports under Medicaid state plan and 1915(c) waiver authorities and Medicaid medical coverage and will be implemented in three phases.

Ask the Expert

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BACKGROUND

Long-Term Services and Supports Presumptive Eligibility, or LTSS PE, was approved by the Centers for Medicare and Medicaid Services in July 2023 with the 1115 Medicaid Transformation Project (MTP) waiver. Under the 1115 MTP waiver, specific Medicaid requirements are waived. LTSS PE is a package of services based on self-attested functional and financial eligibility determination. LTSS PE provides individuals an opportunity for expedited access to both home and community-based services in their own home and Medicaid (Apple Health) medical coverage benefits while full functional and financial eligibility are being determined.

Recipients of PE must be residing in their own home and plan on enrolling in one of the following Washington State programs:

- Medicaid Personal Care (MPC)
- Community First Choice (CFC)
- CFC + Community Options Program Entry System (COPES)

They must then complete a PE Assessment which uses preliminary information based on self-attestation to determine eligibility for the program. If found to be eligible for PE, they will be offered a limited benefit package during the PE period. Services included in the limited benefit package are described in subsequent sections. Rules governing LTSS PE can be found in WAC 388-106-1800 thru 388-106-1855. LTSS PE was developed to be implemented in three phases:

Phase 1 was implemented statewide on December 4, 2023, offered to applicants who will be or have transitioned from an acute care hospital or diverted from a community psychiatric hospital to their own home, in the last 30 days.

Phase 2 statewide implementation occurred on July 1, 2026. Phase 2 expands LTSS PE services to applicants who choose to receive services in their own home. Phase 2 no longer requires applicants to be transitioning from an acute care hospital or diverting from a community psychiatric hospital to their own home as an eligibility criteria.

Phase 3 will be reviewed by Centers for Medicare & Medicaid Services (CMS) at a later date. If approved, LTSS PE will be expanded to include individuals who are interested in receiving LTSS in a residential setting.

WHY LTSS PE?

The goal of LTSS PE is to provide individuals with expedited access to home and community-based services. By doing so, LTSS PE will provide services to assist clients to live as independently as possible in their home.

LTSS PE allows individuals access to Medicaid Apple Health medical coverage and a limited package of services while full functional and financial eligibility is being determined. Individuals already determined financially eligible for Medicaid state plan medical benefits will only require a functional LTSS PE determination.

WHO IS ELIGIBLE FOR LTSS PE?

To be eligible for the LTSS PE program, and before services can be authorized, the client must meet the criteria below.

LTSS MPC PE Eligibility

1. Meet functional eligibility requirements as defined in WAC 388-106-0210.
2. Meet financial eligibility requirements as defined in WAC 182-513-1225
3. Live in their own home, as defined in WAC 388-106-0010.
4. Are not receiving any other Medicaid funded long-term services and supports.
5. Have not received LTSS PE services in the last 24 months.
    a) This will be calculated from the time the previous LTSS PE ended. Applicants who are approved for LTSS PE during Phase 1 but did not receive services during the LTSS PE period could reapply for an LTSS PE Assessment.

LTSS NFLOC PE Eligibility

1. Meet functional eligibility requirements as defined in WAC 388-106-0355(1)(a), (b), (c), or (d).
2. Meet financial eligibility requirements as defined in WAC 182-513-1315.
3. Live in their own home, as defined in WAC 388-106-0010.
4. Are not receiving any other Medicaid funded long-term services and supports.
5. Have not received LTSS PE services in the last 24 months.
    a) This will be calculated from the time the previous LTSS PE ended. Applicants who are approved for LTSS PE during Phase 1 but did not receive services during the LTSS PE period could reapply for an LTSS PE Assessment

Eligibility during LTSS PE Phase 1 was limited to clients who were discharging or diverting from an acute care hospital or a community psychiatric hospital or had discharged or diverted from an acute care hospital or community psychiatric hospital in the last 30 days, as well as the other criteria above.

Note: If a client was discharged from the hospital to a skilled nursing facility (SNF) for less than 30 days before discharging to an in-home setting and did not have contact with the NFCM, they could still be considered for LTSS PE.

WHERE CAN INDIVIDUALS RECEIVE LTSS PE SERVICES?

LTSS PE services will be provided in home and community-based settings. To be eligible to receive LTSS PE services, the client must live in their own home as defined in WAC 388-106-0010. Examples of own home include:

- In an apartment that the client rents.
- In an established home that the client owns.
- In a relative's established home.

- In the home of another where rent is not charged.
- In a motel, where the client pays an established weekly/monthly rate of pay to reside (i.e., rent).

