MAC & TSOA

Chapter 30b provides a description of Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) offered under the Older and Aging Adults and Family Caregivers provision of the 1115 Medicaid Transformation Demonstration waiver. These programs are intended to support unpaid family caregivers and their loved ones so they can remain in their chosen communities.

Ask the Expert

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BACKGROUND

The intent of the Older and Aging Adults and Family Caregivers provision under the Medicaid Transformation Project – 1115 Demonstration Waiver, is to expand care options for people, ages 55 and older, so they can stay at home and delay or avoid more intensive services, and providing assistance to unpaid family caregivers, ages 18 or older, who provide care for their loved ones. The MAC and TSOA programs are both found under the Older and Aging Adults and Family Caregiver's section. These programs are helping change the Medicaid health care delivery system by:

- Providing additional options for people with long-term care needs.
- Increasing access to services for people on the cusp of poverty to reduce:
    - A potential health decline.
    - The need to move out of home.
    - The spending-down of limited resources.
- Slowing the growth trend of traditional Medicaid-funded services, including Medicaid long-term services and supports.
- Providing unpaid family caregivers with supports and knowledge to continue providing care while also taking care of themselves.
- Helping people remain at home for as long as possible, and to maintain independent living.

Both MAC and TSOA are mirrored after the state funded Family Caregiver Support Program (FCSP). FCSP which was established in 2000 and is available in every county in Washington. The FCSP program was developed with the concept that supporting unpaid family caregivers keeps Washington families together and means less people need expensive long-term care placement or services. If family caregivers become unavailable, it is likely that older adults would need to access more costly in-home and residential services. These caregivers need support to help prolong their ongoing caregiving activities as well as ensure their own mental and physical health stays intact while coping with related challenges. Research demonstrates that it is critical to understand how a caregiver is feeling about their role in order to better tailor support to their individual needs. The FCSP has shown that the majority of caregivers show significant improvements on key outcomes when their stresses and burdens are addressed.

For more information about the FCSP see Chapter 17a the LTC manual.

PROGRAM DESCRIPTION & ELIGIBILITY CRITERIA

The Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) fall under the Older and Aging Adults and Family Caregivers provision of the 1115 demonstration waiver. Eligibility for both programs is based on the care receiver, although services may be provided to both the care receiver and/or the unpaid caregiver. MAC provides support for unpaid family caregivers caring for Medicaid-eligible people who are not currently accessing Medicaid long-term services and supports such as Medicaid Personal Care (MPC), Community First Choice (CFC), and Community Options Program Entry System (COPES) programs. The unpaid family caregiver, who must be at least 18 years old, is the individual who provides care to their care receiver and does not receive direct, public, or private payment such as a wage for the caregiving services they provide. An unpaid family caregiver may be a

spouse/partner, adult child, other family member, a friend, or a neighbor and does not need to be a Washington State resident. The unpaid family caregiver and the care receiver are collectively referred to as the dyad.

TSOA serves individuals who are functionally eligible but not yet financially eligible for Medicaid or are receiving limited Medicaid coverage based upon a specific set of criteria (such as Medically Needy or Medicare Savings Program). Services under TSOA can support someone with an unpaid family caregiver (the dyad) or someone who does not have an unpaid family caregiver.

For more information about financial eligibility and ACES coverage groups for MAC and TSOA see the MTP Community Workspace on the ALTSA SharePoint site.

Both MAC and TSOA programs are designed to offer the right amount of services, at the right time in order to divert or delay the need for more comprehensive Medicaid long-term services and supports. Both programs are funded 100% by federal Medicaid dollars and offer the same services, with some exceptions. MAC and TSOA services can only be received by care receivers living in a private residence such as their own home, independent living, or another's home rather than a licensed residential facility (i.e., adult family home or assisted living facility).

A care receiver may have more than one caregiver. However, the care receiver only has one benefit amount (service dollars). The funds must be shared between the identified unpaid caregivers.

An unpaid caregiver may be supporting more than one care receiver. For example, an adult daughter may be providing care to both her mother and her father. In this situation, if both parents are enrolled in MAC or TSOA then each parent would have a separate benefit amount that could be used to support their daughter/unpaid caregiver.

There are also scenarios where a MAC or TSOA dyad caregiver is inquiring about being a TSOA individual. The below is a helpful chart on determining when caregivers can also be care receivers themselves and what necessary steps are required:

Program	Can CG be TSOA Ind?	MTP Exception to Rule (ETR) local required?
Caregiver (such as IP, home care agency or unpaid CG) for CFC/ COPES client	Y	N** Best practice is for MTP case worker to consult with CFC/COPES case worker to ensure there is a safe plan of care for both CFC/COPES client and TSOA Individual.
FCSP CG	Y*	Y**
MAC/TSOA CG	Y*	Y**

		Local ETR must be requested annually for dyad CG to be a TSOA individual.
*Things to Consider: Does the request make sense for the situation? What tasks is the CG doing and what tasks does the individual/CG need help with as a CR? **Why is the ETR needed? What makes this situation different from the majority? Is this a safe plan of care?		

MEDICAID ALTERNATIVE CARE (MAC)

MAC helps unpaid family caregivers provide high-quality care for their loved ones, while also tending to their own health and well-being. MAC serves dyads (care receiver and unpaid caregiver). Applicants may request services through either the AAA or HCS front door. An example of a dyad who may want to access MAC services is one who:

- Does not want or need a more comprehensive Medicaid LTSS program, or
- Doesn't want to risk estate recovery

To be eligible for MAC, the care receiver must meet **ALL** the following eligibility criteria:

- Be age 55 or older
- Live in their own home or another's home (not a licensed residential facility)
- Currently be enrolled on a Categorically Needy (CN) or Alternative Benefit Plan (ABP) Medicaid coverage group (Apple Health)
- Meet nursing facility level of care (NFLOC) but has chosen not to receive Medicaid long-term services and supports through the state's other programs.

There is no client participation/responsibility or estate recovery with MAC and TSOA programs.

TAILORED SUPPORTS FOR OLDER ADULTS (TSOA)

TSOA establishes a new eligibility category and benefit package for people who may need Medicaid long-term services and supports in the future. TSOA helps people and families avoid or delay impoverishment and the future need for Medicaid-funded services. TSOA serves dyads (care receivers and unpaid caregivers) as well as individuals who do not have an unpaid family caregiver. Dyads and individuals without an unpaid family caregiver may access services through either the AAA or the HCS front door. An example of an individual who may want to access TSOA services is one who:

- Does not want or need a more comprehensive Medicaid LTSS program,
- Doesn't want to risk estate recovery, and/or
- Feels that paying participation would cause an unsustainable financial hardship.
- May be over the resource limit for traditional Medicaid LTSS programs.

To be eligible for the TSOA program, whether for the dyad or an individual, the care receiver must meet **ALL** of the following eligibility criteria:

- Be age 55 or older
- Live in their own home or another's home (not a licensed residential facility)
- Be a US citizen or have eligible immigrant status
- Not currently be eligible for Categorically Needy (CN) or Alternative Benefit Plan (ABP) Medicaid coverage (Apple Health)
    - Note: TSOA applicants may be on a Medically Needy (MN) or Medicare Savings Program (MSP) ACES coverage group and still be financially eligible for TSOA. This coverage group only provides limited scope of Medicaid benefits from Health Care Authority (HCA).
- Meet nursing facility level of care (NFLOC)
- Meet financial requirements:
    - Income up to 400% of the Supplemental Security Income (SSI) Federal Benefit Rate per WAC 182-513-1635
    - Countable non-excluded resources are at or below the current monthly private nursing facility rate multiplied by six months for a single applicant or, for a married couple with a community spouse (CS), non-excluded resources are at or below a combination of the current monthly private nursing facility rate multiplied by six months plus the current state spousal resource standard for the spousal impoverishment protections community (SIPC) spouse. The state spousal resource standard may change annually on July 1st. Resource eligibility for TSOA is described under WAC 182-513-1640, WAC 182-513-1660, & WAC 182-513-1640 .
    - Standards chart can be found here.

For MAC and TSOA care receivers, the nursing facility level of care (NFLOC) assessment and the financial eligibility review must be completed annually. Each NFLOC assessment completed post-presumptive eligibility, should be completed by AAA MTP staff and will not require confirmation by HCS staff. HCS financial staff (Public Benefit Specialists) will conduct the annual financial eligibility review.

INTAKE AND SERVICE DELIVERY FLOW

Intake and service delivery flow consists of taking a person through the process of accessing services. Medicaid Alternative Care (MAC) and Tailored Support for Older Adults (TSOA) programs may be requested through either the AAA or HCS front door. During the intake process, applicants are educated about the long-term services and supports provided by HCLA and the settings for which they are offered, including functional and basic financial eligibility criteria. Upon the applicant making an informed decision to receive either MAC or TSOA services; the MTP Presumptive Eligibility (PE) screening can be completed. If an applicant

MAC and TSOA service provision is unique: The AAA GetCare systems interface with the CARE system to ensure seamless service delivery flow.

chooses another service offered by HCLA ; the appropriate referral or intake can be completed. If the applicant indicates that HCLA LTSS are not needed or are declined; the applicant should be referred to alternative community resources, including other state or federal funded programs offered through the aging and disability network including Older Americans Act and Family Caregiver Support Program (FCSP).

The PE screening will be completed in either the GetCare or CARE systems. AAAs primarily use the GetCare systems. GetCare interfaces with CARE, TCARE, Barcode and ProviderOne (P1). PE screenings and confirmations completed by HCS are done in the CARE system.

Role of AAA and HCS staff

AAA MTP staff work in the GetCare system after having person-centered conversations with participants about available programs, services, settings and providers. If MAC or TSOA is the participant's program choice, AAA staff complete the following:

- Intake in GetCare
- Presumptive Eligibility (PE) assessments
- Annual Nursing Facility level of care assessments
- GetCare or TCARE® screenings
- GetCare or TCARE® assessments
- GetCare or TCARE® Care Plans
- Service enrollments and authorizations
- Eligibility notifications and other required notices to care receivers
- Obtain signatures on required DSHS forms (see Forms and Notices section)
- Voter Registration Assistance at intake during the Presumptive Eligibility screening, whenever the care receiver's home address changes, and during annual nursing facility level of care (NFLOC) assessments. Refer to MB H18-030 for more information.
- On-going case management
- Administrative hearings, as necessary

Designated HCS MTP intake workers, using CARE, will also work with clients to conduct person-centered conversations about available programs, services, settings, and providers. If the MAC or TSOA program is selected by the participant, these designated workers will complete the following:

- Intake in CARE
- Presumptive eligibility screenings and initial functional eligibility (NFLOC) determinations
- Confirmation of initial functional eligibility (NFLOC) via review of the PE assessments completed by AAA workers in GetCare and sent to CARE via an interface.

