Residential Services

Chapter 8 gives an overview of residential services to include licensing requirements, contract types, and determining eligibility for a residential setting. The chapter also provides information on Community Integration, Specialized Dementia Care Program, resident rights and bed holds.

Ask the Expert

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LICENSING REQUIREMENTS FOR RESIDENTIAL SERVICES

All residential facilities provide a package of services including personal care services and room and board. There are three types of licensed residential settings: Adult Family Homes, Assisted Living Facilities, and Enhanced Services Facilities.

The Residential Care Services Division (RCS) of Home and Community Living Administration (HCLA) is responsible for licensing and monitoring all Adult Family Homes, Assisted Living Facilities, and Enhanced Services Facilities in Washington State.

Adult Family Home (AFH)

A residential home in which a person or persons provide personal care, special care, and room and board to more than one, but not more than eight adults, who are not related by blood or marriage to the person or persons providing the services.

Adult Family Home may also be designated as a specialty home (on their AFH license) in one or more of the following three categories: Developmental Disability, Mental Illness, and Dementia when they meet all certification and training requirements. See Chapter 388-76 WAC for more information on Adult Family Home licensing requirements and Chapter 388-112A WAC for residential training requirements.

Note: When a Medicaid resident is related to the AFH provider and is residing in a licensed and contracted room; the CM/SSS must authorize AFH services using the daily rate based on CARE classification (the same as an unrelated resident).

Assisted Living Facilities (ALF)

A facility for seven or more residents, with the express purpose of providing housing, basic services (assistance with personal care and room and board) and assumes the general responsibility for safety and well-being of the residents. See Chapter 388-78A WAC for more information on Assisted Living Facility licensing requirements.

Enhanced Services Facilities (ESF)

An Enhanced Services Facility provides 24-hour personal care and behavior support services to a maximum of sixteen residents who have complex personal and behavioral care needs that exceed the capacity of other residential settings. See WAC Chapter 388-107 WAC for more licensing requirements. For additional information on ESF please see LTC Manual Chapter 7f for information.

Note: Adult Family Homes, Assisted Living Facilities, and Enhanced Services Facilities may choose to serve private pay residents, Medicaid residents, or a combination of both.

CONTRACTS

Contract Types

If a residential provider wants to serve a Medicaid resident, the provider must also have a current Assisted Living, Adult Residential Care, Enhanced Adult Residential Care, Enhanced Servies Facility, or Adult Family Home contract with HCLA. The types of contracts are listed below.

The **Assisted Living Facility** (ALF) contract requirements are outlined in WAC 388-110 . There are three types of assisted living contracts:

- Adult Residential Care (ARC)
- Enhanced Adult Residential Care (EARC)
- Assisted Living Services (AL)

There are three Assisted Living Subcontracts:

- Enhanced Adult Residential Care - Specialized Dementia Care:
  EARC-SDC contracts are available only to Assisted Living Facilities with a designated separate dementia care unit and ALFs dedicated solely to the care of individuals with dementia that have been approved by HCLA to deliver SDCP services.

  The Specialized Dementia Care Program (SDCP) is based on Standards of Care specified in WAC 388-110-220 (3). DSHS contracts with licensed and qualified assisted living providers throughout all regions in the State to provide Specialized Dementia Care Program in Assisted Living Facilities. Services are provided in:

  - A facility dedicated solely to the care of individuals with Alzheimer's disease/dementia; or
  - A designated, separate unit/wing dedicated solely to the care of individuals with Alzheimer's disease/dementia located within a larger facility.

  For more information on the Specialized Dementia Care Program in EARC-SDC/ALF, go online to: Specialized Dementia Care Program in Assisted Living Facilities.

- Expanded Community Services (ECS) – see LTC Manual Chapter 7f for more information

- Community Stability Supports (CSS) – see LTC Manual Chapter 7f for more information

Memory Care Certification

In 2025, Washington state lawmakers enacted a certification requirement prohibiting assisted living providers to operate or maintain a memory care facility or memory care unit within this state without a certification for memory care services. The requirement took effect July 1, 2026. If an assisted living provides the Specialized Dementia Care Program, they are required to be Memory Care Certified (MCC). MCC is displayed on the ALF Locator and is also a searchable criterion. If a provider does not maintain their MCC, Residential Care Services may enforce remedies as outlined in WAC 388-78A-3160 Authorized enforcement remedies. Case managers do not need to make any payment adjustments to a provider not being listed as having MCC. Any stop payment, stop placement or termination of licensing will follow the current process with RCS.

The **Adult Family Home** requirements are outlined in Chapter 388-76 WAC. There are two types of Subcontracts in AFH:

- Expanded Community Services (ECS)
- Specialized Behavior Support (SBS)

**Please note in the past there was an HIV/AIDS specialty contract. This contract is no longer available, but two AFHs remain, and they are eligible to receive the published HIV/AIDS rates [Three Cedars (Tacoma) and Sean Humphries (Bellingham)]. No other facilities in the state may receive the HIV/AIDS rate.

The **Enhanced Services Facilities** contract requirements are outlined in Chapter 388-107 WAC and LTC Manual Chapter 7f.

Contract Requirements

AL, ARC, EARC, EARC-SDC, AFH, and ESF contracts are legal agreements between contractors and HCLA. The contract describes the contractor's legal obligations and responsibilities in the statement of work and conditions for receiving payment for services provided.

Facility requests to voluntarily withdraw a Medicaid contract.

If the residential facility is requesting to voluntarily withdraw their Medicaid contract, but continues to provide personal care services, the facility's voluntary withdrawal from participation is not an acceptable basis for the transfer or discharge of residents of the facility. The facility is required to maintain a Medicaid contract as outlined in RCW 18.20.440 to permit the following residents to remain in the facility and not transfer or discharge them:

- Residents who were receiving Medicaid on the day before the effective date of withdrawal (except as described in RCW 70.129.110, Disclosure, transfer, and discharge requirements), and

- Residents who have been paying the contractor privately for at least two years and who will become eligible for Medicaid within 180 days of the date of withdrawal.

To ensure the resident's rights are protected, the contractor may not evict a resident without (1) complying with the transfer and discharge requirements under RCW 70.129.110 and (2) using any appropriate legal processes, including but not limited to unlawful detainer in RCW 59.16 prior to evicting a resident.

Note: If you receive a written or verbal request from a facility for a voluntary withdrawal of a Medicaid contract, forward a copy of the written request to the HCLA Contract Unit or have the facility contact the HCLA Contract Unit directly. By RCW 18.20.440 (5), the facility must give the department and its residents 60 days' advance notice of the facility's intent to withdraw from participation in the Medicaid program.

Change of Ownership (CHOW)

There may be times when there is a Change of Ownership, and the new licensee does not enter into a Medicaid contract which may result in the discharge or transfer of residents:

- RCW 18.20.440 does not apply to assisted living facilities that change ownership.
- Instead, WAC 388-78A-2785 requires the facility to give 90 days' notice to the residents of a facility undergoing a change of ownership if the change is anticipated to result in the discharge or transfer of any residents.
- If the facility does not want to participate in a state Medicaid program, the CM/SSS's will assist residents to move and terminate the Medicaid payment effective the day prior to the move or the same date as the contract termination date.
- If the new owner wants to participate in the Medicaid program, the facility will be asked to sign a Medicaid contract to be paid for Medicaid residents.

Expired Contracts

The HCLA contract department will send the contractors a notice 2-3 months before the contract expires. If the contractors do not renew their contract within 30 days prior to the expiration date, or the contract ends during the mid-month, the authorization in ProviderOne will have a taxonomy error and not be payable to the contractors.

Case Managers/Social Service Specialists **who receive an error message in ProviderOne may need to review the taxonomy error in the ProviderOne authorization to determine whether an expiring**

contract is the cause of the payment error. If so, the CM/SSS will need to notify the contractor of their expiring contract and have the contractor renew their contract before payment can be re-authorized.

Note: The contractors cannot admit new Medicaid residents until they have a signed Medicaid contract in place. For existing Medicaid residents, the contractors will not be able to receive payment until their contracts are renewed and are in signed status.

Medicaid Contract Requirements in Residential Facilities

This chart (below) shows what is required in each licensed facility type as required by contract.

REQUIREMENTS BY LICENSE and/or CONTRACT					
MEDICAID SERVICES AVAILABLE IN ADULT FAMILY HOMES AND ASSISTED LIVING FACILITIES	**Adult Family Home License**	**Assisted Living Facility (ALF) License**			**Enhanced Services Facility License**
	AFH contract (ECS)(SBS)	ARC Contract	EARC Contract (ECS) (SDC) (CSS)	AL Contract (ECS) (SDC) (CSS)	ESF Contract
Facility Assessment	Yes	Yes	Yes	Yes	Yes
Negotiated Care Plan (NCP)	Yes	N/A	N/A	N/A	N/A
Negotiated Service Agreement (NSA)	N/A	Yes	Yes	Yes	N/A
Person Centered Service Plan (PCSP)	N/A	N/A	N/A	N/A	Yes
Personal Care and Supervision	Yes	Yes	Yes	Yes	Yes
Medication Administration	Yes w/RND	Yes w/RND	Yes	Yes	Yes
Medication Assistance	Yes	Yes	Yes	Yes	Yes
Room & Board	Yes	Yes	Yes	Yes	Yes
Activities	Yes	Yes	Yes	Yes	Yes
Private apartment-like unit	No	No	No	Yes	No
Private bathroom	No	No	No	Yes	No
Private kitchen area	No	No	No	Yes	No
Personal care supplies	No	No	Yes	Yes	No
Awake staff 24 hours a day	No	No	Yes w/SDC & CSS	Yes w/SDC & CSS	Yes
Secured accessible outdoor area with environmental & safety requirement	No	No	Yes w/SDC	Yes w/SDC	No
Staff training	Yes	Yes	Yes	Yes	Yes
Coordinate Behavior Support & Team Meetings	Yes w/ ECS and SBS contract	No	Yes w/ECS & CSS	Yes w/ECS & CSS	Yes
Individual Crisis Plan	Yes w/ ECS and SBS contract	No	Yes w/ ECS & CSS	Yes w/ECS & CSS	Yes
6-8 hours of additional staff time per day	Yes w/SBS contact	No	No	No	No
Quality Improvement Committee	No	Yes	Yes	Yes	Yes

Note regarding Assessments: Prior to admitting Medicaid clients in ALF, AFH, ESF; CM/SSS are required to complete CARE Assessment to determine functional eligibility. Provide a copy of assessment details and service summary to the provider. The following assessments are required in these facilities.

Assisted Living Facilities (ALF) are required by (WAC 388-78A-2060) to complete their own preadmission assessment using a Qualified Assessor (WAC 388-78A-2080) prior to admitting any resident and complete a full assessment (WAC 388-78A-2090) at least annually or when the NSA no longer meets the resident's care needs.

Adult Family Home (AFH) are required to obtain a written assessment that contains accurate information about the prospective resident's current needs and preferences before admitting a resident to the home (WAC 388-76-10330). The AFH assessment must be completed by a Qualified Assessor (WAC 388-76-10150) or the department case manager/social service specialist for Medicaid residents (WAC 388-76-10345)

Enhanced Services Facility (ESF) must have an initial person-centered service plan developed for each resident prior to admission to the ESF (WAC 388-107-0110). The plan must include immediate specific support needs and directions to staff and caregivers relating to those needs. The residents must give written informed consent to the content of the plan. The initial comprehensive person-centered service plan must be completed within 14 days of the resident's move-in date, as outlined in (WAC 388-107-0120).

All residential contracted providers (except ESF) are required to update the assessment at least annually, when there is a significant change in resident's physical or mental conditions, when the NSA/NCP no longer reflects the current needs of the resident, and at the resident's request (WAC 388-78A-2100 (ALF) and WAC 388-76-10350 (AFH)). For those residents who are receiving Residential Support Waiver (RSW) services, residential providers must also include a Behavior Support & Crisis Plan and provide Behavior Monitoring documentation as requested. ESF is required to update the assessment every 180 days (WAC 388-107-0080) or when there is a significant change in resident's conditions.

Negotiated Care Plan (NCP), Negotiated Service Agreement (NSA), or Person-centered service Plan (PCSP)

All providers, except ESF, must develop and complete the NCP/NSA within 30 days of the resident's admission. The initial comprehensive person-centered service plan for ESFs must be developed and completed within 14 days of the resident's admission. The NCP/NSA must be reviewed and revised at least annually, when there is a significant change in resident's physical, emotional, mental, behavioral functioning; or any time it no longer addresses the needs and preferences of the resident. Please reference the LTC Manual Chapter 7f for additional documentation requirements for RSW participants.

For detailed information regarding Adult Family Home Negotiated Care Plan refer to WAC 388-76-10355 through 388-76-10385; Assisted Living Negotiated Service Agreement WAC 388-78A-2130 through 388-

78A-2160); and Person-centered service plan for Enhanced Service Facility WAC 388-107-0110 through 388-107-0130.

Nursing Services Available in Each Licensed/Contracted Residential Setting

NURSING SERVICES AVAILABLE IN EACH LICENSED, CONTRACTED SETTING					
Services Provided	**Assisted Living Facility**	**Adult Residential Care**	**Enhanced Adult Residential Care**	**Adult Family Home**	**Enhanced Services Facility**
Intermittent Nursing Services (INS)	Yes	No	Yes	*No	Yes
	Daily Rate, provided by facility	n/a	Daily Rate, provided by facility	n/a	Daily Rate, provided by facility
Nurse Delegation	Yes	Optional	Yes	Optional	Yes
	Daily Rate, provided by facility	Contracted RN	Daily Rate, provided by facility	Contracted RN	Daily Rate, provided by facility
Waiver Skilled Nursing	No	Yes	Yes	Yes	No
	n/a	*DDCS Only	Contracted RN	Contracted RN	n/a
24-hour Nursing Services	No	No	No	No	Yes
					Daily Rate, provided by facility
Nursing Services	Yes	Yes	Yes	Yes	Yes
	Referral to Nursing Services Staff, no additional payment				

* Adult Family Home (AFH) may provide intermittent nursing services if the provider is a licensed nurse or use a contracted nurse with a current license in the state of Washington to provide nursing services (WAC 388-76-10405).