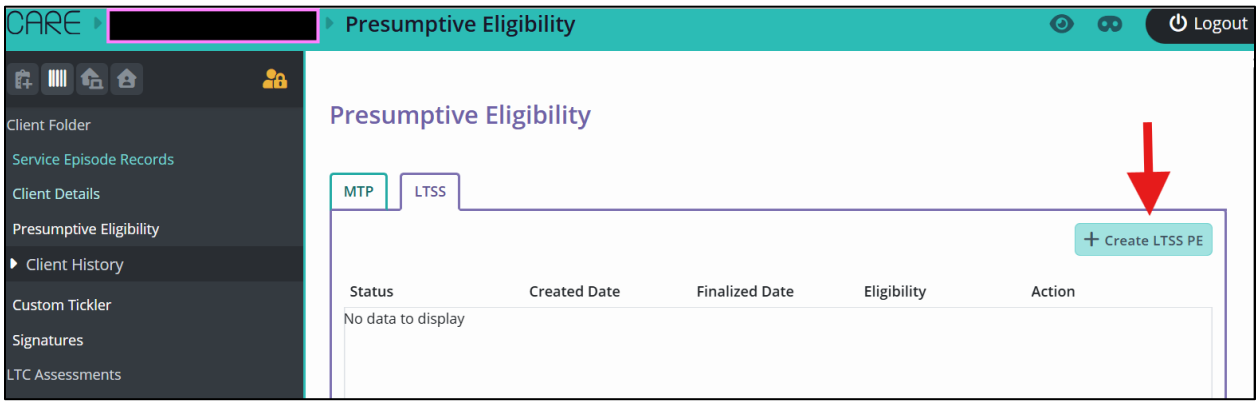
ASSESSING FOR LTSS PE ELIGIBILITY

HCS Social Service Specialist (SSS) or Area Agencies on Aging (AAA) staff will use the LTSS PE Assessment in CARE Web to gather preliminary information that will determine financial and functional eligibility for LTSS PE. The LTSS PE assessment is conducted telephonically.

Full LTSS functional and financial eligibility will be determined while the client is accessing LTSS PE services. The full functional determination will be completed via the CARE Web Assessment which will be conducted via an in-person process, as outlined in Long Term Care Manual Chapter 3: Assessment and Care Planning.

Creating an LTSS PE Assessment in CARE Web

The LTSS PE Assessment can be accessed via the *Client Folder* > *Presumptive Eligibility* > *LTSS* tab > *+ Create LTSS PE*:



The LTSS PE Assessment has three (3) sections: Financial, Functional, and Care Plan. Each section of the Assessment is dynamic, meaning once all required fields in the Financial section have been completed, the PE Assessment will display the Financial indicator as "Eligible" or "Ineligible". When displayed as "Eligible", then the LTSS PE Functional section will enable. When the Functional section is displayed as "Eligible", the LTSS PE Care Plan will be enabled to complete the Assessment process.

LTSS PE Financial Eligibility Overview

LTSS PE applicants who plan to enroll in CFC, CFC+COPES, or MPC programs are either already financially eligible for Medicaid state plan medical benefits or will self-attest to financial eligibility. Eligibility factors for LTSS PE are based on the eligibility criteria for LTSS, and do not necessarily reflect the eligibility criteria for a medical program a client may currently be receiving. The financial criteria for a client's current medical program should not be used in determining LTSS PE. The financial eligibility factors listed below are based on the criteria for the final LTSS application eligibility.

Financial Eligibility for LTSS NFLOC or MPC PE is met when:

1. The applicant is a current recipient of:
    a) Categorically Needy (CN); **or**
    b) Alternative Benefit Plan (ABP) Medicaid coverage; **or**
    c) Individual is not a current recipient of CN or ABP but meets the criteria in a.-f. below and submits a completed HCA form 19-0054 if under age 65.
        i. An S32 will be opened during the period of PE approval.

2. The applicant is financially eligible for LTSS NFLOC PE when a.– d. **and** either e. **or** f. apply:
    a) Has Washington State residency; **and**
    b) Is a U.S. citizen, U.S. national, or eligible immigrant; **and**
    c) Social Security Number (SSN); **and**
        i. If there is no SSN or it is unknown, it will not preclude the applicant from applying for LTSS PE. Provide the individual with assistance applying for an SSN or getting the person's SSN, unless the individual meets the exception under WAC 182-503-0515 subsection (2).
    d) Is Aged, Blind, or Self-Attests to Disability; **and**
    e) If *single*: the single individual's non-excluded monthly income is equal to or less than the Categorically Needy Income Level (CNIL), and the individual's separate non-excluded resources are at or below $2,000; **or**
    f) If *married*: for a married couple with a non-institutional spouse, the individual's non-excluded income is equal to or less than the CNIL with spousal impoverishment protections, and that non- excluded resources (calculated as of the first point at which the individual is deemed to have the status of an "institutionalized spouse") are at or below a combination of $2,000, plus the current state Community Spouse Resource Allowance, based on the individual's self-attested statement of their household resources.

If the applicant attests to resources over the allowable limits as a single person or married person, they do not meet the criteria for LTSS PE services. They can still pursue LTSS services through the traditional eligibility determination process.

Defining "Resources"

A "resource" is any cash, other personal property, or real property that an applicant, recipient or other financially responsible person owns, can convert to cash (if not already cash), and has the legal right to use for support and maintenance (see WAC 182-512-0200). Any asset that does not meet this criterion is not a resource. Resources examples: checking accounts, stocks, bonds, annuities, pensions, vacation property, multiple cars, and cash in a safe.