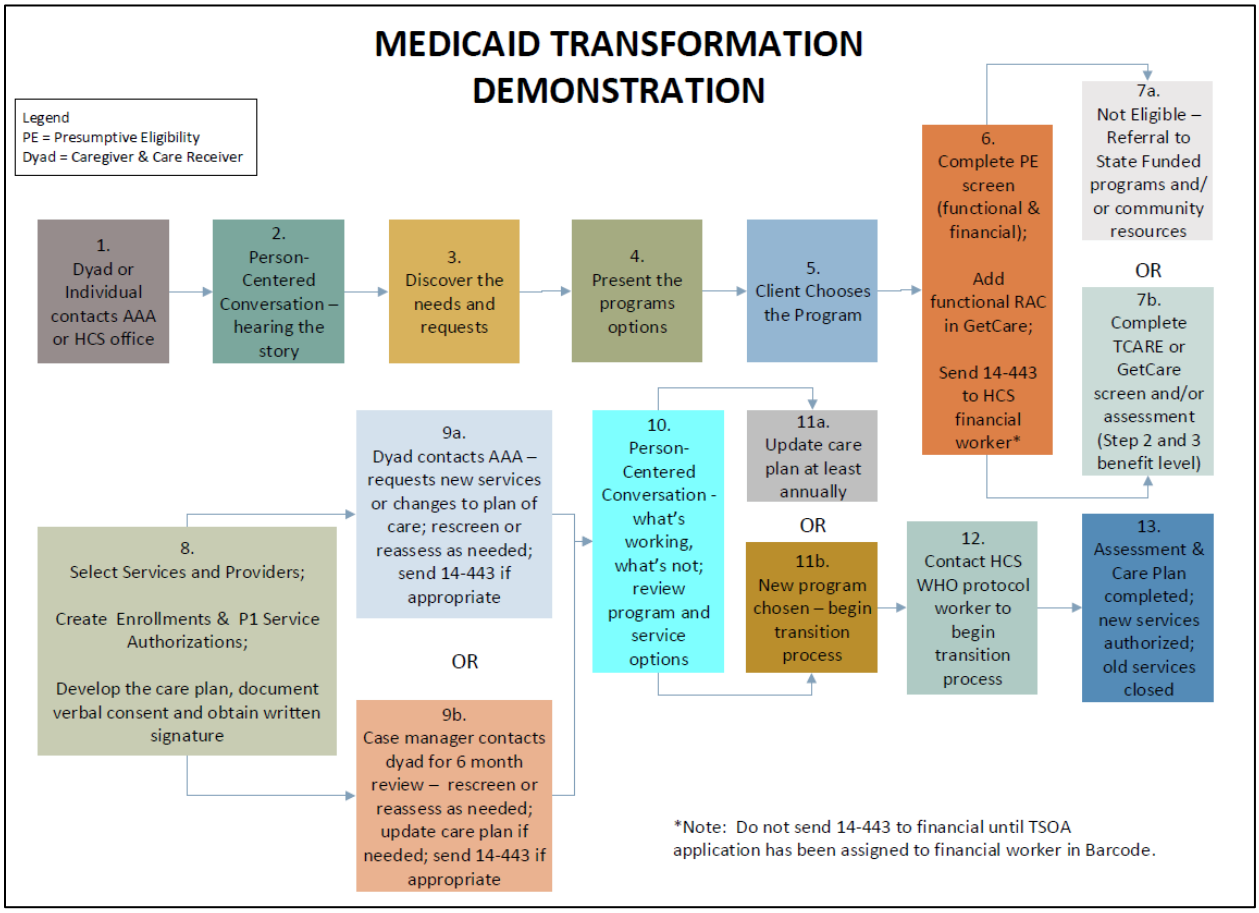
HCS Public Benefit Specialists (PBS)/financial workers will process TSOA applications and confirm financial eligibility for TSOA. Some MAC care receivers, if the applicant is eligible for Medicare or is age 65+, will also be managed by the HCS PBS. HCS PBS complete the annual financial eligibility reviews for the TSOA and MAC cases they oversee. MAC applicants and recipients, authorized under N-track or MAGI group of eligibility, are managed by the Health Care Authority (HCA). PBS utilize ACES, Barcode, AVS, Lexus Nexus Asset Reports, Employment Security Department Data, Washington State Pension

Data, Social Security Online Queries, as well as other additional systems to help determine financial eligibility for programs.

In order for certain tasks, such as full eligibility confirmation to be completed by HCS, information must be confidentially shared between AAA and HCS offices. Warm hand-off (WHO) protocols, developed between each AAA and their respective HCS partner, focus on confidential and quick communication so that participants receive seamless service provision. See the Warm Hand-Off section in this chapter for additional information.

Whether services are requested through the HCS or the AAA front door, HCS ensures the care receiver is assigned a ProviderOne (P1) ID number. HCS will match to existing records or links each new care receiver to the ProviderOne (P1) system. The P1 ID number is sent electronically from the care receiver's record in CARE to their record in GetCare. The P1 ID number allows AAA staff to create enrollments and service authorizations and send them to P1. P1 will then auto-generate authorization notices to the provider, the care receiver, and the caregiver. Once an authorization is accepted by P1 and the service is provided to the care receiver and/or unpaid caregiver, providers may submit a claim to P1 for payment against that specific authorization.

The chart below depicts the intake and service delivery process.



Community Living Connections - GetCare

Community Living Connections (CLC) GetCare is the client management information system used by AAAs to complete intakes, presumptive eligibility (PE) assessments, annual nursing facility level of care assessments, screenings and assessments, PE notices, MTP Service Notices, enrollments and authorizations.

GetCare is also used to create:

- Step 1 and 2 care plans for dyads and TSOA individuals, and
- Step 3 care plans for TSOA individuals.

GetCare is the system of record for care receivers enrolled in the MAC and TSOA programs.

For MAC and TSOA, System of Record means information provided through GetCare takes precedence over information from any other system involved in the service delivery flow with exception to social security numbers. P1 is the system of record for social security numbers.

TCARE®

TCARE® is the evidence-based assessment tool and information system used by the AAAs for completing:

- caregiver screens for Step 2 dyads,
- Step 3 care plans for dyads,
- assessments and consultation worksheets for Step 3 dyads.

Care plans for dyads at Step 1 and 2 and care plans for TSOA Individuals at Step 1, 2, and 3 are completed in GetCare. Care Plans for dyads at Step 3 are completed in TCARE.

CARE

Comprehensive Assessment Reporting and Evaluation, CARE, is the case management information system used by HCS to:

- complete intakes, presumptive eligibility screenings, and initial functional eligibility confirmations;
- obtain ProviderOne ID numbers for care receivers; and
- share information such as functional RACs and AAA staff information with ProviderOne.

ProviderOne

ProviderOne is Washington State's Medicaid Management Information System (MMIS) and is the system used by all Medicaid providers to submit claims to be paid for services provided. It is the system of record for care receiver's Social Security Number (SSN) as this systems interfaces with federal databases to confirm accuracy of SSNs.

ProviderOne "talks" to many different systems such as ACES, Barcode, Agency Contracts Database (ACD), CARE, and GetCare. If any of these systems are down (experiencing technical difficulties) updates from those systems to ProviderOne may be delayed. Some changes made in GetCare and CARE will be processed overnight and updated to the care receiver's file in ProviderOne. For example, when the AAA staff, functional RAC, or RU change, the primary case manager and RU fields will be updated overnight for any authorization with current or future end dates.

All ProviderOne authorizations for payment are made under the Care Receiver's ProviderOne ID in the Care Receiver's GetCare profile.

Refer providers who want more information about ProviderOne (such as how to become a provider or how to get paid) to HCA's website for social service providers.

Agency Contracts Database (ACD)

Medicaid-funded contracts, paid through ProviderOne, are stored in the statewide DSHS system called ACD. In order to validate social service authorizations for contracted services, and for payment to be processed through ProviderOne, a corresponding active contract must exist in ACD. An interface between ProviderOne and ACD will supply contract information for such validation. Once a contract goes into signed status in ACD, the contract and provider information automatically is sent to ProviderOne allowing for service authorizations and payments to be completed.

Automated Client Eligibility System (ACES) and Barcode

ACES is used by the State of Washington's Department of Social and Health Services and supports the operations of the department by integrating DSHS programs under a single, client-based, on-line system. The ACES system is a tool for determining program financial eligibility, issuing Medicaid benefits, management support, and sharing of data between agencies.

Barcode is an application with an array of workflow and document management functionality. It tracks case management contact information, communication with the public benefits specialist and financial eligibility determination and integrates this information with the ACES system.

TIVA2

TIVA2 (Tracking Incidents of Vulnerable Adults) is used by Adult Protective Services (APS) and Residential Care Services (RCS) to assist with tracking and trending critical allegations of abuse and neglect across settings, providers, and alleged perpetrators.

An outbound interface between TIVA2 and CARE identifies when a care receiver with an active MAC or TSOA RAC has been identified as an alleged victim in an APS or RCS intake and then CARE interfaces with GetCare to provide the MTP case manager notification via a message on the AAA staff's GetCare

dashboard. Further information about the intake or outcome notice can be reviewed by clicking on the APS/RCS ribbon in the care receiver's record in GetCare.

Presenting Program Options

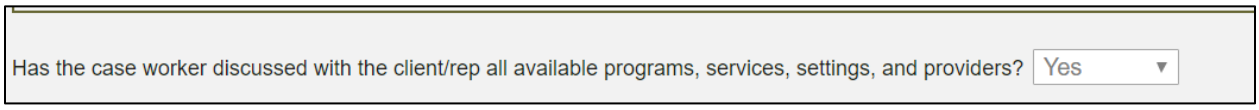
When individuals contact the AAA or HCS office for the first time or when individuals who are currently receiving services want to understand more about available programs, services and supports, it is important for AAA and HCS staff to facilitate a person-centered discussion. The full range of available programs, services, providers and settings should be presented, with enough information to allow people to understand options that best suit their needs.