Intermittent Nursing Services

Intermittent Nursing Services may include, but is not limited to: Medication administration, Administration of health treatments, Diabetic management, Nonroutine ostomy care, Tube feeding Nurse delegation consistent with Chapter **18.79** RCW.

- Assisted Living Facilities (ALF), and Enhanced Adult Residential Care (EARC's) are required to have intermittent nursing contract so nursing staff is in place to provide nursing care to meet the needs of residents (WAC 388-78A-2310).
- Adult Family Home may provide intermittent nursing services if the provider is a licensed nurse or use a contracted nurse with a current license in the state of Washington to provide nursing services (WAC 388-76-10405).
- Enhanced Services Facility (ESF) are required to have a licensed nurse on-site in the facility 24 hours per day, with a Registered Nurse on-site in the facility at least 20 hours per week. Nursing services will be provided as necessary (WAC 388-107-0240).
- Adult Residential Care facilities are not required to provide intermittent nursing services by contract.

Nurse Delegation

Nurse Delegation is provided by a registered nurse delegator who assesses a client to determine whether they are in a stable and predictable condition; then teaches, evaluates the competency and supervises limited nursing tasks to nursing assistants or home care aides who meet the requirements of a certified home care aide, nursing assistant certified and/or nursing assistant registered in the State of Washington (WAC 388-76-10405).

In Adult Family Homes (AFH), the cost of nurse delegation can be covered by the MPC, CFC or RSW program. AFH providers may choose to admit or retain residents requiring nurse delegation. Nurse delegation can occur in ALFs and EARCs, but it is not a reimbursable function. Since ALF and EARC have intermittent nursing services by contract, their nursing staff may delegate if they choose (WAC 388-110-150 and WAC 388-110-220).

Note: Refer to LTC Manual Chapter 13 for additional information regarding Nurse Delegation.

24-hour nursing services

Enhanced Services Facility (ESF) is required to always have a licensed nurse on-site. A Registered Nurse is on-site in the facility 20 hours per week and on-call the remainder of the week to meet any specific nursing needs that cannot be addressed by the licensed nurse on-site (WAC 388-107-0240).

Waiver Skilled Nursing

This waiver service is available in all waiver settings if it does not duplicate a service that is already provided by contract or another source. Skilled Nursing Services provide direct skilled intermittent nursing tasks to clients. Registered nurses, or Licensed Practical nurses under the supervision of a RN, may provide skilled treatment that is beyond the amount, duration, or scope of Medicaid-reimbursed home health services as provided in WAC 182-551-2100.

Nursing Services

Nursing services are available in all residential settings, when the service does not duplicate a service that is already provided by contract or another source. The frequency and scope of the nursing services is based on individual need as determined by the CARE assessment and additional collateral contact information (WAC 388-106-0200, WAC 388-106-0300, and WAC 388-107-0070 for ESF). Services include:

(a) Nursing assessment/reassessment,
(b) Instruction to client or providers,
(c) Care coordination, file review and referral to other health care providers,
(d) Skilled treatment only in the event of an emergency that would require authorization, prescription, and supervision by an authorized practitioner prior to its provision by a nurse and/or,
(e) Evaluation of health-related care needs affecting service plan and delivery.

Note: For additional information regarding Nursing Services refer to LTC Manual Chapter 24

DETERMINING PROGRAM ELIGIBILITY FOR RESIDENTIAL SETTING

All Medicaid clients must meet the functional and financial eligibility program requirements before admitting to the facility or converting to Medicaid. Eligibility is determined simultaneously between the Public Benefit Specialist for financial eligibility and by CM/SSS for functional eligibility. Individuals who do not qualify for CFC, RSW or RCL can only move into a contracted AFH or ARC. The following chart shows which residential facility types can be offered to clients based on the financial program they are eligible for:

PROGRAM AVAILABLE IN EACH CONTRACTED FACILITY					
Program	**AFH**	**ARC**	**EARC**	**AL**	**ESF**
Community First Choice (CFC)	Yes	Yes	Yes	Yes	No
DDA Waivers	Yes	Yes	No	No	No
Medicaid Personal Care (MPC)	Yes	Yes	No	No	No
New Freedom	No	No	No	No	No
COPES Waivers	Yes	No	Yes	Yes	Yes
Residential Support Waivers	Yes	No	Yes	Yes	Yes
Roads to Community Living (RCL)	No	Yes	Yes	Yes	No
State-funded Medical Care Services (MCS)	Yes	Yes	No	No	No

Referring to CBHS Supportive Supervision and Oversight

For Community Behavioral Health Supports (CBHS) see the LTC Manual Chapter 22d for information, eligibility and referral process.

Authorizing/Determining the payment rate for residential services.

Authorization for residential services should be entered/complete prior to the client being admitted to the residential setting.

1. Prior to authorizing payment to a provider; the CM/SSS must obtain the client's approval on the plan of care (Refer to LTC Manual Chapter 3). The CARE Assessment is not complete until it is moved to current. This includes assessments that are completed for a resident converting from private pay to Medicaid in a residential setting. The client must also be financially eligible for residential services or on Fast Track.
2. The CM/SSS must verify the correct amount of the daily rate identified in the CARE Classification for the geographic location of the provider. Current payment rates for Adult Family Homes and Assisted Living Facilities can be found at: Office of Rates Management.
3. Supplementation of the Medicaid rate is only allowed by exception in some limited circumstances. Please see the Supplementing Medicaid Rate information in this chapter.

Capital Add-On & Bridge Rate

ALFs with an assisted living contract may receive an additional payment amount called a Capital Add-on Rate. The HCLA Rates staff determines if an ALF qualifies for the Capital-Add-on rate annually, each July. Once set, these rates will be active through the State Fiscal year (July 1 – June 30). The CM/SSS will receive notification from headquarters of qualifying facilities and are responsible for adjusting the payment rates for Medicaid residents. ALFs may receive Capital-Add-on Rate for both Medicaid residents when in a shared room. Details on the Capital Add-On program can be found in WAC 388-105-0035. A current list of Capital Add-On providers can be found through the Office of Rates Management page under "Home and Community."

ALFs with an assisted living, adult residential care, enhanced adult residential care and/or a specialized dementia care contract may receive an additional payment amount called the Bridge Rate. The HCLA Rates staff determines if an ALF qualifies for the Bridge Rate annually using the same methodology as the Capital Add-On rate. **Funding for the Bridge Rate is allocated by the legislature in the biennial budget and may end on June 30 of any year if not funded for the following State Fiscal year.** A current list of Bridge Rate provider can be found through the Office of Rates Management page under "Home and Community."

ALFs with an assisted living contract may receive both the Capital Add-On Rate and Bridge Rate, these facilities will receive both add-ons for their residents authorized for assisted living services (Service Code: T2031).

Residential Rate Adjustment Capital Add-On and Bridge Add-On on CARE Plan Screen

This field allows Case Managers to track adjustments to the residential rate. The personal care adjustments field is enabled when the planned setting selected is residential.
If the client is receiving personal care in a residential setting and there are adjustments to their rate, they must be calculated and documented in this field. Adjustments will be printed on the Service Summary.
Options available include:

- Bridge Add-on
- Capital Add-on
- Capital Add-on + Bridge rate

Capital Add-On & Bridge Rate Reason Codes

- Staff must begin authorizing new services for October 1, 2025, forward using the new reason codes.
- "Capital Add-On" in Assisted Living Services [T2031] authorizations for residents at facilities that qualify for the Capital Add-On rate and "Capital Add-On and Bridge Add-On" in Assisted Living Services [T2031] authorization for residents at facilities that qualify for both the Capital Add-On rate and the Bridge Add-On rate.
- "Bridge Add-On" in Adult Residential Care Services [T1020, U2] and Enhanced Adult Residential Care Services [T1020, U3] authorization for residents at facilities that qualify for the Bridge Add-On rate.
- Staff will continue to include the specialized dementia care reason codes in Enhanced Adult Residential Care – Specialized Dementia Care Services [T1020, U4] authorization for residents on the Specialized Dementia Care Program.

The Capital Add-On & the Bridge rate are not included on the PAN as they are an incentive for the facility and not based on eligibility criteria for the resident.

COMMUNITY INTEGRATION

Under federal rules, individuals who live in residential settings must have opportunities to engage in community life and not be isolated from their community or other people who do not live in a residential facility.

In contracted AFHs, the Collective Bargaining Agreement provides an increase to the daily rate for community integration of Medicaid residents who have an assessed need for assistance to access and participate in the local community. This does not include PACE clients. To be considered community integration, activities must:

- Be individualized and chosen by the resident based on their interests and preferences,

- Include opportunities to engage in the community with other community members, and
- Occur in the resident's local community.

See AFH Provider Community Integration FAQs for more information.

If there is a cost to the activity, the cost of the activity is covered by the resident or with assistance from the resident's friends, family, or other community resources.

Activities Not Included Under Community Integration:

- Medical and dental appointments
- Essential shopping
- Adult Day Health
- DDA Community Inclusion and employment services.

Community Integration Eligibility Criteria in AFHs:

To be eligible for Community Integration an individual must be assessed in the comprehensive assessment reporting evaluation tool (CARE) as needing assistance to access and participate in activities in the community.

If the client's current assessment does not reflect the need for assistance with community integration and the client is requesting assistance with community integration; the CM/SSS can create an Interim assessment to include the CI rate adjustment and the CI mileage reimbursement prior to the next annual assessment due date.

- AFH Providers must include documentation of the resident's choice to participate in community integration activities in their Negotiated Care Plan (NCP) when the need is also identified in the resident's CARE assessment.

Community Integration Reimbursement:

Adult Family Home providers must provide services to residents with an assessed need for support to access and participate in the community and will receive an adjusted daily rate to provide four (4) hours of community integration per month.

The rate adjustment for community integration may include the following supports provided by the AFH:

- Assisting the resident to select what they want to do and where they want to go in the community.
- Assisting the resident to plan how they will get to the activity.
- Assisting the resident before the activity to solve any issues that may come up.
- Assisting the resident to become members of community organizations that interest them.

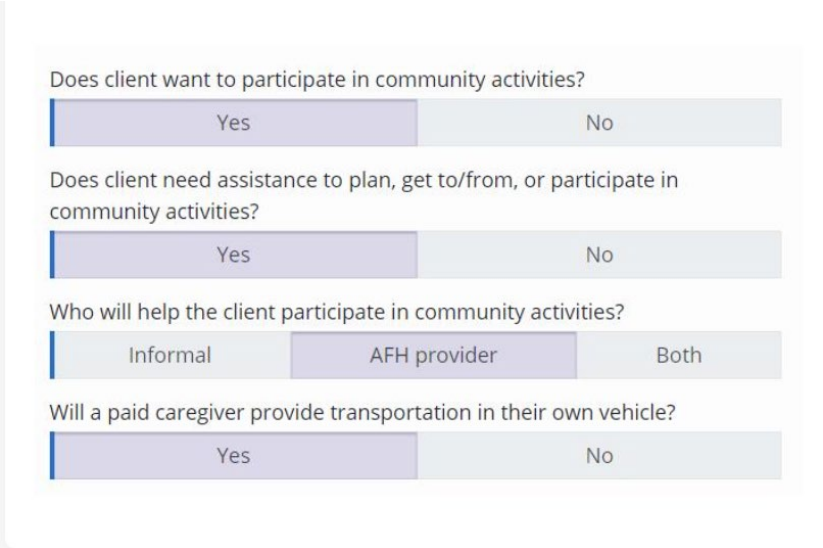
- Assisting residents to identify other people in the community who can accompany them at the event or provide support with transportation.
- Arranging for or providing transportation to and/or from the activity.
- Accompanying the resident during the event to provide personal care assistance.
- Looking for additional opportunities in which the resident may want to participate.

Note: Community Integration may be authorized for residents who receive:

- Specialized Behavior Support
- DDA Community Guide Service
- Expanded Community Services (Refer to LTC Manual Chapter 7f when authorizing ECS)

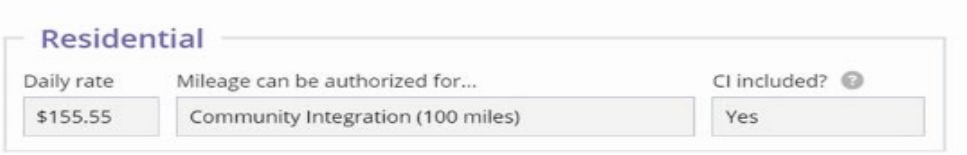
The AFH daily rate generated in CARE will include community integration when a resident:

- Has an unmet or partially met need for assistance with community integration; and
- Chooses to receive assistance with community integration from the AFH provider.



The AFH daily rate generated in CARE will NOT include community integration when a resident:

- Does not need assistance because their informal supports provide all the CI assistance needed,
- Can independently access the community and does not need assistance, or
- Does not want to access the community.
- When community integration is assessed as a need in CARE, the CI adjusted rate will be automatically calculated when the authorization is created in CARE. ***Do not attempt to add rate manually (exception: if client is a resident in an approved HIV/AIDS AFH, case manager should add the CI rate to the published HIV/AIDS rate).***



- Community Integration rate adjustments and Community Integration mileage reimbursement are not available for PACE clients.