A "countable resource" is something that meets the definition of a resource, is not excluded as a resource, and is available to convert into cash (if not already cash). A resource that ordinarily cannot be converted to cash within 20 working days is considered unavailable as long as a reasonable effort is being made to convert the resource to cash (WAC 182-512-0250). A person may provide evidence

showing that a resource is unavailable. A resource is not counted if the person shows sufficient evidence that the resource is unavailable.

An "excludable resource" can be:

- The home, household goods, certain other property (WAC 182-512-0350).
- One vehicle used for transportation (WAC 182-512-0400).
- Life insurance up to $1,500, but the rule can get complex (WAC 182-512-0450).
- Burial fund up to $1,500, but the rule can get complex (WAC 182-512-0500).
- Other resources excluded by federal law (WAC 182-512-0550).
- Certain American Indian or Alaska Native resources (WAC 182-512-0770:).

HCA Form #19-0054 Certification of Potentially Disabling Condition

To be eligible for LTSS PE, client's must be aged, blind, or self-attest to a disability. If the client is not determined Aged, Blind, or Disabled, and S02, S95, or S99 ACES codes are not open for a first-time client, then the HCA #19-0054 form is required for LTSS PE financial eligibility. The #19-0054 form will be needed before the LTSS PE period is over and full financial and functional eligibility is determined. HCS/AAA staff will support the client to have this form completed by a licensed medical professional (as described in WAC 388-449-0010) to confirm a disabling condition for the client on long-term services and supports.

The #19-0054 form would not be required for clients 65 years and older or already active on a DSHS Classic Medical program (S01, S02, S95, and S99 ACES codes) because they would have already been determined Aged, Blind or Disabled in order to be active on a DSHS Classic Medical.

Scenario 1

Q: Do I need to get a 19-0054 presumptive disability form when the client is already receiving Medicaid coverage at the time LTSS PE is requested?

A: No, for clients who are already Medicaid eligible (on MAGI or classic Medicaid coverage) and functionally eligible for LTSS PE services, no 19-0054 form is required. Proceed with authorizing LTSS PE services.

Scenario 2

Q: If the client is already Medicaid eligible under MAGI and receiving LTSS PE services and is found to need waiver services when the full Assessment is completed, do I still need to get the 19-0054?

A: No, you don't need to have the 19-0054 form completed. You will need to communicate with financial and let them know waiver services are required so they can request an application and start the NGMA process (see Chapter 7h) to get disability approved following existing processes. If found eligible after the full Assessment, the client can be approved for CFC only. You can end LTSS PE services and authorize CFC services while waiting for the disability determination (NGMA) for waiver services to be completed. Once the disability determination is completed and approved, the client may move to CFC + COPES, if needed.

Scenario 3

Q: If the client is not already Medicaid eligible (under any program) and is determined financially and functionally eligible for LTSS PE services, do I need to get the 19-0054 form?

A: Yes. Under the terms of the 1115 waiver, a person applying for COPES or CFC may self-attest to disability status. If the client self-attests to having a disability, we must get the 19-0054 form completed by their health care professional to confirm presumptive disability status.

LTSS PE Client Responsibility/Participation/Cost of Care

LTSS PE applicants financially eligible for a CN or ABP Medicaid coverage program does not pay toward the cost of care in an in-home setting.

LTSS PE applicants receiving LTSS MPC PE services **do not** pay toward the cost of care for those services.

LTSS PE applicants receiving LTSS NFLOC PE services **may** need to pay toward the cost of care as outlined (see WAC 182-515-1509).

To calculate Client Responsibility, HCS/AAA staff will use the LTSS PE Participation Calculator to enter/complete:

1. Client's gross earned income (income a client receives when being employed).
2. Client's gross unearned income (such as a pension, SSA income, VA income, etc.).
3. Client Has a Payee? (Check box Yes or No)
4. Does client pay a guardianship fee? (Check box Yes or No)
5. Medical Deductions (such as old medical bills, premiums, out-of-pocket expenses, etc.).

Post-Eligibility Treatment of Income (PETI)

LTSS PE applicants are subject to Post-Eligibility Treatment of Income (PETI) based on self-attested available income and allowable deductions, including a Personal Needs Allowance (PNA) during the LTSS PE period. The cost of care applied during the LTSS PE period will not be adjusted when full eligibility is determined. If applicable, an updated PETI will be applied the first of the month following determination, based on completion of the client's full financial and functional eligibility determinations.

Estate Recovery

LTSS PE applicants are subject to Medicaid estate recovery rules. Estate recovery is the department's process of recouping the cost of Medicaid and LTSS benefit payments from the estate of the deceased client. Information on estate recovery will be provided to an LTSS PE-eligible client via the LTSS PE Approval Notice.

LTSS PE Functional Eligibility Overview

Once financial eligibility is determined as "Eligible", the LTSS PE Functional section will be enabled and the LTSS PE Assessor will complete the LTSS PE Assessment.

LTSS PE AND FAST TRACK

Most often, full financial and full functional eligibility determinations for LTSS will be done concurrently.