The focus of this discussion should be an "important to, important for" approach, which is similar to motivational interviewing and other related approaches to person centered discussions.

The following tool was developed to help with understanding the program options available:
Decision Tool for Program Options

For more information about person centered conversations see the MTP Community WorkSpace on the ALTSA SharePoint site.

HCS and AAA staff must document in CARE – SER notes and in GetCare and TCARE® care plans that they have discussed all available program, setting, provider and service options such as FCSP, MAC, TSOA, MPC, CFC, COPES, New Freedom, nursing facility care, etc. with the care receiver prior to enrollment into a program. Below is a screen shot of the question in the GetCare care plan. The answers available in the drop-down list include "Yes", "No", and "Unknown".



Warm Hand-Off Standards & Protocols

The Warm Hand-Off (WHO) Protocol is the plan for how and when information and/or documents will be shared between AAA staff and HCS staff to ensure seamless and confidential service provision for clients of the MAC and TSOA programs.

In each program there is essential information, such as intakes, presumptive eligibility, P1 ID number and program start/end dates, which must be sent back and forth electronically between GetCare, CARE and Barcode. The Warm Hand-Off Protocol details how this sharing of documents and information is going to occur and within what timelines. The WHO protocol also requires names and contact information of lead staff at local HCS (social services and financial) and AAA offices to be known to each counterpart, providing a point person to ensure seamless service delivery for clients.

The WHO protocol also provides instruction for how information will be confidentially exchanged if usual ways of handing off cases are not operational. For example, when computers are down for a day and documents still need to be warmly handed off between AAA and HCS partners, or there is a delay in

determining final eligibility for a dyad. The contingency section in the WHO protocol details how data will be exchanged so that seamless service delivery is provided to clients.

In the evaluation section of the WHO protocol, each AAA and HCS partner provides a plan for how each area's respective WHO Protocol will be evaluated. For example, it should include details about how the plan will be reviewed to determine if it is working or needs modifications or updates. Also included is information about what systems will be put in place to ensure seamless and timely handoffs and how often the lead contact staff between offices will touch base to review whether the process is working as designed.

WHO Protocol Due Dates:

MAC/TSOA Hand-Offs	Work flow	Maximum # of days
NFLOC Prescreen Information for confirmation of NFLOC eligibility	From AAA Staff to HCS CM	2 business days from PE screening lock date
TSOA Financial Application	From client (with assistance from AAA) to HCS PBS	30 calendar days from PE screening lock date
Prescreen Information for service authorization	From HCS CM to AAA Staff	2 business days from PE screening finalize date
ProviderOne ID for new clients	From HCS CM to AAA Staff	2 business days from receipt of PE screening from AAA
NFLOC Functional Eligibility confirmation	From HCS CM to AAA Staff	10 business days from receipt of PE screening from AAA
TSOA only: Confirmation whether a TSOA financial application was received	From HCS PBS to AAA Staff	30 calendar days from PE start date
TSOA only: Care Receiver Financial Eligibility Determination	From HCS PBS to AAA Staff	45 calendar days from receipt of TSOA financial application

Each AAA is required to develop and maintain a MAC/TSOA WHO Protocol as part of their contract with HCLA for this Medicaid Transformation Project. For additional information or questions about your local MAC/TSOA WHO Protocol, contact your supervisor.

AAA & HCS Warm Hand-off Protocol Standards

PRESUMPTIVE ELIGIBILITY (PE)

What is PE?

PE is a process that allows us to gather preliminary information, based upon the self-attestation of the care receiver/designated representative, to decide that the care receiver appears to meet eligibility criteria. The two components reviewed for determining PE are financial and functional. The ability to authorize services under PE allows services to be delivered to dyads or individuals more quickly while the full eligibility determinations are being completed.

	MAC	TSOA
Financial	• Care Receiver's Medicaid Coverage Group = ✓ Categorically Needy (CN) or ✓ Alternative Benefit Plan (ABP) WAC 182-513-1605	• Income up to 400% of the Supplemental Security Income (SSI) Federal Benefit Rate per WAC 182-513-1635 • Countable non-excluded resources are at or below the current monthly private nursing facility rate multiplied by six months or, for a married couple, that non-excluded resources are at or below a combination of the current monthly private nursing facility rate multiplied by six months plus the current state spousal resource standard for the spousal impoverishment protections community (SIPC) spouse, based on the individual's verified household resources per WAC 182-513-1640 . Rates can be found here.
Functional	Nursing Facility Level of Care (NFLOC) WAC 388-106-0355	Nursing Facility Level of Care (NFLOC) WAC 388-106-0355

PE Time Period

Services are available under PE for a limited time. The PE time period begins on the date the PE screening is completed and ends with the earlier date of:

- The day the decision was made by the HCS public benefits specialist on the TSOA financial application;
- The date it was confirmed by HCS case worker that care receiver did not meet functional eligibility criteria; OR
- The last day of the month following the month that the PE screening was completed (when no TSOA application was submitted).

Any Care Receivers who have already been determined financially eligible (for example, most MAC Care Receivers), will be fully eligible once HCS confirms functional eligibility, therefore may never enter the program under presumptively eligibility.

Example 1: Susy Que's PE assessment was completed in GetCare on August 19, 2024 and the NFLOC confirmation was made by the HCS case worker on 8/21/24. Susy submitted her TSOA application on September 12th and continued to receive services under PE until October 5, 2024, when the HCS financial worker was able to determine full financial eligibility.

PE RAC start date = the date PE was completed and locked (8/19/24)
Initial PE RAC end date = 9/30/24
PE RAC end date extended to allow financial worker time to process application = 10/31/24
Financial worker's eligibility decision = 10/4/24
Full Eligibility RAC start date = 11/1/24
Full Eligibility RAC end date = 8/31/2025
TSOA program start date for 14-443 = the date PE screening was completed and locked (8/19/24)

Example 2: Susy Que was determined to meet TSOA PE criteria on August 19, 2024. Her NFLOC confirmation decision was completed on August 21, 2024 and indicated that she did not meet NFLOC criteria. Susy Que's PE period ends August 21, 2024 and she is no longer eligible to receive services under PE. Had Susy received any paid services between August 19th and 21st, the AAA staff would also need to create the NOPE RAC (start date 8/19/24 and end date 8/21/24) to mirror the closed PE RAC. This will move the service expenditures out of the TSOA funding bucket into the NOPE funding bucket. The PE RAC start and end dates should match the NOPE RAC start and end dates.

PE RAC start date = the date PE was determined (8/19/24)
PE RAC end date = 8/21/24
TSOA program start date for 14-443 = the date PE was determined (8/19/24)
TSOA program end date for 14-443 = the date NFLOC confirmation results (8/21/24)
NOPE RAC start date = 8/19/24 (only use this RAC if care receiver received TSOA services)
NOPE RAC end date = 8/21/24 (only use this RAC if care receiver received TSOA services)

Completed means "Locked" in GetCare and "Finalized" in CARE

Example 3: Susy Que was determined to meet TSOA PE criteria on August 19th and the NFLOC confirmation was made that day. She did not submit her TSOA application before September 30, 2024, the last day of the month following the month her initial services under PE were authorized. Her PE period ends September 30th and she cannot receive TSOA services until she submits a TSOA application and a financial eligibility decision is made by the HCS financial worker. In this case, Susy may decide to receive FCSP services until her financial eligibility for TSOA is completed. However, FCSP services are limited and expenditure levels vary, therefore FCSP may have waitlists depending upon the budget at the local AAA.

PE RAC start date = the date PE was determined (8/19/24)
PE RAC end date = 9/30/24
TSOA program start date for 14-443 = the date PE was determined (8/19/24)

TSOA program end date for 14-443 = 9/30/24

Dyads and TSOA individuals may only receive services under PE once every twenty-four months. For instance, in example 2 above, Susy would not be eligible to apply for PE and receive MAC or TSOA services under PE for two years (October 2024). She would be able to request and receive MAC or TSOA services prior to October 2024, but would need to wait until her full eligibility (both financial and functional) had been determined prior to services being authorized.

Completing the PE Screening

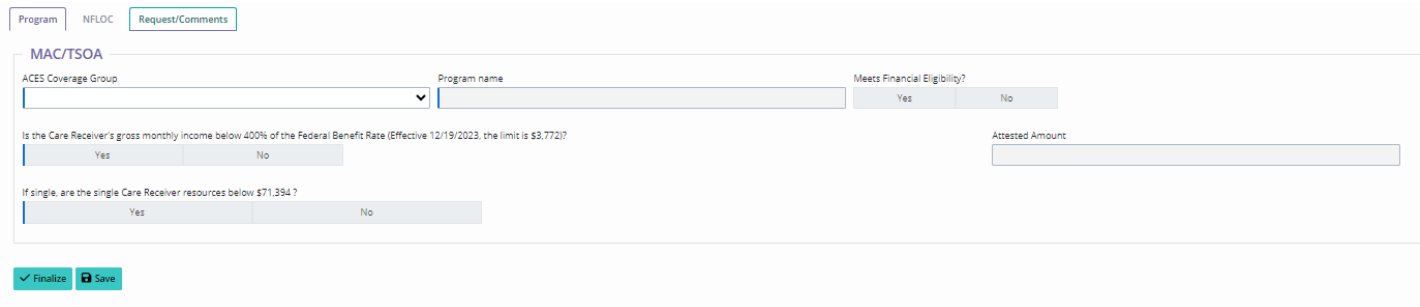
The Presumptive Eligibility screening tool has been built into CARE and GetCare to allow both HCS and AAA workers to complete the screening. This allows a MAC or TSOA applicant to enter either "door" to begin the intake process and access services in the most efficient manner.

CARE, the tool used by HCS, has a MTP node that includes the PE screening functionality. Below are screen shots of the financial and functional sections in CARE.