AFH Providers are expected to maintain documentation on the provision of assistance with community integration and this documentation must be made available to the CM/SSS upon request.

Community Integration Mileage Reimbursement

Adult Family Home providers who transport residents to access and participate in the community as authorized in the resident's CARE assessment will be reimbursed per mile driven for up to 100 miles per month, per participating resident based on the standard IRS mileage rate. This does not include PACE clients.

The Community Integration mileage reimbursement will be authorized when the AFH resident:

- Meets eligibility for Community Integration and the AFH provider or employee will be providing transportation in their vehicle; and
- Chooses to receive transportation from the AFH to and/or from community integration activities.

The Community Integration mileage reimbursement will NOT be authorized when the AFH resident:

- Does not need assistance because their informal support provides all the assistance needed,
- Can independently arrange for all transportation needs,
- Does not want to access the community, or
- Is not driven to and from chosen activities by the AFH provider or employee.

Medical Mileage Reimbursement

Reimbursement is available to an Adult Family Home Provider who transports a resident to medical providers as outlined in the Department's service plan generated by CARE. Reimbursement is available when Medicaid brokerage transportation will not meet the resident's needs.

- The AFH resident must have an assessed need for medical transportation as documented in the CARE service plan.

- Compensation will be paid on a per-mile-driven basis at the standard IRS mileage rate, up to a maximum of fifty (50) miles per month per resident.
- Mileage reimbursement for travel to medical appointments is different from Mileage reimbursement for community integration. Authorization for one does not preclude authorization for the other.
- Mileage reimbursement for travel to medical appointments is not available to AFH provider in the PACE program.
- Non-emergency medical transportation is a covered service under Apple Health. An AFH provider must not be authorized for medical transportation if that service is available through the Medicaid transportation broker.

Medical Escort Fee – S5125, U1

A medical escort means assistance and accompaniment provided to the resident for the duration of a medical appointment where the resident could not otherwise participate in the medical appointment without assistance, due to physical or cognitive challenges which must be identified in the CARE assessment and Negotiated Care Plan.

This service is used to assist a resident:

- Drive resident to appointment
- Accompany resident at the appointment, including waiting room
- Provide assistance at resident's request

In accordance with the CBA, AFH providers who provide a medical escort to accompany a resident to a medical appointment will be authorized for a medical escort reimbursement rate per hour up to a maximum of twenty-four hours (96 units) to be authorized for the entire plan period. Rates can be found on the Office of Rates Management website.

The following conditions must be met for the AFH provider to be reimbursed for the Medical Escort Fee:

- CRM/SSS must document the resident's need for a medical escort in their CARE assessment. Identify the need for the medical escort on the Medical Transportation screen by answering the two questions and then selecting from the five options indicating what will be provided. Please include any pertinent caregiver instructions and clarifications in the comment box.
- The 96 quarter units are for provider time used to assist and accompany the resident to the medical appointment. It is separate from medical transportation.
- The CRM/SSS will SER the medical escort authorized for 96 units for the planned period.
- The adult family home provider must retain the medical documentation from each appointment in the resident's file and make it available to the HCLA/DDA staff upon request.
- The adult family home provider may not request additional Medical Escort quarter units for the current plan period.

If there is a Significant Change Assessment for **HCS residents only**, the annual assessment date could change. If it does, the SSS must:

- Confirm that the resident is financially eligible before extending the services for 12 months.

- End the Medical Escort authorization line according to the previous assessment plan period.

In ProviderOne, using the Medical Escort Fee code S5125, U1 enter a new authorization line for 96 quarter units for the new plan period

If a resident receives Medical Escort in their current plan period and moves to a new AFH, the CRM/SSS will:

- SER the move-in date and assign Medical Escort to the new AFH.
- Determine the exact number of quarter units that the previous AFH claimed in the current plan period.
- In ProviderOne, using the Medical Escort Fee code S5125, U1 enter the authorization line to the new AFH in quarter units for the remaining units available for the plan period.

If CRM/SSS is concerned about the use of the Medical Escort payment to an AFH they should:

- Staff the concern with their supervisor. If needed:
  - DDCS CRM and supervisor can review the case with DDCS State Plan Residential Program Manager.
  - HCS CM/SSS and their supervisor can review the case with the HCS Residential Policy Program Manager.

Notes:

- AFH providers are not eligible for the medical escort fee if the resident is receiving one-on-one caregiver support during the time of the medical appointment.
- Reimbursement will be paid after providing a medical escort service to a Medicaid resident when all other means of escort have been exhausted.

SPECIALIZED DEMENTIA CARE PROGRAM

SDCP Eligibility Criteria

The eligibility for the SDCP program is defined in WAC 388-106-0033. To be eligible for the SDC program an individual must be:

- Financially eligible for CFC as defined in WAC 388-106-0277.
- May not be participating in the PACE Program or on a Residential Support Waiver (RSW).
- Functionally eligible for CFC as defined in WAC 388-106-0277.
- Be assessed by the comprehensive assessment reporting evaluation tool (CARE) as having a cognitive Performance Score of 3 or above.
- Have a current or past with current intervention qualifying Behavior listed in WAC 388-106-0033 or a self-performance code of supervision, limited assistance, extensive assistance or total dependence in eating.
- Have written or verbal confirmation from a health care practitioner of an irreversible dementia diagnosis (such as Alzheimer's disease, Frontotemporal dementia (Pick's disease), Lewy Body

dementia, Vascular dementia, multi-infarct dementia, Alcohol-related dementia, or Major Neurocognitive Disorder) or a diagnosis of Wernicke-Korsakoff syndrome.

Specialized Dementia Care Program Authorization

Any new authorizations for Specialized Dementia Care Program (SDCP) must have prior approval from HCLA headquarters staff. New authorizations do not include extensions of current services.

As the diagnosis is irreversible, CM/SSS also do not need to obtain any additional approvals for SDCP when a resident moves to another SDCP facility even if the resident moves to another setting type and then returns to a SDCP Facility.

SDCP Case Manager/Social Service Specialist Responsibilities:

- When a facility requests an SDCP approval for a current Medicaid client or a resident converting from private pay that resides in the EARC-SDC section of the facility, and meets the eligibility criteria; the client must not be referred to for the SDC program until:
  - A facility provides a copy of the NSA or NCP with clear documentation explaining what positive interventions and supports were used prior to moving a resident in an area that is restricted and explanation of less intrusive methods of meeting the need were tried that did not work.
  - Document approval from the resident or legal guardian to continue to reside in the SDC facility.
  - If a facility did not provide a copy of the NSA or NCP; CM/SSS will need to request a copy.

- The CM/SSS must review the NSA or NCP to make sure that the facility is following Code of Federal Regulations (CFR) §441.301 (4)(F)(1) through (8) federal rules regarding the resident's rights and has documented any restriction or modification in the resident's Negotiated Service Agreement or Negotiated Care Plan. Send a copy to DMS.

- CM/SSS will need to complete initial CARE assessment for a conversion with documentation explaining what less intrusive methods and positive interventions of meeting the resident's needs that have been tried but have not worked. Or an Interim assessment if client is currently on Medicaid services. Note: If the Interim assessment created to add required documentations results in a change in CARE classification a face-to-face Significant Change assessment will need to be completed.

- ***To document the modification of the resident's rights for SDCP:***
  The **Alzheimer's/dementia special care program** must be selected in the CARE/Treatment screen with the following documentation on the comment section explaining:

- The specific client need that is being addressed by moving the client to an area with delayed egress. (It is not acceptable to state see behaviors in assessment; the need must be specific to the client and identified).
- The positive interventions and supports as well as their location that were used prior to address the need before moving the client in an area with delayed egress that were unsuccessful.
- The informed consent of the resident/guardian agreeing to living in a setting with delayed egress. ***Client must be asked regardless of cognition and response noted even when there is a durable power of attorney or power of attorney.***

- Verify that the Assisted Living Facility has a current EARC-SDC contract using the ALF Locator for Professionals & Providers.

- Preference is that the CARE Assessment be finalized, however, to support and facilitate successful transition planning assessments may be approved in pending status.
  - When the assessment is approved in pending status it is the CM/SSS's responsibility to ensure the client is still eligible once the assessment is finalized and prior to authorizing services.
  - If the client does not transition to a SDC facility based on pending approval, the client will need additional approval in the future if they again consider moving to an SDC facility.

- Send the SDCP eligibility checklist form DSHS 14-534 to SDCP@dshs.wa.gov.

- When the CM/SSS receives approval for SDCP authorization, the CM/SSS will need to send a copy of SDCP Eligibility Checklist form to DMS as part of client's record.

- Send a Planned Action Notice to the client or his/her representative of approval for Specialized Dementia Care Program using the SDCP rate.

- Complete the Financial/Social Services Communication 14-443 in barcode to notify Public Benefit Specialist of SDCP authorization rate approval.

Note: Federal rules also require periodic reviews to determine if the modification is still effective, necessary, or could be terminated. At annual review CM/SSS will need to:

- Re-assessed the need for and effectiveness of the restriction or modification with the resident; and
- The modification or restriction continues to be necessary and effective or
- Should be discontinued (e.g., in the SDCP, this documentation could include that the setting with restricted egress continues to be the appropriate setting to meet this resident's needs and that the resident benefits from the services provided in this setting).

For more detailed information regarding modification to a Medicaid resident's rights and where to documents modification in CARE; refer to the Client Rights in HCBS Settings in this chapter.

The approval process:

- When approved or denied, the SDCP Program Manager will post SERs in CARE and will also notify CM/SSS via-email of the approval or denied.

- When CM/SSS receives an approval for SDCP authorization, CM/SSS will need to send a copy of SDCP Eligibility Checklist form to DMS as part of client's record.

- Send a Planned Action Notice to the client or his/her representative of approval for Specialized Dementia Care Program using the SDCP rate.
    - Mark as "Approved" and check "other" in reason.
        - Write in SDC Program
        - In the "other comment" write "You are functionally approved for Specialty Dementia Care Program at a rate of $X.XX."

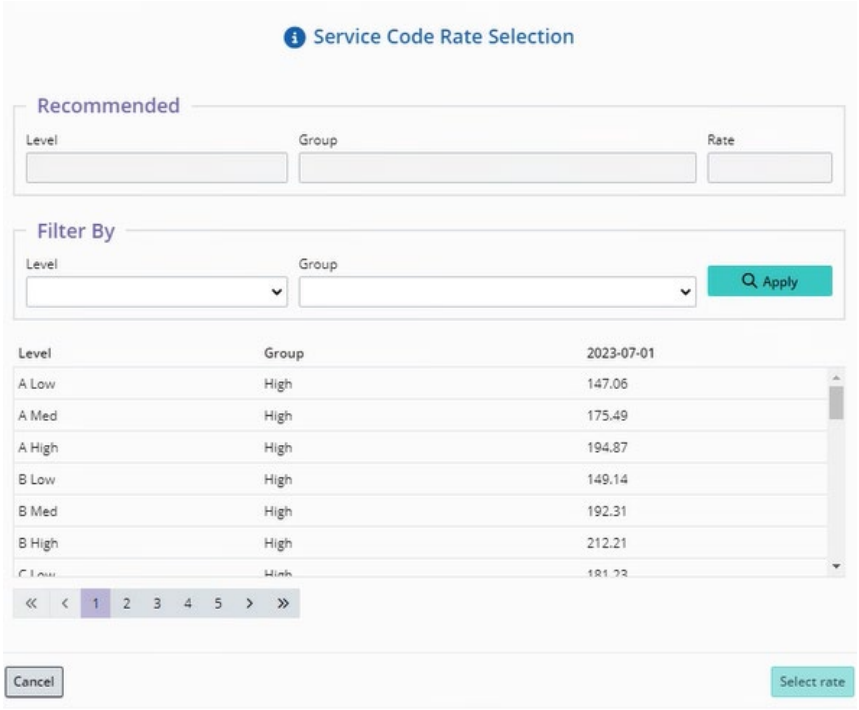
- Complete 14-443 to notify Public Benefit Specialist of SDCP authorization rate approval.

SDCP Authorization Process:

- When authorizing SDCP service in ProviderOne; CM/SSS will need to use SDCP approval rate with:
    - RAC Eligibility 3052 – CFC-Specialized Dementia Care Program
    - RAC Eligibility 3002 – CFC plus COPES-Specialized Dementia Care Program
- Service code of T1020_U4 (Special Dementia Care Services).

- Select the Reason Code based on the service or rate of the SDCP being authorized:
    - Specialized Dementia Care
    - Specialized Dementia Care Enhanced
    - Specialized Dementia Care Acute Care – Reminder this rate is only for the facility the client discharges directly to from an Acute Hospital Bed. The rate does not continue if the client changes SDCP-ALF or any other settings.

Rates are now showing in CARE when you select the "Lookup rate" button on the authorization. To select the correct rate the CARE Classification Level and the Cost Service Area will be needed:



If a resident transfers to another Specialized Dementia Care facility, the CM/SSS is not required to send another SDCP eligibility checklist. The CM/SSS will only need to check if the facility has EARC-SDC contract via the ALF Locator for Professionals & Providers unless:

- Client is requesting transition to SDC Enhanced Program from SDCP, or
- Client is discharging from an acute care hospital, and the acute care add-on needs approval.

- The department **will not approve retroactive payments** unless the resident is converting from private pay to Medicaid, the assessment has been completed and in current showing the resident is eligible, and the resident was waiting for a Public Benefit Specialist eligibility determination that was delayed.

- It is permissible to authorize Fast Track on CFC with Specialized Dementia Care. When a client is eligible (and for Fast Track we are presuming eligibility), the client is eligible for all services they are assessed for.