If the client received a full functional CARE Web Assessment and financial eligibility is not yet determined, the LTSS PE functional Assessment cannot be retroactively accessed during the interim. Consider Fast Track, a process that allows the authorization of HCS services prior to a financial eligibility determination, when staff can reasonably conclude that the applicant will be financially eligible. See Chapter 7a, *Financial Eligibility for Core Programs* for an overview on Fast Track.

Note: A client cannot access Fast Track when accessing LTSS PE.

If the client meets full financial eligibility for Medicaid state plan medical benefits but has not yet received a CARE Web Assessment to determine full functional eligibility, then the LTSS PE functional Assessment can be accessed (given the circumstances that the client has an established home setting).

IDENTIFYING LTSS PE SERVICE OPTIONS

Clients may receive a combination of LTSS PE services once the LTSS PE Assessment indicates LTSS MPC PE or LTSS NFLOC PE functional and financial eligibility, the client provides verbal consent and approval for their LTSS PE Plan of Care, and the client's choice of care provider meets DSHS qualifications (see WAC 388-71-0510).

Clients may receive LTSS PE services in their own home (see WAC 388-106-0010). Clients may also receive LTSS PE services while they are out of their home accessing the community or working while:

1. Within Washington State; **or**
2. In a recognized out-of-state bordering city (see WAC 182-501-0175).

The client's choice of services under LTSS PE cannot duplicate services covered under private insurance, Medicare, state plan Medicaid, or through other federal or state programs.

LTSS PE services may not supplement the reimbursement rate from other resources.

SERVICES AVAILABLE THROUGH LTSS MPC PE

LTSS MPC PE services include up to 34 hours of authorized Personal Care Services per month.

SERVICES AVAILABLE THROUGH LTSS NFLOC PE

LTSS NFLOC PE services are available in two steps. Step 1 services should be offered to LTSS NFLOC PE individuals first if they meet the eligibly criteria for each service. These services could meet people's assessed needs while being more cost effective and while waiting to get services available through Step 2 in place. See Chapter 7b for Assistive/Adaptive Technology & Equipment and PERS and Chapter 7d for Home Delivered Meals eligibility criteria.

Note: Service limits match other program limits. For example, AT would follow the CFC limits of $550 per SFY.

Step 1 Services

1. Home Delivered Meals
    a) When authorizing Home Delivered Meals (HDM), there is no deduction of personal care hours for each meal.
2. Assistive/Adaptive Technology & Equipment
3. Personal Emergency Response Systems (PERS)

Step 2 Services

1. Personal Care Services
    a) Tier 1 Classification = 34 hours per month
    b) Tier 2 Classification = 47 hours per month
    c) Tier 3 Classification = 59 hours per month
    d) Tier 4 Classification = 69 hours per month
    e) Tier 5 Classification = 103 hours per month
2. Nurse Delegation
3. Specialized Medical Equipment and Supplies
4. Community Transition or Sustainability Services (CTSS): Goods and services which are nonrecurring set-up items and services to assist with expenses to move from an acute care hospital or diversion from a psychiatric hospital stay to an in-home setting and may include:
    a) Security deposits that are required to lease an apartment or home;
    b) Activities to assess need, arrange for, and obtain needed resources, including essential household furnishings.
    c) Set-up fees or deposits for utility or services access, including telephone, electricity, heating, water, and garbage.
    d) Services necessary for your health and safety such as pest eradication, and one-time cleaning prior to occupancy.
    e) Moving expenses.
    f) Minor home accessibility modifications necessary for hospital discharge.
5. Community Choice Guide (CCG): Specialty services which provide assistance and support to ensure an individual's successful transition to the community and/or maintenance of independent living.
6. Supportive Housing

Is a person experiencing homelessness eligible for Presumptive Eligibility?

GOSH clients are eligible to utilize the Motel for Interim Stay Transition (MIST) program. MIST can be authorized for up to 6 months. If the HCLA client qualifies for LTSS PE, desires GOSH, and has no safe place to stay or resources to pay for a place, the HCS/AAA staff can utilize MIST. When a GOSH recipient is paired with MIST, they are not considered homeless and can then access the LTSS PE benefits.

> NOTE: Clients eligible for LTSS PE could access WA Roads if they meet eligibility criteria. See Chapter 5a for WA Roads eligibility criteria. Requests for LTSS PE clients to utilize WA Roads must be sent to HQ for approval. These requests are to be sent to the LTSS PE Program Manager.

ETRS AND LTSS PE

Exception to Rules (ETRs) will not be granted for LTSS NFLOC PE or LTSS MPC PE eligibility determinations or service determinations per WAC 388-106-1855.

ADMINISTRATIVE HEARING RIGHTS

Applicants do not have an administrative hearing right as defined in WAC 388-02 on LTSS NFLOC PE or LTSS MPC PE eligibility determinations.

LTSS PE NOTICES

LTSS PE uses four forms:

1. The "**Long-Term Services and Supports Presumptive Eligibility Approval Notice**" (LTSS PE Approval Notice) is used when the client is determined LTSS MPC PE or LTSS NFLOC PE eligible. The notice informs the client of eligibility, and that once a final determination is made, the client may be eligible for different services, more or fewer monthly personal care hours, or be determined not eligible for any services. The notice informs the client of:
    a. Next action steps to make a full financial and functional determination,
    b. inform the client of their rights and responsibilities, and
    c. estate recovery.