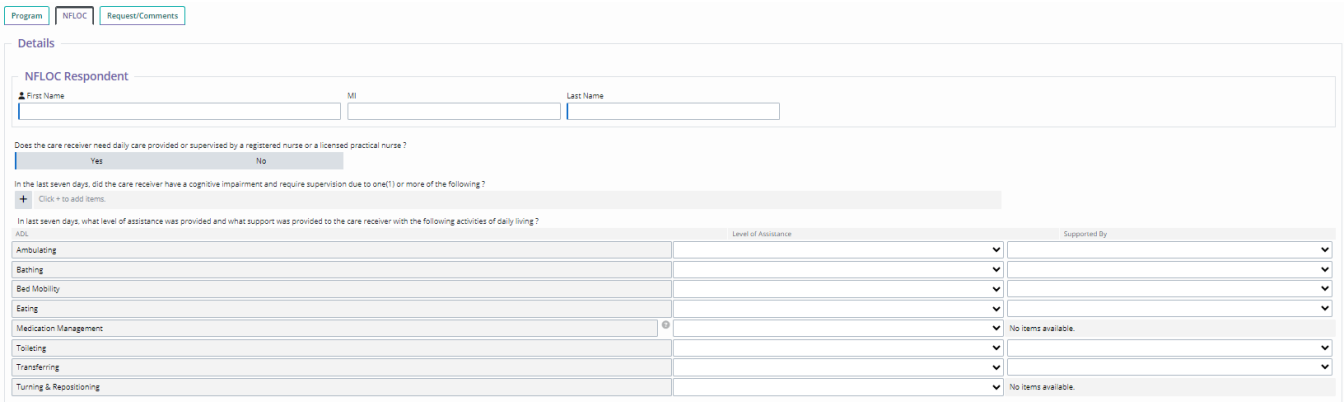
The financial eligibility component of the PE screening includes two main elements: income and resources. For TSOA applicants we use the care receiver's self-attested gross monthly income. For calculating the amount of resources for a care receiver we must consider their marital status. If the care receiver is married, we must use the self-attested amount of resources for both the care receiver and their spouse.

If a married couple are both applying for services, each TSOA applicants self-attested gross monthly income would be used. Example: Married Couple Care Receiver #1 has a self-attested gross monthly income of $2,000 a month and Married Couple Care Receiver #2 has an self-attested gross monthly income of $6,000 a month. Married Couple Care Receiver #1 would be within the income limits and would be PE eligible but Married Couple Care Receiver #2 would show to be over income for the program and would be PE ineligible. For resource amounts, if married, we must use the self-attested amount of resources for both the care receiver and their spouse (regardless if both are applying for services or only one individual in the couple is applying).

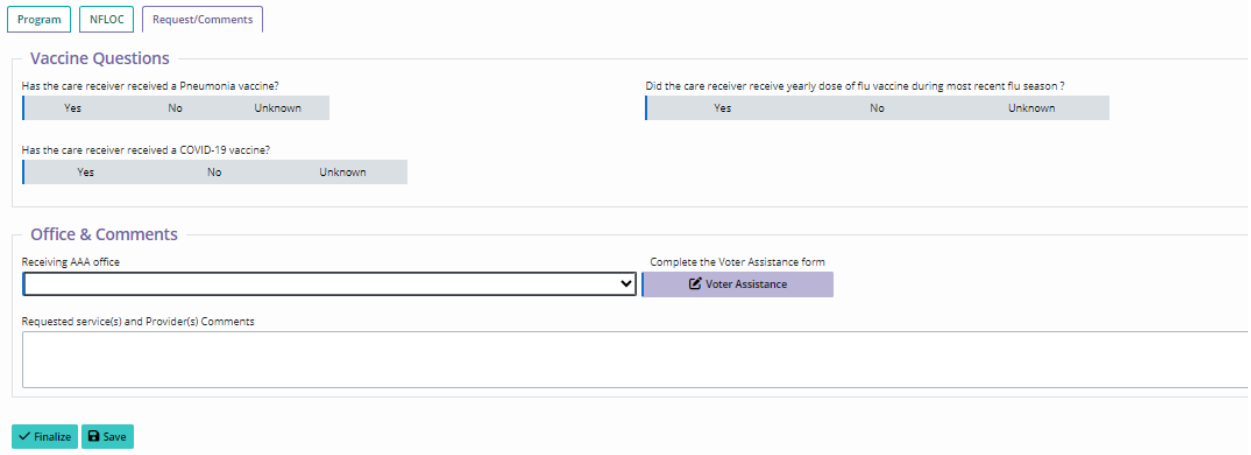
Financial PE questions in CARE:



Functional eligibility questions in CARE:



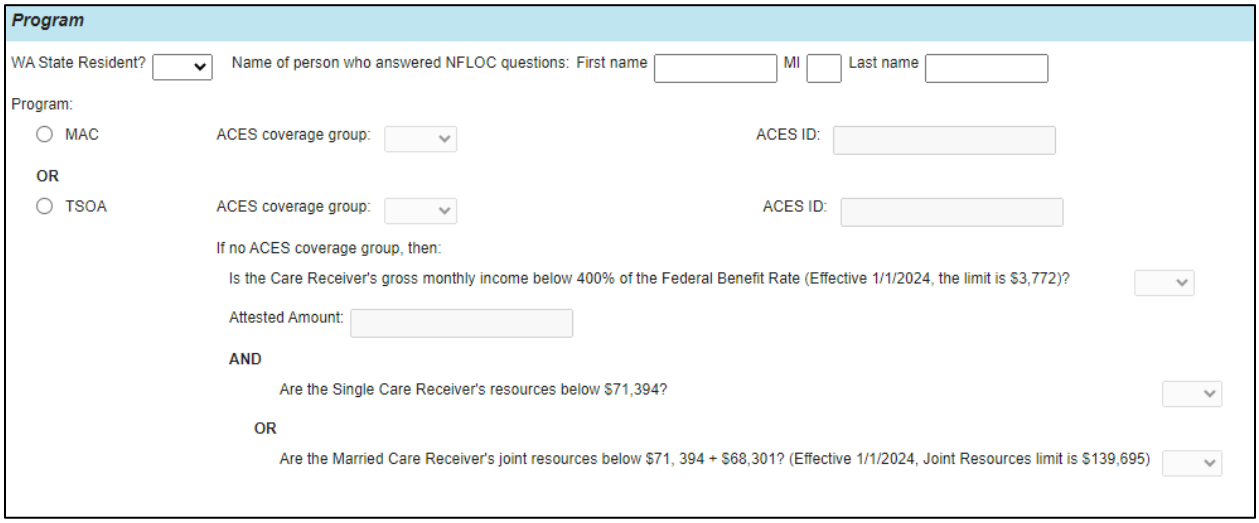
Vaccination Discussion & Comments in CARE:



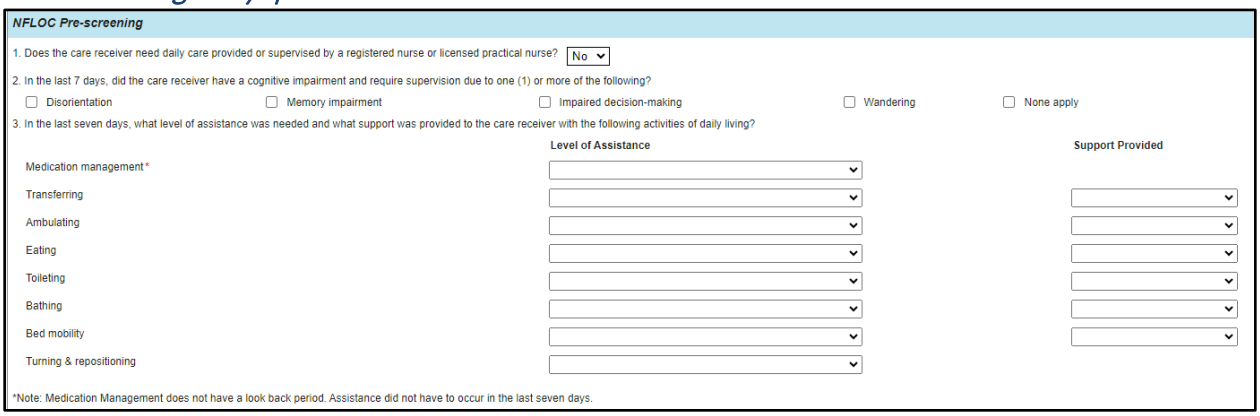
Training materials related to completing PE screening in CARE can be found in CARE Web - CARE Web Help – Presumptive Eligibility.

GetCare, the tool used by AAAs, includes the PE screening in the Assessments section. The screen shots of the financial and functional sections of the PE Assessment in GetCare are as follows:

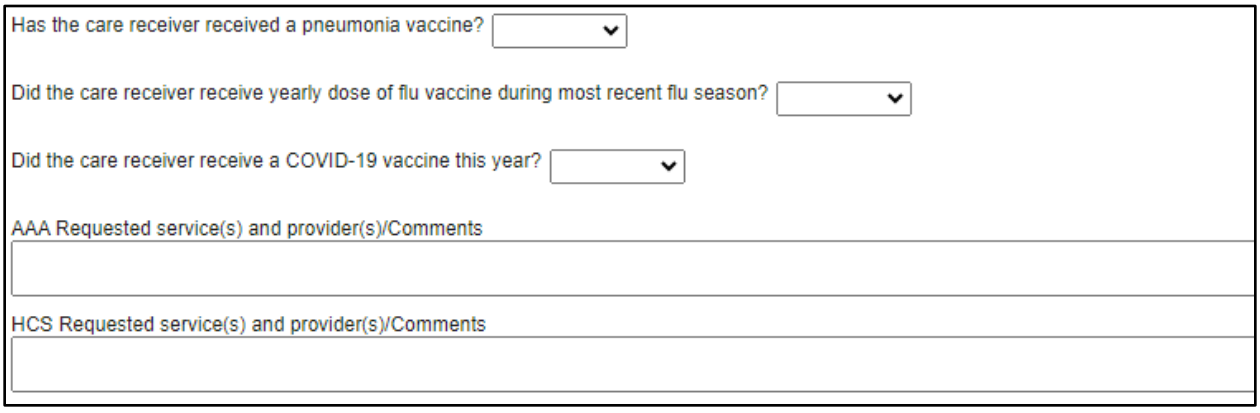
Financial eligibility questions in GetCare:



Functional eligibility questions in GetCare:



Vaccination Discussion & Comments in GetCare:



Training materials related to:

- Completing a PE assessment in GetCare can be found here on the MTP Community WorkSpace
- ACES coverage groups and the related financial (ACES) RACs can be found here on the MTP Community WorkSpace
- A video, Introduction to Recipient Aid Categories, to help with understanding RACs can be found on the MTP Community WorkSpace.