The daily reimbursable rate for this service is set by the Legislature and based on an individual's CARE Assessment Classification and the High Cost or Standard Cost Area they are receiving services. Rates can also be found at Office of Rate Management under Home & Community Services Rates Excel | PDF.

Personal care adjustments: Residential
This field is found on the Care Plan screen and allows CM/SSS to track adjustments to the residential rate. The personal care adjustments field is enabled when the planned setting selected is residential. If the client is receiving personal care in a residential setting and there are adjustments to their rate, they must be calculated and documented in this field. Adjustments will be printed on the Service Summary.
Options available include:

- Specialized Dementia Care Program - $50
- SDCP Acute Hospital - $60
- SDCP Enhanced - $140

If the client is discharging form an Acute Care Hospital, then select both Specialized Dementia Care Program and SDCP Acute Hospital from the drop-down menu.

The SDCP Acute Care Add-On is not included on the PAN as the incentive is for the facility and not based on eligibility criteria for the resident.

DETERMINING ROOM AND BOARD

Determining a client's room and board towards the cost of their personal care.

Clients with income may be required to pay towards the cost of their Room & Board (R&B) as a part of Client Responsibility (CR). CR consists of three parts: R&B, Participation and Third-Party Resources. Clients may keep a personal needs allowance (PNA) for clothing and personal/incidental items. Refer to Program standard for income and resources for overview information on Client Responsibility (CR) and program standard for income and resources. Reference the Social Services Authorization Manual (SSAM) for information on how CR is applied to authorizations. This section will focus on residents served under medical programs, where the CM/SSS is responsible for determining only R&B.

Responsibilities when Case Managers are required to determine Room and Board

For clients whose medical program is maintained by HCA, or they are receiving Medical Care Services (MCS) and in a residential setting, the CM/SSS is responsible for determining the R&B. The chart below notes the ACES Medical Groups, where the CM/SSS determines R&B. All ACES Medical Coverage Groups used in Long Term Supports and Services (LTSS) may be found at the following link: LTSS Medical Coverage Groups. The Client Responsibility Notice (DSHS 18-720) must be completed and sent to clients or client representatives. The CM/SSS enters the client's R&B on the Financial Screen in CARE. This takes the place of the PBS determining CR and entering it into ACES, the R&B entered by the CM/SSS will feed into ProviderOne and reduce the provider's authorization by the set amount. See SSAM – Client Responsibility – Managing Client Responsibility in CARE and the CARE Web Help for how to complete the Financial Screen.

Medical Coverage Groups – CM/SSS determines R&B

ACES Medical Program	LTS Programs & Residential Settings
N01, N02, N03, N04, N05, N07, N23*	**MPC** – ARC or AFH **CFC** - AFH, ARC, EARC, ALF or EARC-SDC ***N23 only covers MPC**
N11 Children (age 19 & under)	**MPC –** ARC or AFH **CFC** - AFH, ARC, EARC, ALF or EARC-SDC
A01/A05/A24 State Funded (Not HCA Program)	**Medical Care Services (MCS)** – ARC or AFH
S30 Overall program eligibility is with DOH	**MPC** – ARC or AFH **CFC** - AFH, ARC, EARC, ALF or EARC-SDC
D01[b], D02[b], D26	**MPC** – ARC or AFH **CFC** - AFH, ARC, EARC, ALF or EARC-SDC
N24/N27	**MPC** – ARC or AFH
R03	**MPC** – ARC or AFH **CFC** - AFH, ARC, EARC, ALF or SDC- EARC-SDC

b – DDCS, for children only and foster care Must have disability, resource, and income determination for HCB Waiver services. (HCB Waiver services can be used for individuals on foster care if a disability determination has been established and coordinated between DDA and HCA foster care.) HCS does not have foster care indicated as a covered group in the HCS HCBS Waivers. For the D track clients that need an HCS HCBS Waiver, an 18-005 must be submitted for eligibility determination under HCS HCBS L22 rules.

Client's receiving SSI Categorically Needy (S01) or SSI-related Categorically Needy (S02) Medical and in Need of LTSS

S01 & S02 clients should be converted to an L-Track to receive LTSS. However, clients may start services while still on S01 or S02 as the HCS PBS transitions them to the L-Track. The CM/SSS should not have to determine R&B as the HCS PBS will enter it into ACES per the typical L-Track process.

CM/SSS responsibilities for R&B determination when Client's receiving ABD Cash Grant on Medical Care Services (MCS)

Clients on MCS fall under ACES Medical Groups A01, A05 and A24 and are held by the HCS PBS staff. For clients in ALF under an Adult Residential Care (ARC) contract, HCS PBS staff reduces the grant amount to the PNA and CM/SSS does not act. However, if the client resides in an AFH the CM/SSS determines the R&B amount and enters it into CARE.

CM/SSS Responsibility for R&B determination when a client is on ABD Cash Grant and a Medical Group held by HCA

Clients on any of the ACES Medical Programs listed above held by HCA and who also receive an ABD Cash, the CM/SSS determines the R&B amount only for those residing in an AFH. For clients in AL, EARC, ARC or EARC-SDC settings, Community Services Division (CSD) PBS staff reduces the grant amount to the PNA and CM/SSS does not act.

When and how do I report changes to CSD for clients with LTSS

There may be times when the ABD Cash Grant is coded incorrectly, a residential client has open food benefits or Ongoing Additional Requirements (OAR) benefits open(20 CFR 416.1121). In those situations, the CM/SSS would report the errors to CSD. To report changes to CSD e-mail: Listmaster Address: listmaster.csd@dshs.wa.gov.
Include the following in your email:

- Head of Household Name
- Client name, if different
- Client ACES ID
- Name of Facility and Facility Type - Please do not use acronyms as they may differ across departments.
- Address of Facility
- Summary of case action needed

Case Manager Responsibility for Income Changes and Room & Board Determination

(For DDCS staff, please see DDCS Policy 6.06 – Client Responsibility).

For HCS Staff:

- CM/SSSs will request clients, payees, and/or guardians report information regarding clients total income any time there is a change. Total income includes Earned Income and Unearned Income.
    - **Earned Income** includes salaries, wages, commissions, bonuses, severance pay, and other cash or in-kind payments received because of employment; net earnings from self-employment; earned income tax credits; tax refunds; payment for services performed in a sheltered workshop or work activities center; and certain royalties and honoraria (20 CFR 416.1110).
    - **Unearned Income** means income that is not earned, including annuities, pensions, Supplemental Security Income, Social Security benefits, disability benefits, Veteran's benefits, worker's compensation, Railroad Retirement annuities, unemployment insurance benefits, alimony and support payments, dividends, interest, and certain royalties, rents, death benefits, prizes and awards, gifts, tribal income and inheritances,

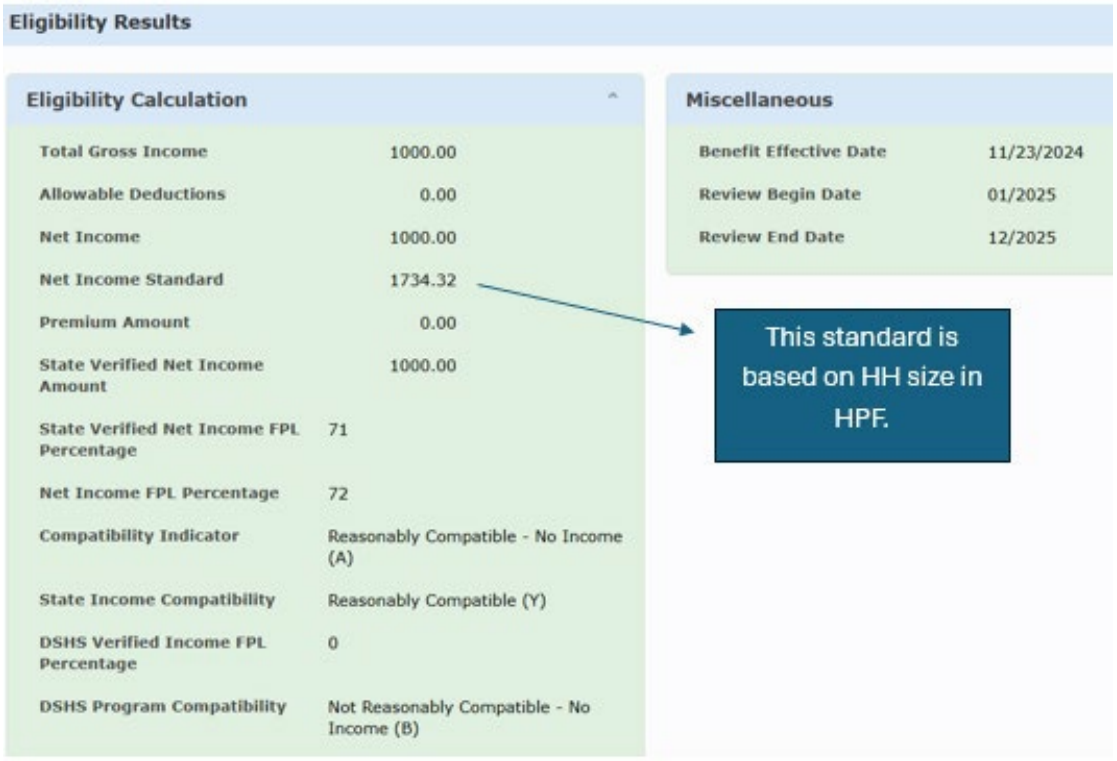
and support and maintenance in-kind (20 CFR 416.1121)**.** For information on Tribal Income review HCA Income Overview 1 and HCA Tribal Income desk aid**.**

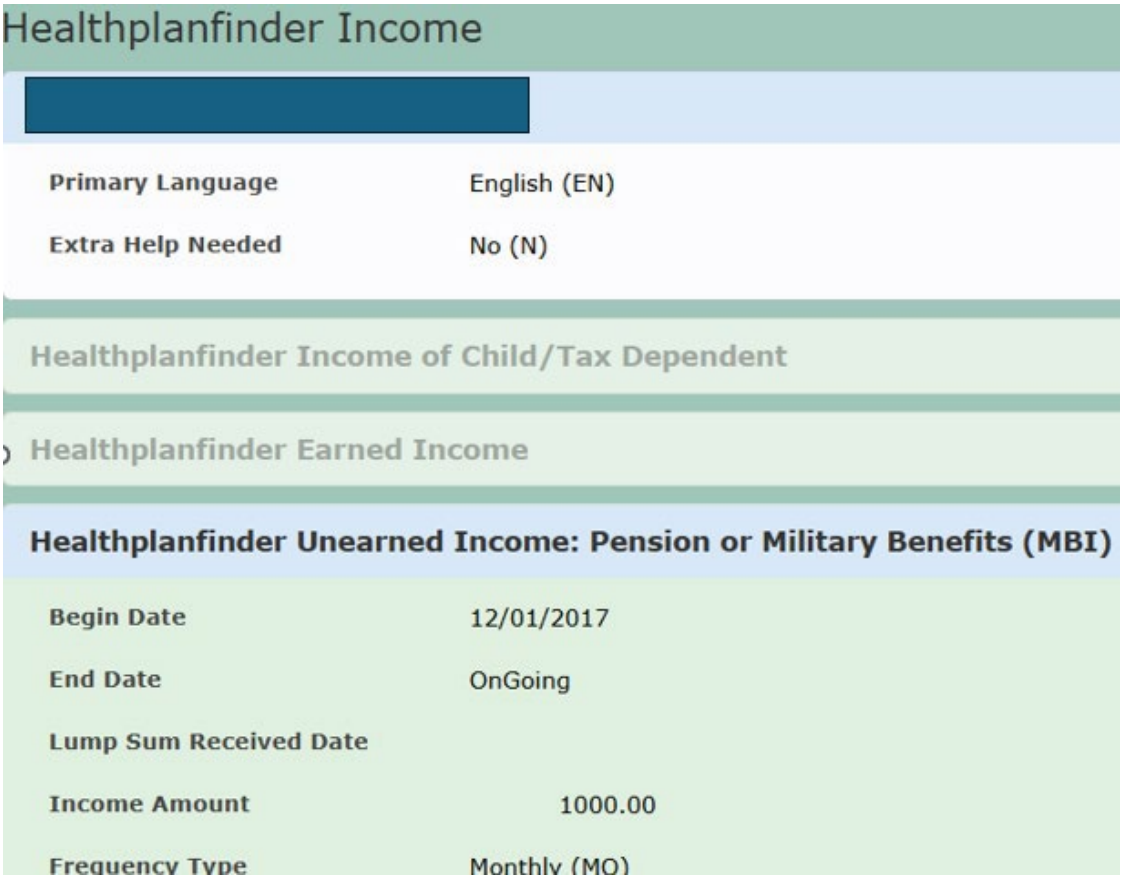
- Clients, payees and/or guardians may report client income by attestation, verbally or written. CM/SSS will note in SER the following as applicable and if written attestation is provided, submit the documents to DMS:
  - Total Gross Earned Income and source
  - Total Unearned Income and source
  - Allowable Exemptions as permitted
- CM/SSS will always encourage clients/payees and/or guardians to update income changes in the HPF.
- CM/SSSs will issue the Client Responsibility Notice (DSHS 18-720) each time the R&B amount is changed.
- For clients who do not report earned income changes timely, the CM/SSS will follow the guidelines in SSAM Reimbursement Related to Client Responsibility.
- The HCS MAGI Room and Board Calculator can be found under **Resources** on the Affordable Care Act Resources website. The calculator may be used to assist CM/SSSs in determining R&B and proration of R&B for partial months.