    HCS/AAA PE staff **MUST** review this approval notice with the client and obtain the client's/authorized representative's signature.

2. The "**Long-Term Services and Supports Presumptive Eligibility Denial Notice**" (LTSS PE Denial Notice) is used when the client is determined ineligible for LTSS MPC PE or LTSS NFLOC PE. The notice informs the client of the reason(s) for ineligibility and informs them of their rights.

3. The "**Presumptive Eligibility Care Plan**", is used as the Plan of Care. This form **MUST** be signed by the client/representative, HCS/AAA PE staff, and the paid provider responsible for implementing the Plan of Care.

4. HCA/AAA PE staff **MUST** obtain client/authorized representative's signature on the **Consent Form** (DSHS Form #14-012).

Financial Ineligibility Notices

When the client submits their application, the Public Benefits Specialist (PBS) will determine a client to be financially eligible or ineligible. When determined financially ineligible, the PBS sends a denial letter to the client. HCS/AAA staff do not need to send additional notice following the PBS worker's financial ineligibility notice in order to close services. Best practice is that the HCS/AAA will contact the client and let them know that services will end the date the decision was made on client's application and the providers on the day the decision is made. The LTSS PE Denial Notice applies to *initial* denial of LTSS PE services before a LTSS PE period were to begin, and therefore, would not be used for this purpose.

If the client fails to cooperate with providing the requested information needed to determine financial eligibility or provides information which indicates they are not financially eligible, the application decision would be to deny LTSS, and they are no longer eligible for LTSS PE as of that date. The client does have a 30-day reconsideration period for their LTSS application, but that does not apply to LTSS PE. The HCA/AAA worker will contact the client and provider on the day the decision is made and the LTSS PE RAC and authorizations for services should be ended.

DEVELOPING THE LTSS PE PLAN OF CARE

After the LTSS PE Assessment is completed in CARE Web, a brief Plan of Care will be generated based on the level of care (LTSS MPC PE or LTSS NFLOC PE) and services chosen. Before identifying and authorizing a service indicated in the client's LTSS PE Plan of Care, the client must have verbally approved the Plan of Care. Utilizing voice signature or electronic signature would replace the need to obtain verbal approval prior to obtaining the signature. See attachment in Appendix for more information about voice signatures. Contact the client to obtain verbal approval for the LTSS PE plan of care.

- In CARE Web, use Service Episode Record (SER) Purpose code, *Plan Approval*, to document verbal approval.
- Review with the client and send the LTSS PE Approval Notice, LTSS PE Care Plan, and Consent Form (DSHS Form 14-012).

Prior to authorizing services in CARE Web, all services must be indicated in the client's LTSS PE Plan of Care, and the paid supports must be qualified:

- Ensure the Home Care Agency and other chosen service vendors of LTSS PE services are qualified and contracted through the local Area Agency on Aging (AAA). Each local AAA maintains a list of contracted, eligible providers for HCS and AAA. Contact the Contract Specialist for each AAA for the current list of contracted vendors.
- CDWA Individual Provider (IP): clients may also choose Personal Care Services be provided by one or more CDWA Individual Providers (IPs), as defined in WAC 388-115-0503.

Additional Reminders:

Work with the client to identify qualified providers and authorize services consistent with the procedures for other programs like CFC (Chapter 7b), MPC (Chapter 7c), or COPES (Chapter 7d).

Send Plan of Care to the Home Care Agency or CDWA per client's choice, if they choose Personal Care Services.

If discharging from a hospital at the time of the LTSS PE Assessment, use the designation "Discharged with HCS services pending".

COMMUNICATING WITH PUBLIC BENEFITS SPECIALIST (PBS)

When HCS/AAA PE staff complete the LTSS PE Assessment in CARE Web, HCS/AAA PE staff will communicate eligibility with the PBS team. If the client is not assigned an ACES ID, the PE staff will email the Application Assistance Unit/AAU at 1115PresumptiveEligibility@dshs.wa.gov requesting an ACES ID be established. The AAU PBS team will respond to the email providing the ACES ID.

PE staff will submit a 14-443 communication via Barcode under the client's ACES ID, checking "LTSS Presumptive Eligibility (PE)" as a program option and indicating the LTSS MPC PE or LTSS NFLOC PE program start date.

The 1115presumptiveeligibility@dshs.wa.gov email address is specific to LTSS PE only and **should not** be used for Medicaid Alternative Care (MAC) or Tailored Supports for Older Adults (TSOA) inquiries or needs.