CARE and GetCare had existing terminology before the two systems were connected for MTP. The below is a cross walk of some of the language which can be used to aid in communication between HCS and AAAs:

NFLOC – Level of Assistance Crosswalk	
CARE	GetCare
Independent	Independent
Supervision	Minimum
Limited	Moderate
Extensive	Maximum (Both Extensive and Total in CARE =Maximum in GetCare
Total	Maximum (Both Extensive and Total in CARE =Maximum in GetCare
Did not occur/No Provider	Did not occur/No Provider
Did not occur/Client not able	Did not occur/Client not able
Did not occur/Client declined	Did not occur/Client declined
Independent (CARE does not have the GetCare value of "Declined to State". It is not part of the NFLOC eligibility criteria. If "Declined to State" is selected in GetCare, CARE will display "Independent"	Declined to State (This GetCare value does not count in NFLOC eligibility)

For more detailed information about RACs see the RAC section of this chapter.

NFLOC Confirmation

HCS MTP workers must confirm all initial NFLOC eligibility decisions (whether the care receiver is found eligible or ineligible). AAA workers complete all annual NFLOC reassessments. HCS does not need to confirm annual NFLOC decisions.

Confirmation of NFLOC will be completed using the following processes:

AAA Intake:
When completing the PE assessment in GetCare, in order to facilitate WHO protocols, the AAA worker will:

- describe in the comment box the type of *daily* care provided or supervised by a RN or LPN if the answer to NFLOC question #1 is "Yes";
- describe in the comment box the cognitive impairment that caused the need for supervision, if the answer to NFLOC question #2 is something other than "None Apply"; and
- add any additional information in the comment box that may be useful for the HCS worker confirming NFLOC eligibility.

To complete the NFLOC confirmation, the HCS worker will review:

- any comments submitted with the PE screening completed by the AAA worker;
- the level of assistance and support provided coding to ensure the coding looks accurate based upon the definitions of the coding; and
- contact the AAA worker who completed the PE screening when clarification is needed on the comments submitted or the coding selected by the AAA worker.

HCS will avoid contacting the care receiver or NFLOC respondent to ask the NFLOC questions again, if at all possible.

HCS Intake:
When completing the PE screening in CARE, the HCS worker will:

- describe in the comment box the type of daily care provided or supervised by a RN or LPN if the answer to NFLOC question #1 is "Yes";
- describe in the comment box the cognitive impairment that caused the need for supervision if the answer to NFLOC question #2 is something other than "None Apply"; and
- add any additional information (including an unpaid family caregiver if identified in the screening process) in the comment box that may be useful for the AAA worker to know.

When the PE screening completed in CARE is sent to GetCare, the NFLOC decision is considered confirmed and will be reflected as such in both CARE and GetCare.

When the PE screening is completed in CARE, the AAA worker will:

- review the comments submitted by the HCS worker who confirmed NFLOC eligibility and seek clarification as needed;
- if the care receiver does not meet NFLOC eligibility, proceed with the program denial process; and
- if the care receiver does meet NFLOC eligibility, proceed with sending the PE program approval notice, completing screening and assessments, care plans and creating the enrollment(s) and service authorization(s).

Additional information:
The AAA and HCS worker may decide to complete the PE screening via a 3-way conference call or have additional ways to communicate information related to the PE screening. Please add this to your area's Warm Hand-Off Protocol if using this approach.

PE Notices

The following templates for the required PE notices are in GetCare and are accessible by clicking the "Write Client" button which is visible after opening the identification ribbon of the care receiver's file section. The care receiver's specific details can be added into the templates, printed and mailed to the care receiver and unpaid caregiver, if there is one. GetCare will also send the completed notice to Barcode to be entered into the care receiver's Electronic Case Record (ECR). All PE notices will be generated by AAAs in GetCare even for those that begin as HCS intakes.

NOTICE TYPE	PURPOSE	# of TRANSLATED LANGUAGES
MAC PE Approval	To provide notification to care receiver that PE has been approved	8
TSOA PE Approval	To provide notification to care receiver that PE has been approved	8
MAC PE Denial	To provide notification to care receiver that PE has been denied	8
TSOA PE Denial	To provide notification to care receiver that PE has been denied	8

The top eight languages available besides English are:

- Spanish
- Korean
- Somali
- Russian
- Laotian
- Cambodian
- Chinese
- Vietnamese

The translated version of the PE approval or denial document must be stored in the care receiver's GetCare electronic file cabinet (ECF).

FINANCIAL ELIGIBILITY

As noted previously, HCS financial workers otherwise known as Public Benefit Specialists (PBS), determine full financial eligibility for TSOA care receivers based upon information submitted on the financial application (18-005– Washington Apple Health Application for Aged, Blind, Disabled/Long-Term Services and Supports). The HCS PBS workers also manage MAC care receivers who are not receiving this service under a MAGI coverage group (N-track). If the MAC care receiver is receiving their CN – ABP Medical through the N-track then those cases are managed by the Health Care Authority (HCA). HCS and HCA financial workers are also responsible for completing the financial eligibility review (ER) each year.

Applications can be completed electronically through Washington Connection web portal (www.washingtonconnection.org) or by using the paper form 18-005. Paper applications can be submitted to:

- a local Home and Community Services (HCS) office visit dshs.wa.gov/office-locations
- faxed to 855-635-8305
- mailed to PO Box 45826, Olympia WA 98504-5826.

Intake workers at HCS or AAA offices may also assist the client with submitting their application.

Documents Needed by Financial Workers

Financial workers will need to gather information from the care receiver in order to determine their financial eligibility. The table below identifies the types of documents that may be requested:

Verification Needed	Examples of what may be used
NAME, AGE, CITIZENSHIP, ID	Birth certificate Driver's license Immigration documents Passport Adoption papers Military papers Divorce decree
SOCIAL SECURITY NUMBER	Social Security card or application receipt Tax statement Pay stubs
INCOME SOURCES	Pay stubs* Tax returns Self-employment records Letter from employer Proof of unemployment Social Security* SSI
RESOURCES & OTHER ASSETS	Bank/credit union statements (for the month the TSOA application was received)* Note: if TSOA was requested on the LTC application 18-005 then bank statements may be requested for additional months Passbooks Life and burial insurance policies Stocks, bonds, annuities, notes, trust*
VEHICLES (CARS, BOATS, RV's, ETC.)	Title Registration Sales contracts
LAND, BUILDINGS, PROPERTY	Deed Tax statements Sales contracts
OTHER IMPORTANT INFORMATION	Financial Power of Attorney Legal Guardian Include the following for both: • Phone numbers • Addresses

*most commonly used document to verify financial eligibility

An ACES Coverage Group Guide that identifies the most common eligibility groups for MAC and TSOA can be found in the financial tile on the MTP Community WorkSpace. Below is a screen shot of the summary page of this document.

ELIGIBLE FOR MAC - NOT ELIGIBLE FOR TSOA			
Most common ACES coverage group	Description		Scope
N05	Adult 19-65 Medicaid Expansion coverage (ABP)		ABP
S01	A person who receives an SSI cash payment and medicaid		CN
S02	A person who does NOT get an SSI cash payment but is eligible for medicaid due to low income.		CN
Eligible for MAC - not common	Description		Scope
N01	MAGI Parent/Caretaker		CN
N02	MAGI Parent/Caretaker on 12 months transitional coverage		CN
S08	Healthcare for Workers with Disabilities (under 65 and working)		CN
S30	Breast & Cervical Cancer recipient (Women only)		CN
L32	Hospice SSI-related recipient		CN

ELIGIBLE FOR TSOA - NOT ELIGIBLE FOR MAC			
TSOA coverage group	Description		Scope
T02	Tailored Supports for Older Adults		N/A
Most common ACES coverage group	Description		Scope
S95/S99	Medically needy (with spenddown)		MN
S03	QMB - Qualified Medicare Beneficiary		MSP
S04	QDWI - Qualified Disabled Working Individual.		MSP
S05	SLMB - Specified Low-Income Medicare Beneficiary		MSP
Eligible for TSOA - unlikely	Description		Scope
P05	Family planning		FPSO
P06	Take charge family planning		FPSO

NOT ELIGIBLE FOR MAC OR TSOA (ONGOING) - NON CITIZENS			
ACES coverage group	Description		Scope
A01	Blind/disabled or 65+ non-citizen		MCS
A05	Temporary incapacity - non-citizen		MCS
L24	State-funded LTSS program		SFCN
N21	AEM - MAGI parent/caretaker - Emergency Related Services		ERSO
N25	AEM - MAGI new adult - Emergency Related Services Only		ERSO
S07	AEM - Alien Emergency Medical - Emergency Related Service		ERSO

LTSS IN-HOME COVERAGE GROUPS - USE CAUTION!			
ACES coverage group	Description	Participation?	Scope
L21	HCS waiver recipient with SSI cash and Apple Health	No	CN
L31	PACE recipient with SSI cash and Apple Health	No	CN
L41	Roads to Community Living recipient with SSI cash and Apple	No	CN
L51	Community First Choice recipient on SSI cash and Apple Health	No	CN
L22	HCS waiver - low income Apple Health, without SSI cash	Yes*	CN
L32	PACE recipients, on Apple Health, without SSI cash	Yes*	CN
L42	Roads to Community Living recipient on Apple Health, without	Yes*	CN
L52	Community First Choice recipient on Apple Health, without SSI	No	CN

* These groups usually pay towards cost of care but not always. Check ACES

Changes and reporting requirements for TSOA and MAC

Reporting requirements are different for each program.

TSOA recipients only report minimal changes per WAC 182-513-1650 (2):

(a) A change in residential or mailing address, including if the TSOA recipient moves out-of-state;
(b) When a person admits to an institution, as defined in WAC 182-500-0050, and is likely to reside there for thirty days or longer; or
(c) The person dies.

The only change for TSOA that must be reported within 30 days of the date of the change, is admitting into an institution (b).

Once a person is determined eligible for TSOA, they remain continuously eligible throughout the 12-month certification unless one of the following changes happens:

- The person no longer meets NFLOC;
- The person is no longer a WA state resident;
- The person moves into an institution (nursing facility);
- The person becomes eligible for CN or ABP Medicaid; or
- The person passes away.

More information can be found at: TSOA certification periods, change of circumstances, and renewals | Washington State Health Care Authority

MAC recipient must report changes within 30 days per the program they are receiving care under. MAC authorized under S-track and N-track have different reporting requirements.