Verifying Income in ACES On-line (except ABD Cash Grant)

The MAGI income information in ACES can be updated directly by clients through the HealthPlanFinder (HPF), but the system does not show when or by whom the information was changed. Because of this, MAGI data in ACES may not be the most reliable source for verifying income, especially for clients that have earned income. HCA uses the client reported MAGI amount when determining whether the information is compatible with data sources at the time of review.

Verification of the most current information can be found by reviewing narratives by HCA workers as well as reviewing the Client Level Eligibility Results Screen and/or the Healthplanfinder Income screen.


Eligibility Results
Eligibility Calculation
Total Gross Income 1000.00
Allowable Deductions 0.00
Net Income 1000.00
Net Income Standard 1734.32
Premium Amount 0.00
State Verified Net Income Amount 1000.00
State Verified Net Income FPL Percentage 71
Net Income FPL Percentage 72
Compatibility Indicator Reasonably Compatible - No Income (A)
State Income Compatibility Reasonably Compatible (Y)
DSHS Verified Income FPL Percentage 0
DSHS Program Compatibility Not Reasonably Compatible - No Income (B)
Miscellaneous
Benefit Effective Date 11/23/2024
Review Begin Date 01/2025
Review End Date 12/2025
This standard is based on HH size in HPF.



If the HPF Income screen does not match the Client Level Eligibility Results Screen, then only use the Eligibility Results Screen. When the HPF Income screen has a green box or background, this indicates that the information is loaded from the HFP. If the background or box is blue, this indicates that the information was entered by HCS or CSD. As prior information is not removed, income entered by HCS or CSD may be past, this is why we use only the Eligibility Results Screen unless there is narrative, information or an open benefit from CSD to indicate the information is current.

If there are other members listed in the household this may mean the client has not updated their address with HCA. Please use caution and ensure client confirms income amounts for R&B as household income is used for MAGI eligibility.

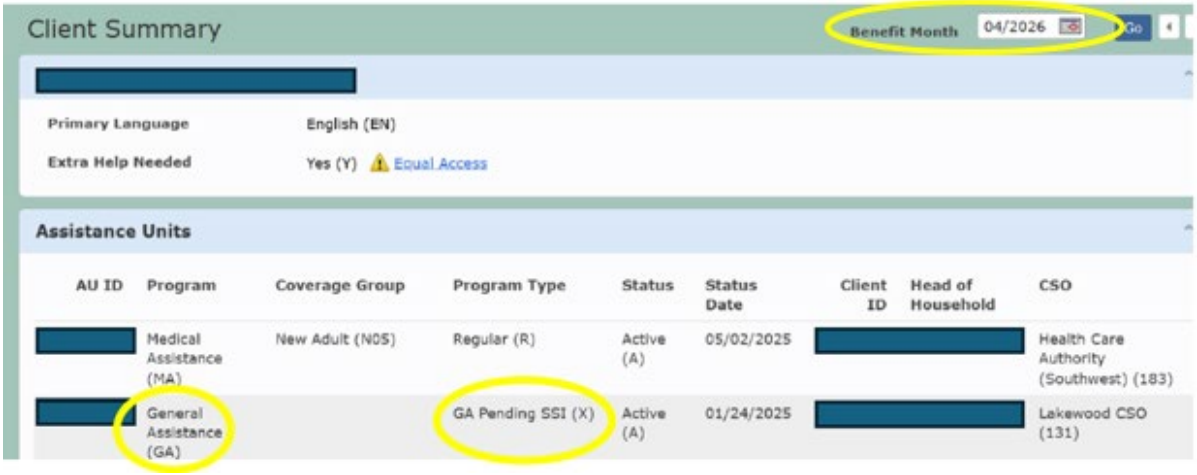
If the Earned or Unearned Income is in a green box, the information was pulled from HPF. If the Earned or Unearned Income is in a blue box, it was entered into ACES by HCS PBS or CSD. Always use information for HPF

CM/SSS responsibilities for reporting income changes to HCA when client refuses

It is the responsibility of the client, payee and/or guardian to report and update their income in the Healthplanfinder. When a client reports a change in income, use the Information Sharing for HCS and DDCS document for instruction on to report income changes. Additionally, if a client indicates they have no intention of notifying HCA of a change in income and the change is expected to last two months or more and exceeds the Net Income Standard indicated on the Eligibility Results screen, CM/SSS may follow the instructions per the HCA document, MAGI Information Sharing for HCS and DDCS for reporting themselves.

Verifying ABD Cash Grant Amount

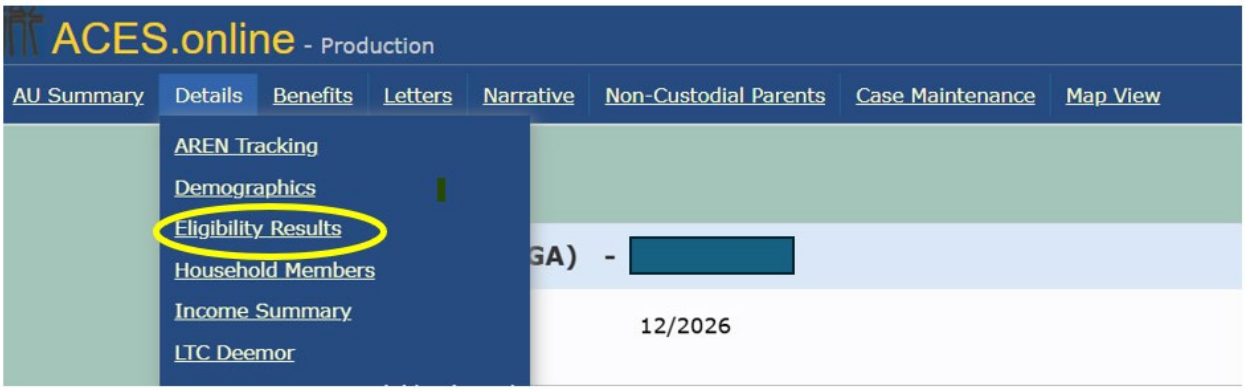
When a client is active on General Assistance (GA) there are two types, GA Pending SSI (X) or Unemployed (U), they receive a cash grant up to $450.00. To verify the amount a client is receiving, click on the client's AU ID for General Assistance (GA). Review the Benefit Month in the upper right-hand corner as ACES displays a month ahead of the current month, you may need to adjust to the past or the future depending on the timeframe you are seeking.



This will take you to the AU Summary page.



From the AU Summary page, when you will then select Eligibility Results from the Details section.



Scroll to the bottom of the Eligibility Results page and it will give the grant amount to use for R&B as the Benefit Amount.

SUPPLEMENTING THE MEDICAID RATE

Supplementation of the Medicaid daily payment rate is an additional payment requested from a Medicaid recipient or a third-party payer by an Adult Family Home (AFH) contractor or a licensed Assisted Living (AL) contractor with a contract to provide adult residential care (ARC), enhanced adult residential care (EARC), assisted living (AL) services, or an enhanced services facility (ESF).
By federal rule (42 CFR 447.15), the state must limit participation in the Medicaid program to only providers who accept the Medicaid state payment and client participation as payment in full.

Supplementation for services or items

The AFH, AL, ARC, ESF, or EARC contractor **may not** request supplemental payment of a Medicaid recipient's daily rate for services or items that are covered in the daily rate, and the contractor is required to provide:

A. Under licensing Chapter 388-76 WAC, Chapter 388-78A WAC, Chapter 388-107 WAC, and/or

B. In accordance with his or her contract Chapter 388-110 WAC with the department; and
C. As outlined in the resident's CARE plan.

Supplementation for a unit or bedroom

When a contractor only has one type of unit or all private bedrooms, the provider may not request supplementation from the Medicaid applicant/resident or a third party, unless the unit or private bedroom has an amenity that some or all the other units or private bedrooms lack e.g., a bathroom in the private bedroom, a view unit, etc.

A facility cannot request supplementation for a private room when the room is only large enough for one person.

Adult Family Homes are required to provide a minimum of 80 square feet for single occupancy rooms. Double occupancy rooms must be at least 120 square feet. More information on bedroom space in Adult Family Homes can be found in WAC 388-76-10690.

Sleeping rooms within EARCs and ARCs must be no less than 80 square feet for a one-person room and no less than 70 square feet per person for a two-person room. Private units within an ALF must be a minimum of 220 square feet. More information on Resident Units can be found in WAC 388-78A-3010.

When a contractor may request supplemental payment

A. Before a contractor may request supplemental payments for items **not covered in the Medicaid rate**, the contractor must have a supplemental payment policy that has been given to all applicants at admittance and to current residents. The policy must be in accordance with WAC 388-105-0050 and WAC 388-105-0055 and must follow the department contract per WAC 388-76-10205 and WAC 388-105-0050. The Contractor may not request supplemental payment of a Medicaid recipient's daily rate for services, items covered by the Medicaid daily rate, move-in fees, and/or refundable or non-refundable deposits, in accordance with Chapter 388-76 WAC, RCW 70.129.030 (4), RCW 74.39A.901, this Contract, and the Client's NCP.

B. The Contractor must disclose in the Admission Agreement per WAC 388-76-10540 and the 'Policy on accepting Medicaid as a payment source' WAC 388-76-10522, any changes that could occur if a resident becomes eligible for Medicaid funding. The Contractor shall refund to the Client, on a prorated basis, the amount prepaid for care of that Client if the Client becomes eligible for Medicaid funding or moves out of the home before the end of the month.

C. If a family member or friend purchases additional items or services through the contractor that are not provided for under the Medicaid contract, he or she must pay the Contractor directly to avoid jeopardizing the resident's financial eligibility.

In all cases of supplementation, the contractor is required to notify the department case manager of the additional charges, what they are for, and who is paying them. Violations of the supplementation rules will be reported to the Complaint Resolution Unit (CRU). The CRU will investigate and refer to the Medicaid Fraud Unit if appropriate. The Complaint Resolution phone number is: **1-800-562-6078**.

Examples of supplementation

1) If a residential room is approved by Residential Care Services (RCS) for double occupancy and a Medicaid resident's family wants to pay extra for a private room, the contractor can charge extra if the facility has included this in their supplementation payment policy. The exception would be if the facility agreed in the NSA/NCP to provide a private room to meet the resident's needs. If the room is a single occupancy room, the provider is not allowed to charge extra for the room. The extra fee associated with a single occupancy room should be a reasonable amount. If the resident or family feels it is not a reasonable amount, they should be directed to call the CRU. If the family chooses to pay this extra amount, they must pay the provider directly.

2) In the case of a Medicaid client who is assigned participation greater than the cost of care, and the individual wishes to use their excess income to purchase additional care and/or services from the provider, the resident can use his own financial resources to hire additional assistance following the same guidelines for supplementation. The services must be above and beyond what the facility is already contracted to provide for <u>any</u> resident in the facility under their Medicaid contract. The facility cannot stop providing any current level of services to the resident nor have the person hired by the resident take over any services required under the contract and the client's CARE plan.

3) If a resident prefers a brand name incontinent brief rather than the generic brand the home provides. The client would be expected to pay the difference in price.

Note: When a Medicaid client is related to the AFH provider and is residing in a licensed and contracted room; the CM/SSS must authorize AFH services using the daily rate based on CARE classification (the same as an unrelated client).

CASE MANAGERS/SOCIAL SERVICE SPECIALISTS RESPONSIBILITIES

An AAA or HCS CM/SSS may assist a client to enter a residential facility. HCS provides initial and ongoing case management to all Medicaid clients in residential facilities. The CM/SSS is responsible for:

- Completing Initial, Annual, and Significant Change Assessments,
- Doing a 30-day contact,
- Assisting the client with identifying residential setting options,
- Coordinating admissions with providers,
- Reviewing the assessment, service summary, and negotiated service agreement/ negotiated care plan,
- Ensuring Client Rights,
- Requesting Necessary ETRs,
- Completing Bed Hold requests,
- Monitoring Social Leave,
- Coordinating with RCS, and
- If necessary, helping to coordinate a client's move.

NOTE: If a copy of the NCP or NSA has not been returned within 30 days but has been requested by the CM/SSS, make a report to the Complaint Resolution Unit (CRU) by phone at 1-800-562-6078 or online. For those residents receiving Residential Support Waiver services, a copy of the Behavior Support and Crisis Plan are also required to be provided to the assigned case manager/SSS. See LTC Manual Chapter 7f for more information.

Assisting a client to move into a residential setting.

Prior to the move the CM/SSS must:

- Complete a CARE Assessment to determine functional eligibility.

- Discuss/Review with the client, and/or his/her representative the Client's Rights and Responsibilities Form 16-172 and answer any questions about the client's rights and responsibilities. Have the client or the client's representative sign two copies of the form when completing the initial CARE assessment. File one copy in DMS and give the other copy to the client.

- Discuss with the client, and/or his/her representative, client's rights in HCBS settings and Long-Term Care Resident's rights as outlined in Chapter 70.129 RCW and the Client's Rights Section of this chapter.

- Discuss with the client, and/or his/her representative about Medical/Social Leave Policy as outlined in WAC 388-105-0045 and WAC 388-110-100. For detailed information, refer to the Bed Hold and Social Leave Policy section of this chapter (Bed Holds for Medical Leave).

- Provide information to clients so they can make informed choices about residential options.

- Discuss with the client his/her preferences identified on the Care Plan screen in the CARE assessment and then assist the client in selecting a residential setting that will meet his/her needs. Document in the SER the client's choice of long-term care setting and provider.

- Ensure that the client meets the functional and financial eligibility for HCS programs.

- Coordinate with the HCS residential CM/SSS assigned to the facility. For details information refer to LTC Manual Chapter 5.

- Review and provide copies of the Assessment Details and Service Summary to the provider prior to a client's admission and document in SER.

- Have the client approve and sign the Department's plan of care and inform the client and/or their representative of any client responsibility and room and board. Document plan approval in the SER. For addition information refer to LTC Manual Chapter 3.