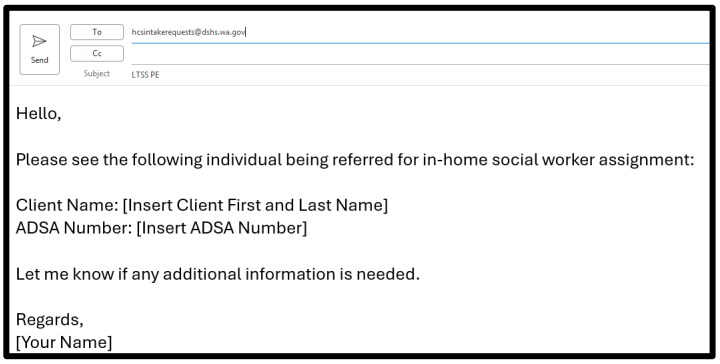
COLLABORATION BETWEEN AAA AND HCS INTAKE AND IN-HOME ASSESSOR

With LTSS PE, intake can occur at either the AAA or HCS front door. Due to this, a feature called "Case Sharing" is available in CARE Web. Case Sharing allows a client to be assigned in one Reporting Unit (RU) to an AAA LTSS PE Assessor while simultaneously being assigned to an HCS In-Home Assessor.

To begin Case Sharing, the AAA must email HCS Intake at hcsintakerequests@dshs.wa.gov with the request to assign an HCS In-Home Assessor. HCS In-take will then assign an HCS In-Home Assessor to the case.

The email must include the following information:

- Client first and last name
- ADSA ID



COLLABORATION BETWEEN AAA AND HCS IN-HOME ASSESSORS

When an LTSS PE case originates at an AAA, communication between the AAA and HCS is critical. CARE Web has automatic ticklers to keep workers assigned in the CARE Web Overview screen aware of action taken on the case. CARE Web also has a custom tickler feature which will allow workers to send information to other workers in the Overview screen in other RUs.

PERIOD OF LTSS PE

LTSS PE begins the date the applicant is determined to be eligible for LTSS PE and ends with the earlier date of:

- The date the decision was made on the client's full LTSS application (see WAC 388-106-1835);
  - The date the client was determined by a CARE Assessment to **meet** functional eligibility.
    - The LTSS PE RAC ends that day and the LTSS program RAC starts the next day.
- The date the client was determined by a CARE Web Assessment to **not meet** functional eligibility (see WAC 388-106-0355 or 388-106-0210), at which time the In-Home worker will close the PE authorizations and notify the providers to stop service; **or**
- If the client does not submit an application, then the LTSS PE period and all LTSS PE services will end on the last day of the month following the month in which the client's LTSS PE services were authorized.
- The date client voluntarily withdraws or dies.
- If the HCS In-Home Assessor was not able to contact the LTSS PE client for a full Assessment. A 10- day letter must be issued.

HCS/AAA staff must discuss with the client that LTSS PE is not a final eligibility decision. LTSS PE services are temporary, unless the client takes action to apply for LTSS. The client needs to complete the functional determination (CARE Web Assessment) and complete a financial determination (telephone interview and providing necessary verifications after review of the submitted application). HCS/AAA staff will explain that once a final determination is made, the client may be eligible for different services, more or fewer monthly personal care hours, or be determined not eligible for any services.

LTSS PE is intended to end on the last day of the month following the month in which the client's LTSS PE services were authorized. For example, when a client is found eligible for LTSS PE in October, then the LTSS PE period will end on the last day of November. However, the LTSS PE RAC can be added for 90 days from when eligibility is determined.

A Medicaid application must be submitted within 10 days from the LTSS PE Assessment completion date. If the client does not submit their application, LTSS PE services will end the last day of the following month that LTSS PE was determined.

When a Medicaid application is submitted, the LTSS PE period can be extended beyond the initial end date, until the earlier date of:

- Full functional and financial eligibility has been determined.
- An ineligible decision was made on the client's Medicaid application.

- The date the client was determined by a CARE Web Assessment to not meet functional eligibility. (*When found functionally ineligible, it is the responsibility of the HCS In-Home worker to close the PE authorizations, contact the providers to stop services, and inform the AAA PE Assessor when the case originated with an AAA and case sharing is occurring).*

LTSS PE PROGRAM RACS

Before authorizing an LTSS PE service, a program RAC must be established. The RAC start date must be on or after the LTSS PE Assessment was completed/locked in CARE Web. When establishing services to implement the Plan of Care, the RAC end date must not be greater than the initial LTSS PE period. The initial LTSS PE period will end on the last day of the month following the month in which the client's LTSS PE was determined. For instance, when a client is found eligible for LTSS PE in October, then initially, the LTSS PE period should end the last day of the following month, being the last day in November, but the LTSS PE RACs can be added to CARE Web for up to 90 days.

LTSS PE has two program RACs:

- LTSS MPC PE RAC: 3209
- LTSS NFLOC PE RAC: 3208

AUTHORIZING LTSS PE SERVICES

The LTSS NFLOC PE or LTSS MPC PE service authorization(s) start date may begin when:

- Verbal approval and consent are obtained from the client/authorized representative for the LTSS PE Plan of Care,
- LTSS NFLOC PE or LTSS MPC PE Assessment is completed and locked, and
- The appropriate RAC is determined.

The service authorization end date must not exceed the LTSS PE RAC end date.