If the care receiver is N-track, age 19-64 and not eligible for Medicare, they report changes to the Health Care Authority based on N-track MAGI rules:

- Income over the limit for their household size and expected to last over 30 days
- Address change
- Citizenship/Immigration Status change
- Change in Marital Status
- Moved out of state
- No asset test for N-track, no need to report resource changes if on N05, for example.

If the MAC recipient is receiving services under S-track, Example S02, they would report all changes mentioned above, including resources, within 30 days to Department of Social and Health Services - HCS.

More information can be found in the Washington Apple Health Manual at:
Changes of circumstances reporting requirement | Washington State Health Care Authority

Eligibility When in Hospital, Jail or Rehabilitation Facility

When a MAC or TSOA care receiver is in the hospital, jail or a rehabilitation facility for less than thirty (30) days, their financial eligibility is not impacted.

However, for TSOA recipients, if their stay in any of these locations is thirty (30) days or more, based on WAC 182-513-1650, the care receiver would no longer be financially eligible. The PBS worker would close the TSOA T02 coverage group. T02 can be reopened when the care receiver discharges home if the care receiver is not active on CN or ABP Medicaid and the T02 is still within the original certification period. If a CN or ABP Medicaid coverage is opened by the PBS, this typically is scheduled to end at the end of the month. The T02/3199 financial RAC cannot be screened in by the PBS until after the CN or ABP Medicaid is closed. If outside the original certification period, a new application would need to be submitted. However, if they were receiving Medicaid services while in a nursing facility, they wouldn't need to complete a new application as the financial worker would be able to do a program change in ACES.

MAC care receivers in a hospital, jail, or rehabilitation facility for thirty (30) days or more, depending on the Categorically Needy (CN) or Alternative Benefit Plan (ABP) Medicaid coverage group (Apple Health) they are enrolled with, will have different actions taken by PBS staff. It is important to check the care receiver's coverage in ACES or Barcode, prior to re-establishing services when the care receiver returns to their home and community-based setting.

Eligibility When Temporarily Out of the Country or Requesting to Put Paid Services on Hold temporarily

If the care receiver is temporarily out of the country or has requested to put their paid services on hold, but their intent is to return and re-engage in services, TSOA can stay open in ACES within their annual financial eligibility period. The intent to return is key. It is important to check the care receiver's financial coverage in ACES prior to re-establishing services to ensure financial RACs remain opened and unchanged.

When is a New Application Required

As care receiver and unpaid family caregiver's situations change; transitions in both functional and financial programs may occur. The below are some scenarios on when a new LTSS 18-005 application would not be needed:

- If the care receiver has transitioned to LTSS and would like to return to TSOA they wouldn't need another application. The PBS would complete a program change.
- If the TSOA coverage group has not been closed yet by the PBS, we wouldn't need a new application. Example: it's been 30 days, but the PBS hasn't been able to go in and close the program yet, or the PBS wasn't aware of the situation which resulted in the closure (example: 30+ days in an institutional status).
- Care receiver is active on a classic Medicaid program (S02, S95, S99) PBS could complete a program change, and no application would be required.

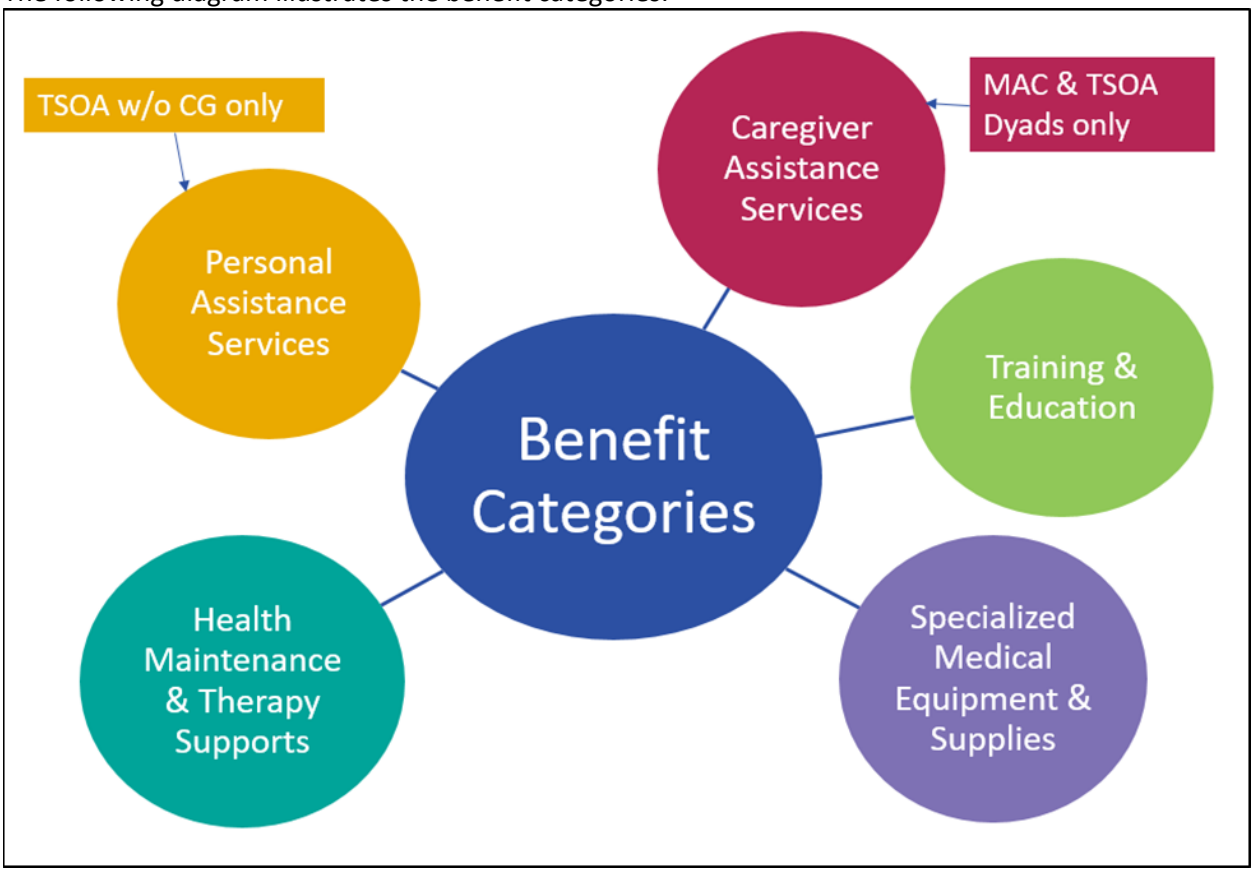
After the ACES Coverage group is closed, the PBS worker could use equal access (EA) rules to reinstate a care receiver within thirty (30) calendar days from when coverage ended, if the PBS is provided proof the care receiver is still qualified. An application or ER would only be needed if they are currently in an annual eligibility review month.

BENEFIT CATEGORIES, SERVICES AND STEPS

For MAC and TSOA programs there are five benefit categories and within each category are a selection of available services.

Benefit Categories

The following diagram illustrates the benefit categories:



- Personal Assistance Services (the orange circle) are available only for TSOA individuals who do not have an unpaid family caregiver.
- Caregiver Assistance Services (the red circle) are available for only MAC and TSOA dyads.
- Services within Training & Education, Specialized Medical Equipment & Supplies, and Health Maintenance & Therapy Supports are available for MAC and TSOA dyads and TSOA individuals.

Services

Network adequacy, mandatory for MAC and TSOA, requires that specific services be available in at least one location within each AAA planning and service area (PSA). The following contains a list of the types of services within each benefit category for MAC and TSOA. **Bolded** items in italics represent the categories used in the Centers for Medicare and Medicaid Services (CMS) Special Terms and Conditions (STCs) for MTP. Underlined subcategories and bulleted service details represent the language used in Family Caregiver Support, CLC- GetCare, and TCARE®. A purple * denotes services that may be received by a unpaid family caregiver and a care receiver. Additional services may be added to this list into the future.

Caregiver Assistance Services

Services that take the place of those typically performed by the unpaid caregiver in support of unmet needs the care receiver has for assistance with activities of daily living (ADLs) and instrumental (IADLs).

Caregiver Assistance Services are not available to TSOA individuals without an unpaid caregiver – see Personal Assistance

Respite

- Adult Day Care (where available)
- Adult Day Health (where available)
- Memory Care and Wellness Services
- Overnight Facility-Based Respite
- Overnight In-home Respite
- In-Home
- Nurse Delegation, in conjunction with respite care

Supplemental Services

- Transportation
- Home Safety Evaluation
- Housework and Errands in the Care Receivers Home*
- Yardwork
- Snow Removal
- Home Delivered Meals (HDM)*
    - Maximum limit of 2 meals per day (3rd meal can be requested via local ETR)
    - Meals may be provided for both the caregiver and the care receiver (up to 2 per day for each participant)

    Note: Unlike someone receiving HDM via traditional LTC, such as COPES, a care receiver or caregiver does not have to be homebound. The cost of the meals must be deducted from the care receivers step level benefit amount (no additional hourly deductions of personal care hours are needed).

- Bath Aide
- Home Modifications and Repairs
- Specialized Deep Cleaning
- Pest Eradication

- Community Choice Guiding Service

Training & Education

Services and supports to assist caregivers with gaining skills and knowledge to implement services and supports needed by the care receiver to remain at home or skills needed by the caregiver to remain in their role. Also available for TSOA individual care receivers as applicable.

Support Groups
- Online Support Group*
- Support Group*

Training/Consultation (Group Training; Health and Wellness Consultation; Consultation on Supported Decision Making; Financial or Legal Consultation)
- Occupational Therapist Consultation*
- Physical Therapy Consultation*
- Dementia Consultation/Training*
- Long Term Care Planning*
- Legal Services*
- Caregiver Conference
- Caregiver Consultation
- Family Caregiver Training/Education
- Powerful Tools for Caregivers
- Dietician Consultation*
- Chronic Disease Self-Management Program*
- Fall Prevention Workshop*
- Medication Management*
- STAR-C
- RDAD (Reducing Disease in Alzheimer's Disease)

Each AAA must have at least one service that provides:
1. Coping/skill building, and
2. Training to meet the needs of the care receiver)

Specialized Medical Equipment & Supplies

Goods and supplies needed by the care receiver.