- Verify if the AFH/ALF is licensed and contracted by clicking the following link:
    - AFH Lookup
    - ALF Lookup

Verify Specialty Designation

Clients who have a developmental disability, mental illness, or dementia can only be served in facilities with a specialty designation. Case Managers/Social Service Specialists are required to verify if the provider has the correct Specialty Designation training by going to the RCS "AFH Look-Up" to verify if the provider has completed the Specialty Designation training. This look-up is not always up to date. *If the provider has proof of a certificate* but is not listed on the lookup as having completed the specialty designation, follow these steps:

1**. To check for Mental Health or Dementia Specialty Training:**

Go to the Providers and Professionals page on the HCLA website at:
https://fortress.wa.gov/dshs/adsaapps/Professional/training/training.aspx

- On Find a Training Class Section
- Check both boxes in the Mental Health and Dementia Specialty section, then click on **Find Instructors box** (at the bottom)

- Once you click on Find Instructors box, you will find the list of approved instructors in the training class search results section.
- Review the list to verify the name of the instructor who signed the certificate.

2. To check for Development Disability Specialty Training: To find Development Disabilities Specialty Training, please go here.

Note: DDA, MH or Dementia. If the person who signed the certificate's name appears on the list of approved instructors, the CM/SSS will need to document in the client's SER verifying that the provider does have the specialty designation required to care for clients with Developmental Disability, Mental Health or Dementia diagnosis.

Adult Family Homes/Assisted Living Facilities Specialty Training Requirements must be the Manager Specialty Training. Manager specialty training is required for assisted living facility administrators (or designees), adult family home applicants or providers, resident managers, and entity representatives who are affiliated with homes that serve residents who have one or more of the following special needs: developmental disabilities, dementia, or mental health per RCW 18.20.270 and RCW 70.128.230 and WAC 388-112A-0400.

If a resident develops special needs while living in a facility without a specialty designation the provider, entity representative, resident manager and facility administrator (or designee) has 120 days to complete manager specialty training or developmental disability caregiver training, and demonstrate competency per WAC 388-112A-0490.

Providers serving residents with different specialty needs. When providers serve two or more residents with different specialty needs, they must obtain a separate specialty designation for each of the specialty needs. CM/SSS are required to verify if the provider has the correct Specialty Designation training.

Providers serving residents that have more than one special need. When a provider serves a resident that has needs in more than one of the special needs areas, by WAC 388-112A-0410, the AFH, ALF, or ESF must determine which of the specialty training classes will most appropriately address the overall needs of the resident and ensure that the appropriate specialty training class is complete. If additional training beyond the specialty training is needed to meet all the resident's needs, the AFH, ALF, or ESF must ensure additional training is completed.

If a resident has more than one specialty needs, CM/SSS must document in SERs which specialty training the AFH, ALF, or ESF has determined to meet all the resident's needs.

DSHS form 10-234a, Individual with Complex Behaviors (Home and Community Living Administration) applies to HCS and DDA clients in all residential settings. Send the original copy of the form to the provider and a copy to the Hub Imaging Unit (HIU) to become part of the client's record.

Note: Assisted Living Facilities are required by (WAC 388-78A-2060) to do their own preadmission assessment prior to admitting any resident. Adult Family Homes are NOT required to do the same. AFH providers are however required to obtain an assessment completed by the CM/SSS, or a qualified assessor that documents the prospective client's needs and preferences before admitting the client to the home, (WAC 388-76-10330)

Once admission is approved the CM/SSS will need to:

1. Help coordinate the client's move, if needed.

2. Notify the Public Benefit Specialist of the date of admission, the program authorized, and any other pertinent information using the Financial/Social Services Communication Form 14-443.

3. When client's responsibility and room and board is determined, authorize the payment in ProviderOne to the provider effective the day the client moves into the facility. Refer to Social Services Authorization Manual.

4. Notify the receiving CM/SSS of the admission date to the new facility. Inform the receiving CM/SSS that a 30-day contact is required within that time frame. Refer to LTC Manual Chapter 5 for additional clarification on when a 30 day visit is required instead of a telephone contact within 30 days of admission.

5. CM/SSS must complete the Individuals with Complex Behaviors (DSHS 10-234a) form for clients with challenging behaviors (assaultive, destructive, self-injuries, inappropriate sexual behaviors, or history of misdemeanor behavior). Refer to LTC Manual Chapter 5; under resources for additional information.

6. Transfer the client's file and CARE assessment using instructions found in the Assessment Chapter of the LTC Manual Chapter 3.

Assisting with community integration in AFHs

CM/SSS responsibilities include:

- Assessing the need for assistance with community integration,
- Assessing the need for assistance with community integration mileage reimbursement for AFH providers,
- Authorizing community integration mileage reimbursement for AFH providers, and
- Completing planned action notices.

ASSISTING A CLIENT WITH RELOCATION

Clients may be required to move for several reasons. This section outlines the responsibilities for RCS, HCS and providers when a facility is requiring residents to move.

When a client wants to move out of the facility, the facility will need to assist and coordinate the client's transfer or discharge. Clients may move at will and are not required to give notice.

RCS responsibilities

As a result of a facility inspection/survey, Residential Care Services can:

(a) Issue a statement of deficiency.
(b) Stop the admission of new residents into facilities. When RCS determines the need for a Stop Placement, they will notify appropriate local entities and governmental organizations of the decision.
(c) Suspend or revoke a facility's license. When RCS decides to revoke or suspend the license of a facility, both HCS and RCS work together to ensure the transfer of Medicaid clients to another residential setting.
(d) Close a facility.

Be aware that **notices from RCS are confidential** when related to potential or planned closures, License Revocations, and Summary Suspensions. Also note that the facility administration, clients and families will not be advised of pending action.

HCS responsibilities

When an ALF, AFH, or ESF is closed, HCS is responsible for assisting clients to relocate in a timely manner. Moving can be a stressful time for any client. When assisting a client to move, you may need to use other resources such as:

A. The Long-Term Care Ombudsman Program,
B. The regional RCS staff assigned to that facility,
C. The RCS Complaint Resolution Unit,
D. Your supervisor or Regional Administrator; and
E. The headquarters Residential Program Manager.

Note: The above is for closure of a facility and not termination of the Medicaid Contract.

When a Medicaid client requests to move, you will need to:

1. Work with the facility staff.

2. When eligible, consider using the discharge resources if the client is moving to a less restrictive setting. See LTC Manual Chapter 10 more information on relocation resources.

3. Coordinate with other CM/SSS, if necessary (e.g., DDA or BHA).

When a provider wants a client to move

1. Review or complete an assessment and review the current Negotiated Service Agreement/Negotiated Service Plan/ Person Centered Service Plan to determine if there is a legitimate reason for the move that is consistent with RCW 70.129.110. For RSW service recipients, review the Behavior Support and Crisis Plan and the residential facility's behavioral monitoring documentation. If after reviewing/completing the assessment and reviewing the NSA/NCP/PCSP and other accompanying documentation:

    a. You find the facility has tried to reasonably accommodate the client's care needs and the care needs still exceed the license or contract limit of the facility; you will need to coordinate the relocation of the client to a different setting. If necessary, contact the RCS District Manager to obtain clarification of any license or contract requirements.

    b. You find there is no valid reason for discharge, and if the client wants to stay, try to resolve the issue with the provider. If you are unable to resolve the conflict, consult with your supervisor about referring the case to the Residential Care Services Complaint Resolution Unit at: **1-800-562-6078.** Also, let the client know he/she can contact the Ombudsman or file a complaint with RCS.

    c. Ensure the client has received a Notice of Transfer or Discharge with information for appropriate legal counsel information and encourage or assist client to contact appropriate legal counsel.

Note: Be aware that periodically facilities may require the residents to sign new/revised admission agreements. Residents and informal supports should carefully read these agreements to ensure that rules surrounding reasons for eviction are still acceptable. Residential facilities cannot discharge a resident simply because their status changes from private pay to Medicaid unless it is spelled out in the admission agreement and resident signs agreeing to it.

Other situations where moving the client is problematic may occur when the:

a. Client wants to move from the facility, and the family/alternate decision maker does not want the client to move, or

b. Family or alternate decision maker wants the client to move and the client desires to remain in the facility. In these situations, refer the situation to the Ombudsman for resolution.

For any change in setting, you will need to update payment information:

1. The department does not pay for the last day of service if a client moves out of the facility unless the last day of service is the date of death.

2. The CM/SSS must terminate the P1 authorization line using the date before the client moved out of the facility.

3. Notify the Public Benefit Specialist via the electronic DSHS 14-443 of the change in client residence, circumstance, date of the action and other pertinent information.

When a facility voluntarily closes or does not renew their contract:

WAC 388-76-10615; RCW 70.129.110; RCW 18.20.440.

1. For facilities that have a large number of clients, develop a plan with the Regional Administrator to locate new facilities and relocate the clients. This effort may involve several CM/SSSs from around the region.

2. Work with the facility staff when transferring/moving a client.

3. If a client is moving to a less restrictive setting, consider using the residential discharge allowance for relocation. Follow the discharge allowance procedures outlined in LTC Manual Chapter 10.

4. If the client is case managed by DDCS or BHHA, coordinate the move with other CM/SSSs.

For additional information regarding termination of a Medicaid contract, refer to section II. Contract Types of this chapter.

When the facility's license is suspended and/or revoked, or there is an involuntary closure:

1. The CM/SSS will need to coordinate with RCS to ensure the clients move in a timely manner.

2. Provide assistance in relocating private pay residents if they request it.

When there is a Stop Placement:

Get RCS approval for any clients who are hospitalized or in a nursing facility for a short stay and want to be readmitted to the facility with the Stop Placement. A private pay resident converting to Medicaid is not considered a new resident.

Provider responsibilities

Before transferring or discharging a client, the provider must:

1. First attempt, through reasonable accommodation, to avoid the transfer or discharge, unless agreed to by the client.
    a. In SDCP contracted facilities, a provider is required to have a policy to obtain consultative resources to address behavioral issues for residents prior to discharge.

2. Notify the client and representative in writing, 30 days prior to the transfer or discharge date, unless:
    a. There is an emergency per RCW 70.129.110; or
    b. The client has been in the facility for less than 30 days.

3. The client notification must provide information about legal resources and that subject to legislative appropriation (funding), clients have the right to legal counsel at public expense upon notice of transfer or discharge.

4. Notify the HCLA case manager and the Long-Term Care Ombudsman Program within three business days of issuing the notice.

5. Record the following in the client's record:
    a. The reason for transfer or discharge,
    b. The effective date of transfer or discharge, and
    c. The location to which the client is transferring or discharging.

6. Refund any unspent participation within 30 days of the client's move. The provider and the client will receive correspondence from ProviderOne notifying them of the change in client responsibility. Providers are required to refund the difference between the amount paid and the new amount identified in correspondence to the client. If the client or client's family notifies you that they have not received the expected fund, report the incident to the RCS Complaint Resolution Unit at: 1-800-562-6078.

Residential Facilities, including ESFs, are required to:

- Document the significant changes in a client's condition in the NSA, NCP and PCSP and provide a copy a to the department CM/SSS. For RSW services recipients, a copy of the Behavior Support and Crisis Plan and any behavior monitoring documentation should also be included.

1. Notify a resident's next of kin, guardian, or other individuals or agencies responsible for, or designated by, the resident as soon as possible regarding:

    a. A serious or significant change in a resident's condition.
    b. The relocation of a resident to a hospital or other healthcare facility.
    c. The death of a resident. In case of death, the facility must notify the coroner, if required by RCW 68.50.010.

2. AFHs should notify the CM/SSS by submitting DSHS form 15-558, Adult Family Home (AFH) Resident Significant Change Assessment Request if there has been a significant change in the client's care needs, whether or not related to a medical discharge.

When Notified of a Change in Resident Condition Case Managers/Social Service Specialists are required to:

- If requested by an ALF, AFH, or ESF, prior to completing a significant change; the CM/SSS must request a copy of the NSA, NCP, and/or PCSP from the facility with documentation of the changes in the client's care needs. For RSW participants, this would also include the Behavior Support and Crisis Plan and any behavior monitoring documentation. The CM/SSS will need to review the client's NSA, NCP, or PCSP to determine if the changes meet the criteria of a significant change as defined in WAC 388-76-10000 for AFH, WAC 388-78A-2020 for ALF, and WAC 388-107-0060 for ESF.

1. Perform a Significant Change assessment if there has been a change in the client's condition that warrants a new assessment.

2. If the new assessment results in a change to the daily rate, remember that the new payment cannot be made earlier than the date the assessment was finalized. Also, staff cannot authorize payment until they have obtained the client's consent, and the assessment is in **Current status**.

Refer to Chapter 3 for additional information regarding Significant Change Assessments and Getting Approval on the Plan of Care.

For PACE clients, please note that each PACE organization is autonomous and has their own internal procedure for monitoring significant change requests. PACE contracted providers are to submit their significant change requests to the PACE organization, as the case management entity, not directly to HCS and then follow the prescribed communication protocol required by the PACE organization for those requests.

Reviewing the Negotiated Service Agreement/Negotiated Care Plan

Negotiated Plans between the resident and the facility.

Assisted Living Facility:

- The Assisted Living Facility (ALF) per WAC 388-78A-2130 (2) is required to develop a negotiated service agreement (NSA) for each resident using the resident's preadmission/full assessment and using the CARE assessment for Medicaid residents, within 30 days of the resident's admission. The NSA must include a list of the care and services to be provided, with details on the resident's preferences and choices, and how services will be delivered to accommodate these preferences and choices.