Example: The LTSS PE Assessment determined the client was eligible for LTSS PE MPC services on August 19, and the client's verbal approval and consent to services was obtained on this same date. Client submitted their Medicaid application on September 21 and continued to receive LTSS PE MPC services. The HCS In-Home Assessor conducts an *Initial* CARE Web Assessment on October 1. The PBS determined full financial eligibility on October 5. The HCS/AAA worker obtains verbal plan approval for the full LTSS Assessment on October 15. **HCS adds a SER stating LTSS PE RAC ended and LTSS program RAC opened. AAA staff will then end case sharing in CARE Web.**

- LTSS MPC PE RAC start date = 08/19
- LTSS MPC PE RAC end date = 10/15 *(authorized hours used under LTSS PE up till the 15th then end LTSS PE. There is no carryover of unused hours)*
- Full Eligibility RAC start date = 10/16 *(If the client is eligible for a core program (MPC/CFC/CFC+COPES), the client will be authorized the full benefit of that program to include*

the personal care hours for the remainder of that month and each month thereafter through the plan period).

- **If case-sharing with the AAAs, this is when case-sharing ends.**
- Full Eligibility RAC end date = 10/31 of the following year (to match the Assessment Plan Period End date).

If a client identifies additional services needed that are not already in an approved Plan of Care, a new approval from the client/representative will be required to be obtained.

AUTHORIZING SERVICES AND RACS WHEN CASE SHARING

When LTSS PE cases originate at an AAA, Case Sharing between the AAA will occur in CARE Web with the HCS In-Home Assessor. AAAs are responsible for building the client in CARE WEB, sending an email notification to the HCS Intake team (see this Section for more information on this), completing the LTSS PE Assessment, opening LTSS PE RAC and authorizing services (if eligible). The AAA PE Assessor will monitor the Plan of Care, update authorizations, and adjust RACs as determined necessary through their primary case management role. If the RAC needs to be extended beyond 90 days, the AAA PE Assessor and HCS In-Home Assessor may need to communication. This can be done through SERs or custom ticklers.

An example of when this may occur is if the full functional or financial determinations are postponed or not completed by the end of the 90 days. HCS In-Home Assessor may need to use custom ticklers to notify the AAA PE Assessor to extend the RAC and authorizations.

However, the exception of this is when HCS makes the full functional or financial eligibility determinations. Whether there is an approval or denial for full LTSS, the HCS In-Home Assessor will be responsible for ending the LTSS PE RAC.

- If the client was denied (financially or functionally), the HCS In-Home Assessor will be responsible to notify the client of the outcome of the full eligibility determination and notify providers. HCS In-Home Assessor will then end the authorizations for services and RACs. The HCS In-Home Assessor will also complete a custom tickler to the AAA PE Assessor with notification of the end of case sharing.

- If the client was approved (financially and functionally), the HCS In-Home Assessor will be responsible for notifying the client of the outcome of the full eligibility determination, update services based on the newly created full Plan of Care, notify providers as appropriate, update service authorizations, close the LTSS PE RAC, and open new program RAC(s).

The LTSS PE RAC must be ended, whether approval or denial, on the date the determination was made on the full LTSS application (see WAC 388-106-1835).

WHAT IF THE LTSS PE CLIENT IS HOSPITALIZED OR ADMITTED TO A SKILLED NURSING FACILITY (SNF)?

Contact all service providers the day an individual is admitted to ta SNF or hospital. All service authorizations should be suspended as applicable, when the service intended for the in-home setting cannot be provided in the client's own home (due to reasons such as hospitalization/SNF admit), this includes Personal Care Services provided by CDWA Individual Providers (IPs) and/or Home Care Agencies. HCS/AAA staff must contact to the provider immediately.

If the client does go to the hospital or SNF on a **short-term basis**, authorizations should be suspended under LTSS PE. If the client is staying longer than 14 days, close LTSS PE services and notify PBS.

Scenario: Client on the LTSS PE S02 workaround enters a SNF during the LTSS PE period.

Once the client is in the SNF 14 days, HCS/AAA staff will end the LTSS PE service authorization(s) and notify the PBS that the client is in the SNF and the date LTSS PE services will end.

PBS will close the S02. S02 will continue through the end of the month if closure is completed prior to 10-day notice deadline. PBS will suppress the termination letter.

If the PBS closes the S02 after 10-day notice deadline, the system will still show a paid through date through the following month.

If the client discharges from the SNF prior to the 30th day, a short stay letter can be issued off the S02 LTSS PE AU for an admission under 30 days.