Supplemental Services
- Personal Emergency Response Systems (PERS)
  - PERS is a monthly service with optional add-on services such as medication reminder, falls detection, or GPS locator.
- Assistive/Adaptive Equipment
- Durable Medical Equipment (DME)
  - Requires a health care provider's order/prescription in order for DME provider to claim for payment
- Care Supplies (such as incontinence supplies)

Note: Bedrail policy in Chapter 3 should be followed if a bed rail has been determined as a need in the person-centered care plan.

Health Maintenance & Therapy Supports

Clinical or therapeutic services that assist the care receiver to remain in their home or the caregiver to remain in their caregiving role and provide high quality care. Services are provided for the purpose of preventing further deterioration, improving or maintaining current level of functioning. Supports and services categorized here include those typically performed or provided by people with specialized skill, certification or licenses. Also available for TSOA individual care receivers as applicable.

Counseling*

- Must be short-term and solution oriented

Supplemental Services

- Adult Day Health (where available)
- Health promotion wellness service. This health promotion wellness service may be offered under Training/Consultation for example, Powerful Tools for Caregivers or Chronic Disease Self-Management Education (CDSME)
- Wellness Programs and Activities*
- Health promotion and wellness services such as Acupuncture* and Massage*
- RDAD (Reducing Disability in Alzheimer's Disease)
- Evidence-Based Exercise Programs*

Personal Assistance Services

Supports involving the labor of another person to help TSOA individual participants carry out everyday activities they are unable to perform independently. Services may be provided in the person's home or to access community resources.

- Personal Care
- Nurse Delegation, in conjunction with personal care
- Housework and Errands
- Yardwork
- Snow Removal
- Pest Eradication
- Specialized Deep Cleaning
- Community Choice Guide Services
- Adult Day Care
- Transportation
- Home Delivered Meals
    - Maximum limit of 2 meals per day (3rd meal can be requested via local ETR)

      Note: Unlike someone receiving HDM via traditional LTC, such as COPES, a care receiver does not have to be homebound. The cost of the meals are to

be deducted from the care receivers step level benefit amount (no additional hourly deductions of personal care services should occur).

- Home Safety Evaluation
- Home Modifications and Repairs

Some of the services available through the MAC and TSOA programs are defined in WAC:

Adult Day Care: WAC 388-106-0800 through WAC 388-106-0805
Adult Day Health: WAC 388-106-1810 through WAC 388-106-1815
Nurse Delegation: WAC 246-840-910 to 960
Personal Care Services: WAC 388-106-0010

CMS requires in federal policy that Medicaid is the payer of last resort. Below is the general funding hierarchy used for HCLA programs and services beginning with first payer:

- Private insurance
- Personal resources
- Medicare
- Medicaid
- Waiver funded programs (such as CFC, COPES, MAC, TSOA)
- State funded programs (such as Washington Roads)

Steps

Once a care receiver has been determined to be eligible, either presumptively or fully confirmed, services are provided at one of three different steps. The chart below lays out the steps and criteria for accessing services at each step. AAAs are responsible for tracking care receiver expenditures to prevent over-expenditures at any step.

Program	Step 1 Based on demographics & program eligibility; may receive under PE	Step 2 Based on demographics, program eligibility, & results of a TCARE® or GetCare Screening; may receive under PE	Step 3 Based on demographics, program eligibility, & results of a TCARE® or GetCare Assessment; may receive under PE
MAC/TSOA Dyads	$250 one-time only	$500 annually minus any expenditures at Step 1	Avg. $844 monthly not to exceed $5,064 in a six-month period*
TSOA Individual w/o CG	$250 one-time only	$500 annually minus any expenditures at Step 1	Avg. $844 monthly not to exceed $5,064 in a six-month period*

*as of 7/1/2024. The Step 3 benefit level formula uses the home care agency hourly rate in its calculation. Therefore, the Step 3 benefit level will change according to the rate determined by the rate setting board. Please see the "MAC-TSOA" tab on the HCS Rates website for the most current step 3 benefit level.

As is the policy for Family Caregiver Support Program, if someone had an initial risk score qualifying them for Step 3 benefit level and the next screening showed a lower risk score, we would not move

them "down" to Step 2 benefit level. The lower risk score may be an indication that the Step 3 services are benefiting the participant.

A caregiver may provide services to multiple care receivers (such as an adult daughter caring for both her mother and her father). Each care receiver has a benefit level that can be used to support their caregiver. However, the case worker needs to ensure that the funds for each care receiver is not duplicating services for their shared caregiver.

A care receiver may have more than one caregiver (such as a father that has two adult children sharing the caregiving tasks). However, the care receiver has only one benefit level that must be shared in order to provide the supports to both caregivers.

SCREENINGS AND ASSESSMENTS

Screenings and assessments for MAC and TSOA are completed in the CLC/ GetCare or the TCARE® system. Screenings must be completed at least every six months or more frequently if there is a change in the caregiver's or care receiver's condition.

- Example: Screening is completed January 15th. Next screening is due by July 31st.

If the six-month rescreen does not result in a change in the risk scores, then a six-month assessment is not required. However, both GetCare and TCARE® assessments must be completed at least annually or more frequently if there is a change in the caregiver's or care receiver's condition.

- Example: Assessment is completed January 15th. Annual assessment is due by January 31st the following year.

Assessments and Screenings may be completed outside of the care receiver's residence. For example, the assessment for the TSOA individual can be completed in the hospital or rehabilitation facility in preparation for discharge home. A benefit of doing so is facility staff may be present during the assessment to provide their feedback about the current support needs for the care receiver. Another benefit of doing the assessment and screening in an alternative setting is getting care planning started prior to discharging to expediate service delivery.

The TSOA individual care plan can be created with the services that are intended for the care receivers' home and community-based setting. Consent can be given by the care receiver and the care plan can be created while the care receiver is still in the facility. The start date of the care plan should be the discharge date or later (e.g., should not be a date when the care receiver is still in the facility). The important item to remember (CMS rule) is that the service enrollment/authorization must have a "from" date that is equal to or later than the discharge date. A face-to-face visit should occur after the care receivers discharge to view the living environment of the care receiver. The face-to-face visit does not need to occur prior to care plan creation and authorization of services but must be completed during the annual care plan period, best practice being within 30 days of discharge.

For dyads, the TCARE® assessment with the unpaid family caregiver may be completed when the care receiver is in the facility and preparing for discharge. In this situation, it may also be useful to have a

facility staff provide feedback about the current support needs for the care receivers ADLs. For dyads, the care plan can also be completed with the unpaid family caregiver while the care receiver is still in the facility. The unpaid family caregiver would need to respond and select services based upon what supports the unpaid family caregiver will need once the care receiver returns home. Consent can be given by the caregiver and care receiver and the care plan can be started while the care receiver is still in the facility. One face-to-face visit during the TCARE® assessment or consultation process is required before services can be authorized during the initial assessment/consultation process as well as during subsequent annual TCARE® reassessments/consultations. If the caregiver and care receiver live together, at least one home visit must occur in the home with both caregiver and care receiver present. This home visit allows the assessor to evaluate the living situation and must be completed before the care plan is created. When caregiver and care receiver don't live together, a home visit in the care receiver's home is strongly encouraged, though not required. Again, we still need to follow the CMS rule ensuring that the service enrollment/authorization must have a "from" date that is equal to or later than the discharge date.

GetCare

GetCare is the primary case management information system for MAC and TSOA. This system contains many elements necessary for implementing the MAC and TSOA programs including but not limited to:

- Demographic information for caregivers and care receivers
- Screening tool and assessment for TSOA individual without a caregiver
- Presumptive Eligibility assessment
- Annual NFLOC assessment

The GetCare Screening (TSOA without a CG Screening) is a process that gathers information about the individual without a caregiver in order to determine risk scores. The information gathered includes functional needs, fall risk, availability of informal support, memory and decision-making issues, and emotional well-being. The risk scores from the screening are used to determine if the individual will be referred for a TSOA without a CG Assessment.

The TSOA without a CG Assessment is a process that gathers information about an individual without a caregiver in the following areas: functional needs (All ADL's should utilize a 7-day look back period. All IADL's – essential shopping, housework, meal preparation, and medical transformation should use a 30 - day look back period. Medication management would be selecting the highest level of need (no 7 days look back period), diagnoses and conditions, behavioral health supports, oral health, and nutritional health needs. The assessment will assist the individual with choosing the Step 3 services that will address their assessed needs.

For TSOA without a caregiver care receivers, the TSOA Individual without a Caregiver Assessment may be completed remotely although best practice is to complete a face-to-face assessment. Assessments must be completed at least annually in a location convenient to the care receiver. One face-to-face visit must occur at least annually to view the living environment of the care receiver. The face-to-face visit does not need to occur prior to care plan creation but must be completed during the annual plan period.

TCARE®

The TCARE® process is based on the premise that providing the right service at the right time supports those unpaid family caregivers who are burdened by their caregiving responsibilities. TCARE® includes screening, assessment, consultation, and service planning elements that are designed to be utilized with the Family Caregiver Support Program (FSCP), Medicaid Alternative Care (MAC), and Tailored Supports for Older Adults (TSOA) programs which are administered through the Area Agencies on Aging (AAA). The TCARE® process:

- Validates the family caregivers' feelings and experiences along their caregiving journey,
- Stimulates caregivers to reflect on their caregiving responsibilities through relevant and insightful questions,
- Provides structure to the interview between the assessor and the caregiver, and
- Identifies a broad range of support services available through public and private funding that address the specific stressors and burdens of the caregiver

There are several parts to the TCARE® process, two of which are the TCARE® Screening and the TCARE® Assessment. The TCARE® Screening can be conducted in a variety of settings: in person, by telephone, or through a self-screen form called the Personal Caregiver Survey. The scores from the screening determine whether the caregiver should be referred for the third part of the TCARE® protocol which is the TCARE® Assessment. The assessment includes all of the screening questions, as well as additional questions focused on both the caregiver's experience and the care receiver's situation. Some of the major areas covered in the assessment are care receiver behaviors, memory issues, ADLs, IADLs, Cognitive Performance questions and diagnoses/conditions. When the need for an assessment is indicated by the screening, the assessment and care plan must be completed within 30 calendar days of the screening.