- The ALF per WAC 388-78A-2120, is required to review and update each resident's negotiated service agreement (NSA) annually, when there is a significant change in resident's physical, mental, or emotional functioning, or when the negotiated service agreement no longer adequately addresses the resident's current care needs and preferences. The Assisted Living Facility (ALF) must involve the resident, the resident's representative to the extent he or she is willing and capable, the department's case manager/social service specialist for a Medicaid resident, and facility staff when developing the resident's negotiated service agreement.

Adult Family Home:

- The Adult Family Home (AFH) per WAC 388-76-10355, is required to develop the negotiated care plan (NCP) by using the resident assessment, or CARE assessment for Medicaid residents. The NCP must include a list of the care and services to be provided, with details on the resident's preferences and choices, and how services will be delivered to accommodate these preferences and choices.

- Per WAC 388-76-10360, the AFH must ensure the negotiated care plan (NCP) is developed and completed within 30 days of the resident's admission. When developing the NCP per WAC 388-76-10370, the AFH must involve the resident, the resident's representative, professionals involved in the care of the resident, and the department case manager/social service specialist for Medicaid clients. Per WAC 388-76-10375, the AFH must ensure that the negotiated care plan is agreed to and signed and dated by the resident and AFH provider.

- The AFH per WAC 388-76-10380, is required to review and update each resident's negotiated care plan (NCP) annually, when there is a significant change in the resident's physical, mental, or emotional functioning, or when the negotiated care plan no longer adequately addresses the resident's current care needs and preferences, or at least every twelve months.

- For Medicaid clients (WAC 388-76-10385), the Adult Family Home must give the department case manager/social service specialist a copy of the negotiated care plan each time the plan is completed or updated, and after it has been signed and dated. The AFH has 30 days from the time the assessment is moved to current to return the NCP, regardless of the reason for the update. The AFH provider can send a copy of their negotiated care plan through email or fax to the department case managers/social service specialists.

Enhanced Service Facility:

- The Enhanced Service Facility (ESF) must develop an initial Person-Centered Service Plan (PCSP) as a replacement for the Negotiated Service Agreement/Service Plan for each resident prior to the admission as outlined in WAC 388-107-0110, a Comprehensive Person-Centered Service Plan within 14 days of the move-in date per WAC 388-107-0120, upon significant change in the client's condition, upon the

client's request, or at least every 180 days if there is no significant change in condition per WAC 388-107-0130.

Case Managers/Social Service Specialist are required to:

- Review the NSA/NCP/PCSP for Initial, Annual, and Significant change assessments and compare it to the current CARE assessment. If the NSA/NCP/PCSP does not address all the client's current care needs, the CM/SSS must have a discussion with the Assisted Living Facility staff, Adult Family Home provider, or Enhanced Services Facility staff regarding how the client's current care needs will be met.

- If there are changes in the client's needs that would affect the CARE classification and/or change to the caregiver instructions, the CM/SSS must complete a Significant Change Assessment. For Residential Support Waiver service recipients, the Behavior Support and Crisis Plan are also required documents and should be provided to the assigned CM/SSS to incorporate into any face-to-face assessment. For additional information regarding RSW, reference the LTC Manual Chapter 7f.

  Send NSA/NSP/PCSP to the HIU:

  - When the NSA/NCP/PCSP has been reviewed and finalized by the CM/SSS, make a copy and send the original back to the facility.

  - Send the copy of the NSA/NCP/PCSP and required RSW documentation to the Hub Imaging Unit (HIU) to become part of the client's record.

Additional information regarding Residential Case Management Responsibilities can be found in LTC Manual Chapter 5 – Case Management.

CLIENT RIGHTS

All residents living in licensed assisted living facilities, and adult family homes are protected by the rights granted in Chapter 70.129 RCW, Long-Term Care Residents Rights**.** CM/SSSs need to be familiar with the rights outlined in Chapter 70.129 RCW. As an CM/SSS, you are responsible for reporting any significant or repeated resident rights violations to the RCS Complaint Resolution Unit (CRU) for review and investigation. A provider's failure to respect these rights is a violation of licensing requirements.

ESF residents have specific rights, as outlined in WAC 388-107-0190.

Abuse, Neglect, Abandonment, or Exploitation

All DSHS employees are mandatory reporters. When you have reasonable cause to believe that abuse, neglect, abandonment, or financial exploitation of residents in facilities that are currently

licensed/contracted (or required to be licensed/contracted) has occurred, you must report the concern to CRU. Residential Care Services (RCS) is responsible for the intake, screening, and investigation. In addition, under certain circumstances you are also required to call law enforcement. See the Adult Protective Services APS Policy & Procedure site for more information about mandatory reporting requirements.

Client Rights Violations

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.**

CLIENT RIGHTS IN HCBS SETTINGS

The federal rules regarding Home and Community Based Settings (Medicaid contracted ALFs, AFH, and ESFs) mandate basic participant rights in all home and community-based settings. These are the rights listed in the federal rule:

- Full access to the greater community,
- Receive services in the community,
- Control over personal resources, and
- Autonomy and independence in making life choices, including but not limited to daily activities, physical environment, and with whom to interact.

In addition, in provider owned and controlled residential facilities, participants have the right to have:

- A lockable entry door
- A choice of roommate
- Control of her or his own schedule
- Access to food at any time
- Visitors of their choice at any time
- Protections from transfers or discharges comparable to landlord tenant law

Documenting modifications to Client Rights:

Any time clients are not afforded all the rights required in federal rule, the rules require specific documentation. To meet these federal requirements with any modifications to a Medicaid resident's rights, the following conditions must be met and documented in the Negotiated Service Agreement, Negotiated Care Plan, or Person-Centered Service Plan and in CARE assessment. The documentation must include:

- Identify a specific and individualized assessed need for this restriction or modification (Example – Unsafe wandering behavior).
- The positive interventions and supports that were used prior to placing this restriction or modification on the resident.
- Less intrusive methods that have been tried but did not work to meet the need (What accommodations or strategies were made to address the behavior prior to this that did not work).
- A clear description of the restriction or modification.
- An assurance that the interventions and supports will cause no harm to the individual.
- The informed consent of the resident for the use of this restriction or modification.

Note: Prior to moving a resident to a facility or an area within a facility with delayed egress, the CM/SSS must ensure that all the conditions above are met and documented. If a facility is requesting the move, request a copy of their NSA/NCP/PCSP indicating the changes in the client's care needs with the above documentation. The CM/SSS must also document the reason for the move in the CARE assessment as described below.

Informed Consent Requirements:

Sometimes, modification or removal of a client's rights is necessary to implement services.

A common example of a modification of client rights occurs when a client verbalizes disagreement in any form to transition to a delayed egress facility. In such cases, the alternative decision maker (POA, agent or guardian/conservator) may only consent to the transition when the POA document or guardianship/conservatorship orders contain specific language and authorities, similar to the following:

1. Agent/Guardian/Conservator/Special Agent/Court Visitor has authority to use "Best Interest" decision making standard instead of "Substituted Judgement" decision making standard or the document references in RCW 11.130.330 *and*
2. Agent/Guardian/Conservator/Special Agent/Court Visitor has authority to establish the client's place of dwelling and who providers care to the client.

Without such language, the Department cannot accept consent from the alternative decision maker on behalf of the client for delayed egress facility transitions. For more information, please see LTC Manual Chapter 3 – Getting Approval on the Plan of Care.

Full guardianship orders typically grant the level of authority outlined in subsection 1; however, "Limited" guardianship orders and Power or Attorney documents do not typically grant this level of authority without additional court intervention. Each document should be reviewed to determine the sufficiency of the agent's authority.

When modification or removal of a client's rights is necessary to implement services, often a court hearing is required to obtain an active order from the Administrative Office of the Courts (AOC) removing or modifying the specific right(s) and expanding the authority of the alternative decision maker.

- When seeking orders to expand authorities for POAs, motions are filed through the Uniform Power of Attorney Act outlined in RCW 11.125.
- When seeking orders to expand authorities for guardianship or conservatorship, motions are filed through the Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act (UGA) outlined in RCW 11.130.

Once an order of expanded authority is issued by the AOC, a copy must be received by the Department, attached to the original POA document or original guardianship/ conservatorship orders and scanned to DMS prior to the department accepting consent for delayed egress transition from the alternative decision-maker. When modification or removal of a client's rights is necessary to implement services, often a court hearing is required to obtain an active order from the Administrative Office of the Courts (AOC) removing or modifying the specific right(s) and expanding the authority of the alternative decision maker.

Where to document modifications to Client Rights in CARE:

The CM/SSS must provide clear documentation by explaining the reason for any modification to client rights in the most relevant location:

- In the intervention screen for a behavior, if the modification is relevant to any of the behaviors,
- In the comments/caregiver instructions section, if it pertains to the one of ADL or IADL screens,
- In the pertinent medical history screen or
- In the psych/social screen if there is no other applicable location,
- In the comments/caregiver instructions section if it pertains to the Specialized Dementia Care for Alzheimer's/dementia special care program.

Review the Plan and the need for modification:

Federal rules also require periodic reviews to determine if the modification is still effective, necessary, or could be terminated.

The plan must be reviewed and revised at least:

- Every 12 months, or
- When the client's circumstances or needs change, or
- At the client's request

Facilities must document the following in the annual NSA/NCP/PCSP and as indicated by a significant change in the resident's condition that the facility has reviewed the need for and effectiveness of the restriction or modification with the resident; and

- The modification or restriction continues to be necessary and effective **OR**
- Should be discontinued.

For example, for the Specialized Dementia Care Program, this documentation could include whether the setting with restricted egress continues to be the most appropriate setting to meet this resident's needs and that the resident continues to benefit from the services provided in this setting.

Note: If the client or client's family notifies you of any violation of HCBS rules, you must report the violation to the RCS Complaint Resolution Unit at: 1-800-562-6078.

EXCEPTION TO RULE

You may need to request an Exception to Rule (ETR) for some of your clients. ETRs for increases in the daily rate related to personal care must be approved by the HQ ETR committee. For related policy see Chapter 3. All requests related to a daily rate increase must be completed on the ETR/ETP screen in the Client Details folder of CARE and processed electronically for review and approval. For instructions related to the functionality in CARE Web, refer to the CARE Web help files (Assessors Manual).

For AFH Provider post card notices about ETR requests; refer to LTC Manual Chapter 3.

Bed Hold ETRs may be requested; please submit ETR requests to the AFH or ALF Policy Program Manager for consideration. For more information, see the Bed Hold section of this chapter.

RESIDENT CHOICE REGARDING ALF ROOM EXEMPTIONS

Physical Plant Exemptions in an AL Room

Only RCS may grant an exemption to the requirements provided in WAC 388-110-140 in accordance with WAC 388-78A-2820. If any of the items listed in WAC 388-110-140 are not present in the Medicaid resident's room, and an exemption has not been granted by RCS, report this to CRU.

- According to WAC 388-110-140, (2) (a), and (b) a facility with an AL contract is required to provide each resident a private apartment-like unit that is a minimum of 220 square feet.

Examples of exemptions in Assisted Living settings are included below:

- Residing in a room that does not meet the physical plant requirements identified in WAC 388-110-140; or
- According to WAC 388-110-140, (2) (a), and (b) a facility with an AL contract is required to provide each resident a private apartment-like unit that is a minimum of 220 square feet.

The provider must offer the client a choice of units that meets contract requirements. The request to remain in a unit that does not meet the contract requirements or to share a unit must be the client's

choice. The client must be advised of the physical requirements (under WAC 388-110-140) that they are entitled to have.

When a client is residing in an exempted room, the CM/SSS will continue to authorize the ALF rate.

Sharing an AL Room

Residents residing in AL rooms are entitled to private units. Clients may choose to share their room with another resident, either related or unrelated.

Through June 30, 2022, when two clients are sharing a room, the CM/SSS will authorize payments for the EARC daily rate effective the day that the second resident moves into the shared room. **July 1, 2022**, the AL daily rate and the EARC daily rate are now equal. CM/SSSs do not need to make any authorization adjustment when two clients are sharing a room and will authorize the AL rate using the AL service code.

When two residents reside in a two-bedroom apartment-like unit, each resident has their own bedroom, and they share other amenities such as kitchen area with refrigerator, microwave oven, range or cooktop, bathroom, etc., the CM/SSS may authorize the AL rate using the AL service code.

Documenting Resident Choice:

Once the HCS CM/SSS has been notified that a client would like to share a room or is residing in a room that does not meet physical plant requirements, the HCS case manager will meet with the client or their representative to notify client of their room rights.

Use DSHS Form 15-447, Resident Choice Regarding Assisted Living Facility (ALF) Room Requirements (Home & Community Services) to document your discussion with the client and the client's choice regarding:

1. Residing in a room that does not meet the physical plant requirements,
2. Residing in a room that has been granted an exemption from RCS when the client is converting from private to public assistance.; or
3. Sharing an AL room with another resident.

When completing DSHS Form 15-447:

1. Enter the specific room number.
2. For a room that does not meet physical plant requirements:
    a. Check which of the listed items are missing from that room.
    b. Select the client's choice to remain in a room that does not meet the contract requirements for an AL under WAC 388-110-140 (listed on the back of the form)
3. When a client wishes to share an AL room with another resident:
    a. Select the name of the resident that will be sharing the room

b. If two Medicaid residents are wishing to share a room, separate forms will need to be completed for both clients.

4. Have the client sign the document.
5. Send the form to HIU to be placed in the client's file.

The Resident Choice Regarding Assisted Living Facility (ALF) Room Requirements (Home & Community Services) form only applies only to the specific room number and only for the resident(s) listed on the form. The agreement does not permit other Medicaid residents to occupy the room, nor does it permit the residents listed on the form to be relocated to another "non-qualified" room. If either resident chooses to relocate within the facility listed, arrangements should be made for each of them to move into a room that meets the Assisted Living Facility physical plant requirements.