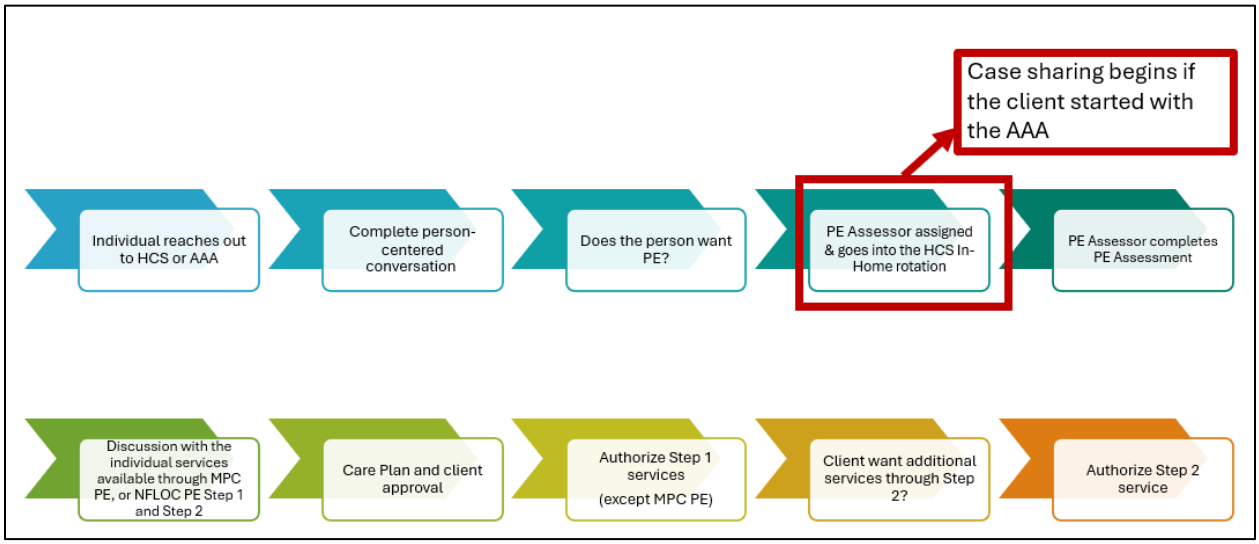
Notify HCS/AAA staff when the client has discharged from the SNF.

LTSS PE WAITLIST

Should program expenditures or enrollment exceed funding availability, a statewide waitlist will be implemented. If a waitlist for LTSS NFLOC PE or LTSS MPC PE is implemented:

1. LTSS PE Assessments will be put on hold; **and**
2. If additional funding becomes available, LTSS NFLOC PE or LTSS MPC PE applicants on the waitlist will be considered on a first come first serve basis. This will be based on the applicant's request date for LTSS NFLOC PE or LTSS MPC PE.

LTSS PE WORKFLOW



RESOURCES

Related WACs

WAC 388-106	Long-Term Care Services
WAC 388-106-1800	What definitions apply to LTSS PE?
WAC 388-106-1805	Am I eligible for LTSS NFLOC PE services?
WAC 388-106-1810	What services may I receive under LTSS NFLOC PE?
WAC 388-106-1815	Am I eligible for LTSS MPC PE Services?
WAC 388-106-1820	What services may I receive under LTSS MPC PE?
WAC 388-106-1825	Who can provide long-term care services when I am eligible for LTSS NFLOC or LTSS MPC PE services?
WAC 388-106-1830	When will the department authorize my LTSS NFLOC or LTSS MPC PE services?
WAC 388-106-1835	When do LTSS NFLOC PE or LTSS MPC PE services end?
WAC 388-106-1840	Where can I receive LTSS NFLOC PE or LTSS MPC PE services?
WAC 388-106-1845	What do I pay for if I receive LTSS NFLOC PE or LTSS MPC PE services?
WAC 388-106-1850	Do I have the right to an administrative hearing on LTSS NFLOC PE or LTSS MPC PE determinations?
WAC 388-106-1855	Can an exception to rule (ETR) be granted for eligibility or service determinations?
WAC 388-449-0010	What evidence do we consider to determine disability?

Acronyms

A complete list of Washington State DSHS acronyms can be found here.

AAA	Area Agency on Aging
ABP	Alternative Benefit Plan
CARE	Comprehensive Assessment Reporting Evaluation
CCG	Community Choice Guide
CDWA	Consumer Direct of Washington
CN	Categorically Needy
COPES	Community Options Program Entry System
DSHS	Department of Social and Health Services
ETR	Exception to Rule
HCA	Health Care Authority
HCLA	Home and Community Living Administration
HCBS	Home and Community Based Services
HCS	Home and Community Services
HQ	Headquarters
LTSS	Long-Term Services and Supports
MPC	Medicaid Personal Care
PBS	Public Benefit Specialist
RCW	Revised Code of Washington
SER	Service Episode Record
SME	Specialized Medical Equipment
SNF	Skilled Nursing Facility
SSS	Social Service Specialist
WAC	Washington Administration Code

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
6/2026	Annie Moua	Updated throughout for clarity Eligibility criteria updated for Phase 2 implementation Stepped services Tiered Personal Care classifications	TBD
11/2025	Annie Moua	Clarification for PE and WA Roads	H25-057
8/2025	Rhonda Widhalm	Improved guidance	H25-039
5/2025	Rhonda Widhalm	Improved guidance Language clarification	H25-010
11/2024	Rhonda Widhalm	Language clarification	H24-062
7/2024	Rhonda Widhalm	Language clarification	H24-044
12/2023	Dru Aubert	Initial draft	H23-081

APPENDIX

Certification of Potentially Disabling Condition
19-0054-hospital-certification-disabling.pdf

Voice Signature Instructions
Voice Signature Chapter 30E Attachment.docx

GOSH and Supportive Housing Brochure
GOSH and Supportive Housing.pdf