The DSHS form 15-447 not required for married couples who request to share an apartment-like unit under an assisted living contract if both residents understand that they are each entitled to live in a separate private unit; and both mutually request to share a single apartment-like unit.

Note: If a facility wants to request more money for non-contracted room; please follow the supplementation policy.

Documenting the client's approval in CARE:

1. Enter the room number in "ALF/ESF Room #" box located on the Residence screen in CARE.
2. For clients, including married couples, wishing to share an AL room, select "Shared Room in AL" Category and Type in the ETR/ETP screen. This selection documents the client's approval.
3. Submit the ETR request to the supervisor or SHPC for field review and approval.
4. Document in the SER the actions taken and the client's approval.

BED HOLD FOR MEDICAL LEAVE

For Clients on MPC, CFC, and CFC + COPES Waiver

Per WAC 388-105-0045 (2), residential facilities (AFH, ARC, EARC, or AL) are required to hold a client's bed for 20 days when the client needs short-term care for medical reasons in a nursing home or hospital.

Per WAC 388-105-0045 (6), a Medicaid resident's need for a short stay in a hospital or SNF must be longer than 24 hours before a bed hold can be authorized. This only applies to the following residential facilities: ARC, EARC, and AL.

Per WAC 388-105-0045 (5):, Adult Family Homes (AFH) may be authorized Bed Hold for a Medicaid resident's need for a short stay in a hospital or SNF lasting less than 24 hours, as long as all other criteria are met.

Per WAC 388-105-0045 (8), if a resident is transitioned back to the residential setting and returns to the hospital, the Medicaid resident must be back in the residential setting 24 hours prior to being on medical leave again to begin a new 20-day hold period.

For Clients on the Residential Support Waiver (RSW)

For clients receiving services through RSW there are additional short-term care facilities that qualify for a bed hold. The client must be in the following settings and receiving a RSW service available in that setting.

Residential facilities (ESF, AFH with SBS or ECS contract, EARC with ECS or CSS contract, or AL with ECS contract) are required to hold a client's bed for 20 days when the client needs short-term care for medical reasons in a nursing home, hospital, Institute for Mental Disease (IMD) or inpatient behavioral health agency.

A Medicaid resident's need for a short stay in a nursing home, hospital, IMD or inpatient behavioral health agency must be longer than 24 hours before a bed hold can be authorized. This only applies to the following residential facilities: ESF, EARC with ECS or CSS contract, and AL with ECS contract.

Adult Family Homes (AFH) with ECS or SBS contract may be authorized Bed Hold for a Medicaid resident's need for a short stay in a nursing home, hospital, IMD or inpatient behavioral health agency lasting less than 24 hours, as long as all other criteria are met.

If a resident is transitioned back to the residential setting and then is transferred back to a nursing home, hospital, IMD or inpatient behavioral health agency, the Medicaid resident must be back in the residential setting for 24 hours prior to being on medical leave again to begin a new 20-day hold period.

What is an Institute for Mental Disease (IMD)

IMDs, or "institutions for mental diseases," are defined as hospitals, nursing facilities, or other institutions of more than 16 beds regardless of licensure that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, which includes SUD. For more information go to HCA's Behavioral Health page.

Notification Process for short-term Medical Leave and Return

- According to WAC 388-105-0045 (7), residential facility (ESF, AFH, ARC, EARC, or AL) contractors must notify the CM/SSS by e-mail, fax, or telephone within one working day whenever the resident is out of the facility for more than 24 hours on medical leave at an approved facility.

- Facilities may use the Notice of Bed Hold form (**DSHS 05-249**), to notify the CM/SSS of a client's discharge and return to the facility. This form can be faxed to (855)635-8305 or mailed to DMS at P.O. Box 45826 Olympia, WA 98599-5826.

- Timely notification of needs for short-term medical care remains critical in reducing overpayments.

Authorizing Bed Holds

When the department CM/SSS received notification from a facility reporting that the client is receiving short-term medical care; within two working days of learning of a client's transition, the CM/SSS must determine whether or not the client is likely to return to the residential facility by verifying with the short-term medical care provider, if stay may be less than 20 days.

1. If the client will likely return to the facility, the Residential CM/SSS will:
    a. End Date residential services service line in P1.
    b. End Date other open service lines in P1. Please note special instructions exist in the SSAM for Wellness Education, PERS Units/Add-ons, and Nurse Delegation.
    c. Use DSHS 14-443 to send required notification to the Public Benefit Specialist.
    d. Document all related bed hold actions in SER.
    e. Once the client's outcome is known (meaning they have returned to the residential facility, died, or transferred to an alternate setting) then authorize the bed hold.

2. If the client has already returned to the facility, the Residential CM/SSS will:
    a. Split the residential services service line in P1 as of the last full day prior to admission, then remove the dates the client receiving short-term medical care.
    b. Split other open service lines in P1. Please note special instructions exist in the SSAM for Wellness Education, PERS Units/Add-ons, and Nurse Delegation.
    c. Authorize the bed hold.
    d. Use DSHS 14-443 to send required notification to the Public Benefit Specialist
    e. Document all related bed hold actions in SER.

3. If the client is unlikely to return to the facility, the Residential CM/SSS will:

a. End Date all open service lines in P1. Residential services should be ended as of the last full day prior to discharge from the residential facility. Other services may end on the date of discharge. Please note special instructions exist in the SSAM for Wellness Education, PERS Units/Add-ons, and Nurse Delegation.

b. Notify the client and the provider of the department's decision to terminate payment. Document in the SER related actions taken regarding terminating the authorization of services.

c. Notify the Public Benefit Specialist (PBS) by completing an electronic DSHS 14-443 in Barcode. The HCS PBS will receive this as an assignment on their To-Do-List and can review the action.

d. Per federal HCBS rules, a client is entitled to the same eviction rights as any renter residing in a private unit. This is called out in HCBS settings rule- 42 CFR § 441.530, Section (a)(1)(vi)(A). RCW 70.129.110 requires a provider to meet before discharging or transferring a resident the following, including first attempting through reasonable accommodations to avoid the transfer or discharge and giving at least 30 days' notice before the transfer or discharge. The transfer or discharge notice must contain specific information that is called out in WAC 388-76-10506(5) for AFHs, WAC 377-78A-2651(5) for ALFs and WAC 388-107-0161(5).

When a client is hospitalized and unlikely to return to the facility, please see LTC Manual Chapter 9 Inpatient Hospital Assessments and Transitions "What is the Role of Residential Case Managers in Transitioning Clients Back to Residential Settings?" for further instruction.

The CM/SSS will be responsible for determining and processing an overpayment if the client does not return to the facility and the providers continue to claim for services. For detail information on an overpayment process; refer to Social Services Authorization Manual.

What is the payment for Bed Hold?

From the:	The department:
Date of discharge through the 7th day	Pays 70% of the daily rate for ARC, EARC, ALF, and AFH. (WAC 388-105-0045) (4), (5)
8th through the 20th day	Payment reduced to $11.66 per day for ARC, EARC, and ALF. $15 per day for AFH, except ESFs, which are paid at 70% of the daily rate for days 1-20 (WAC 388-105-0045) (3). See current rates on the Office of Rates Management website. These rates are subject to legislative action.

Date of discharge through the 20th day	Pays 70% of the daily rate for ESF (WAC 388-105-0045 (3).
21st day forward	No longer pays for the bed hold. The provider may seek a third-party payment and/or procced with discharging requirements.

The date of discharge entered in the bed hold database is the date the client left the residential facilities (AFH, EARC, ARC, ALF or ESF) on medical leave.

- Bed Hold days are not processed until there is an outcome.
- In case of client's death, the last date of payment for bed hold is the day of death.
- Client Responsibility is never counted toward bed hold days.

SOCIAL LEAVE

Social Leave is defined as planned leave that is for recreational or socialization purposes, not for medical, therapeutic, or recuperative purposes nor for incarceration.

- HCLA permits Social Leave in all residential settings. Social Leave is limited to no more than **18 days per calendar year per** WAC 388-110-100 (2).
- Residential Facilities are responsible for self-reporting and self-tracking Social Leave for their clients.

when do I authorize this service and for how long?

If a client takes Social Leave and the residential provided notifies the CM/SSS; CM/SSS should: Maintain the current P1 authorization.

- Discuss with the provider how the client's personal care needs will be met while the client is out of the facility on social leave. Document in the SER actions taken relating to social leave.

Are Local Exception to Policies (ETP) allowed for Social Leave?

Evaluate whether there is a need for a local ETP and consider the following questions:

- Do the additional days meet the client's needs and desires?
- Is there a person willing and able to meet the client's care needs while the client is out of the facility?
- Is there a temporary service plan in place to meet the client's needs during his/her absence?
- If you determine the need for additional days, submit a local ETP in CARE for your Appointing Authority (FSA/RA) for review/determination.

RESOURCES

Rules and Policies

The following rules apply to clients receiving care in residential facilities. RCS and HCS work in partnership to provide quality service delivery in all residential care settings. HCS is responsible for the assessment and case management of residential clients; accurate payments to the providers and complying with state and federal regulations. RCS is responsible for the licensing, inspection, and surveying of all licensed Adult Family Homes, Assisted Living Facilities, and Enhanced Services Facilities. HCS and RCS work together to resolve issues for residents.

RCW	
Chapter 70.129 RCW	LONG TERM CARE RESIDENT RIGHTS
Chapter 70.128 RCW	ADULT FAMILY HOMES
Chapter 70.97 RCW	ENHANCED SERVICES FACILITIES
Chapter 43.190 RCW	LONG TERM CARE OMBUDSMAN PROGRAM
WAC	
Chapter 388-76 WAC	ADULT FAMILY HOMES MINIMUM LICENSING REQUIREMENTS
Chapter 388-78A WAC	ASSISTED LIVING FACILITY LICENSING RULES
Chapter 388-107 WAC	ENHANCED SERVICES FACILITIES
Chapter 388-105 WAC	MEDICAID RATES FOR CONTRACTED HOME AND COMMUNITY RESIDENTIAL CARE SERVICES
Chapter 388-106 WAC	LONG TERM CARE SERVICES
Chapter 388-110 WAC	CONTRACTED RESIDENTIAL CARE SERVICES
Chapter 388-112 WAC	RESIDENTIAL LONG TERM CARE SERVICES (TRAINING)
Chapter 182-515 WAC	ALTERNATE LIVING – INSTITUTIONAL MEDICAL
Chapter 182-527 WAC	ESTATE RECOVERY

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
TBD	Emily Watts	• Updated Ask the Expert contacts • Added information on Memory Care Certified requirements • Added required RSW documents that are submitted with NSA/NCP • Removed AFH options for RCL • Added Residential Rate Adjustment Information for the Care Plan Screen • Expanded language on Medical Escort Fee and link Service Code Data Sheet • Removed SDCP-Plus references • Added information on when SDCP approval is necessary after initial approval	TBD
5/18/26	Emily Watts	• Updated requirements by license/contract chart • Updated determining R&B to include ACES Medical Program IDs, steps of determining R&B and how to contact CSD, if needed. • Updated bed holds for medical leave • Updated social leave policy • Added and updated Social Leave ETP process. • Update Informed Consent section	H26-019
9/03/2025	Anna Cavanaugh/ Emily Watts	• Remove Meaningful Day references • Update Capital Add-On and add Bridge Rate information • Updated Medical Escort Fee • Update transfer and discharge instructions • Removed Social Leave ETR process	H25-057
5/10/25	Anna Cavanaugh/ Emily Watts	• Added wording to SDC process to include approval of pending assessments • Added PACE process for monitoring significant change assessments • Added DSHS 15-558 Adult Family Home (AFH) Resident Significant Change Assessment Request to steps for monitoring significant change assessment requests.	H25-010

		• Added reference to Chapter 9a for further instruction when a client is hospitalized and not returning to facility • Updated Nursing Services Chart • Updated template and branding	
11/8/24	Anna Cavanaugh/ Emily Watts	• Update Medical Escort Fee rate & documentation • Clarified client cannot participate on RSW while on SDCP • Edit to CBHS to correct language	H24-062
8/7/2024	Emily Watts	• Addition of MCO Community Behavioral Health Support reference • Updating of SDCP to add Reason Codes • Updated all links to forms and chapters	H24-044
4/16/24	Emily Watts	• Update staff assigned • Removal of Meaningful Day • Reformatting to move SDCP items into one section. • Update on share ALF rooms	H24-018
10/13/2023	Emily Watts	• Revised formatting, including moving some items to the Appendix • Updated service area information for SDCP • Community Stability Supports (CSS) information added • Clarified SDCP Referral Process • Clarified HIV/AIDS rate information, including Community Integration • Clarified Meaningful Day Process • Added Revision History	H23-071
6/14/2023	Emily Watts	• Updated contact information	H23-039
3/28/2023	Natalie Lehl	• Clarify room sizes • Update SDC guidance	H23-017
12/22/2022	Natalie Lehl	• Updated contact information • Added additional language to “Social Leave”	H22-064
9/14/2022	Natalie Lehl	• Updated guidance on Specialized Dementia Care Program referrals • Title change for MPC Calculator • Enhanced Services Facilities (ESF) subject matter expert name and contact information updated	H22-042
6/21/2022	Natalie Lehl	• Removed use of “placement” throughout the chapter	H22-028

		• Updated Specialized Dementia Care Program instructions	
4/12/2022	Natalie Lehl	• Adding Meaningful Day Program Manager • Update process for Meaningful Day approval (VI, E) • Meaningful Day Checklist added	H22-020

APPENDIX

AFH Providers FAQs about Community Integration

Community Integration FAQs