For MAC and TSOA dyads, one face-to-face visit during the TCARE® assessment or consultation process is required before services can be authorized during the initial assessment/consultation process as well as during subsequent annual TCARE® reassessments/consultations. If the caregiver and care receiver live together, at least one home visit must occur in the home with both caregiver and care receiver present. This home visit allows the assessor to evaluate the living situation and must be completed before the care plan is created. When caregiver and care receiver don't live together, a home visit in the care receiver's home is strongly encouraged, though not required.

For complete details on the TCARE® process, see Chapter 17a of the LTC manual.

CARE PLANS AND SERVICE NOTICES

The Centers for Medicare and Medicaid Services (CMS) require that a care plan must be completed *prior* to authorizing services. Additionally, MAC and TSOA enrollees must receive a formal written notice of the services being authorized.

Step 1, 2, and 3 care plans

Care plans are created in GetCare for MAC & TSOA dyads and TSOA individuals who are receiving Step 1 or Step 2 services. TSOA individuals receiving Step 3 services will also have a GetCare care plan. MAC & TSOA dyads receiving Step 3 services will have a care plan developed in TCARE®.

PROGRAM	STEP 1:	STEP 2:	STEP 3:
MAC or TSOA dyad	Care plan in GetCare	Care plan in GetCare	Care plan in TCARE®
TSOA w/o a caregiver	Care plan in GetCare	Care plan in GetCare	Care plan in GetCare

The care plan includes paid and unpaid services addressing the identified needs of the caregiver and the care receiver. The care receiver must provide consent of the plan before services can be authorized. Verbal consent can be provided initially (and documented in the care plan) with written consent provided within 60 days of completing the plan. For MAC and TSOA dyads, the TCARE® care plan requires both the care receiver and caregiver verbal consent. The caregiver signature is best practice per FCSP policy. Written consent may be provided by secure email or other electronic means for Step 1 and Step 2 services per WAC 388-106-1980(3).

The care plan must be reviewed and updated at least annually. If there are no changes in the services/supports identified in the care plan during the 6-month rescreening process then a new care plan does not need to be created, if the 'Next Expected Care Plan Date' is in the future. The care plan should represent the services each dyad or individual has chosen to address the areas identified in their assessment and discussed during the person-centered conversation.

It is important that the care plan is locked, and verbal consent has been received from the care receiver before any service authorizations are created. There is an option to link service enrollments (linking is optional) in the GetCare care plan as a simple way to identify requested services into the plan or you can create an enrollment directly in the care plan. All paid services must be included in the care plan. Once the care plan is locked it cannot be edited.

For dyads who are receiving Step 3 services, workers will complete the Care Plan using the TCARE® process. If a caregiver has had a significant change or a change in their service needs at 6-month TCARE® screen, and/or requests to have a new assessment, a new assessment must be conducted, and a new care plan must be created that reflects the changing needs of the caregiver.

Unpaid services (services or referrals that do not require payment authorization through ProviderOne) still need to be captured on the care plan. If the care receiver is enrolled in MAC or TSOA and only receiving unpaid services such as a support group, they still need to have a locked care plan.

NOTE: If a service such as respite or personal care will be part of the care plan but you are waiting to find a home care agency with an available provider in order to complete the enrollment, you can add the service and select status of "pending" or you can identify the service in the care plan (i.e. Respite Paid Provider or Personal Care Paid Provider) and then document in the progress notes the search for a

qualified provider is underway. There should be updates on the search, ongoingly documented in progress notes until the provider is found.

There are 4 different types of Care Plans in GetCare:

- Initial – select this for the first care plan created in GetCare
- 6 month – used only if you intend to create a new care plan based upon the 6-month rescreening process and outcome
- Annual – used for on-going care plans that are completed at least every 12 months
- Change in condition – use this option if changes to care plan (such as adding new services) are identified due to change in the care receiver or caregiver's condition outside of the annual care plan process

There are 4 different types of Care Plans in TCARE® as well:

- 6 month – used only if you intend to create a new care plan based upon the 6-month rescreening process and outcome.
- Annual – used for on-going care plans that are completed at least every 12 months.
- Review – rarely used in the care planning process as the other 3 types of care plans typically are used
- Other – use this option if changes to care plan (such as adding new services) are identified due to change in the care receiver or caregiver's condition outside of the annual care plan process.

The auto-populated due date for care plans falls on the last day of the month (6 or 12 months) from the date the care plan 'Type' indicates. For example, on 6/15/24 the care annual plan is created and the 'Expected Next Care Plan Date' is populated with date of 6/30/25. This date can be edited.

For the initial care plan, when moving from Presumptive Eligibility to Full RAC, you do not need to create a new care plan if the 'Expected Next Care Plan Date' is in the future unless there is a change in condition or if you are adding/deleting services in the care plan.

If there are no changes to the care plan during the 6-month re-screening process then a new care plan does not need to be created, if the 'Expected Next Care Plan Date' is in the future. If there is a change in condition of the caregiver or the care receiver resulting in a change to the care plan such as a new service being put in place or a service being removed, then a new assessment must be completed along with a new signed care plan.

Service Notices

The purpose of the MTP Service Notice (DSHS 15-492) is to provide the care receiver with information about the amount of funding available for accessing goods and services under their specific benefit level (Step 1, 2 or 3). The notice also includes information about their administrative hearing rights if they disagree with the amount of funding approved or denied. Service notices are not required under presumptive eligibility (PE) but must be completed and sent to care

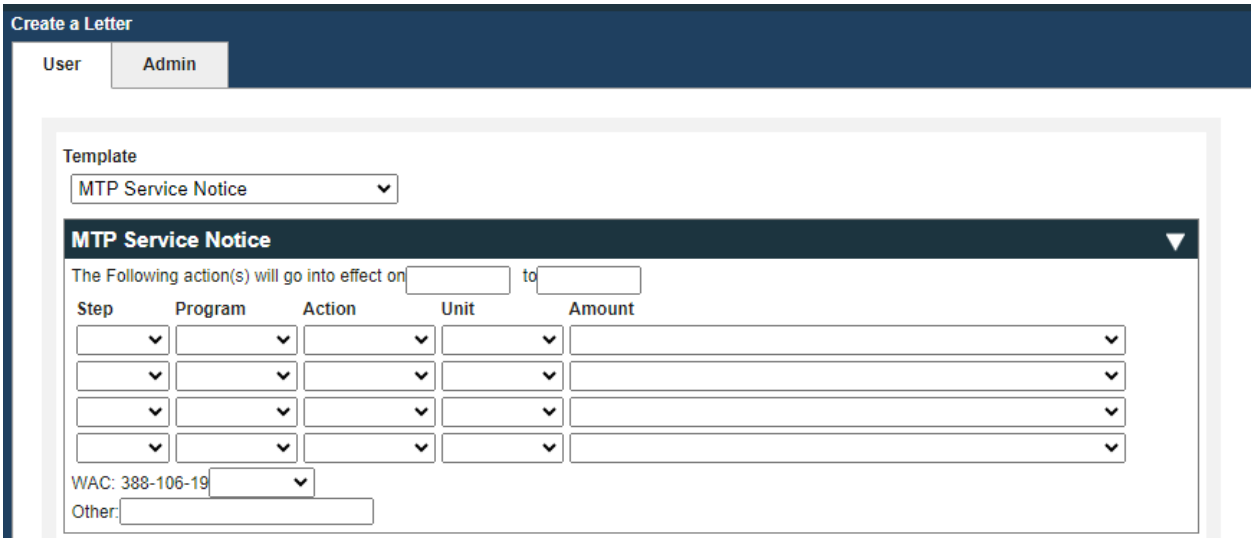
Reminder: Ensure enough time is allowed for translations, when needed. The MTP English and Translated versions should be mailed to the Care Receiver together.

receivers once they move out of PE into full eligibility. The service notice should be sent to the care receiver along with the care plan that needs to be signed.

Service notices must be sent to the care receiver at least (ten) 10 calendar days before the effective date of an adverse action such as denial, reduction, or termination. The service notice needs to describe what action is being taken and under what authority that action is being taken (the specific WAC reference).

A MTP Service Notice (DSHS 15-492) also needs to be sent when the care receiver changes from one step/benefit level to another.

Approved (includes annuals/renewals and changes)	• Initial eligibility decision for full services • Continued eligibility/services when there is no change • A change in services from one step level to another Example: - Client was receiving Step 2 benefits and at the annual is now eligible for Step 3 benefit level.
Withdrawn	• Requests for services that are withdrawn by the client after the assessment was initiated and before services were initiated or authorized. Example: - Client went from PE to Full but never received any authorized services. If client, indicates they would like to withdraw then the action 'withdrawn' can be utilized.
Denied	• Not eligible for requested service/program and services were never initiated or authorized. Example: - Client was found to be eligible for Step 2 but is requesting services only offered under the Step 3 benefit package.
Terminated	• Services/program terminated Example: - Client was found to no longer be eligible for services at the annual NFLOC - Client started services but later requested to withdraw. As services had been provided, terminated would need to be used as the action.



Example: Care receiver was found to no longer be financially eligible. TSOA AAA Staff was notified via Barcode that the last day of financial eligibility will be 8/31/2024. MTP Service Notice should be sent out no later than 8/20/2024 (allowing at least 10 days' notice due to an adverse action). The following action date would be 8/31/2024. All RACs and Authorizations would need to be ended and not extend beyond 8/31/2024.

There is an instruction form providing guidance on how to correctly fill out the MTP Service Notice. It can be found on the DSHS forms page at https://forms.dshs.wa.lcl/formDetails.aspx?ID=38862 .

Translated versions of the Medicaid Transformation Project Service Notice DSHS 15-492 are available on the DSHS forms page. If needing a language, not available on the DSHS forms page, please contact Adrienne Cotton and Resa Lee-Bell. Any translated version of the MTP Service Notice (15-492) document must be stored in the client's GetCare electronic file cabinet.

RACS

Recipient Aid Categories (RACs) identify to the ProviderOne system under which program (MAC, TSOA, or other) the dyad or individual without an unpaid family caregiver is going to receive services either through presumptive eligibility or fully confirmed eligibility. Additionally, ProviderOne has been configured to know which services can be authorized under which RAC. Selecting the correct functional RAC is important so that data extracted from ProviderOne accurately reflects service provision and providers are correctly paid. The functional RAC must match the financial RAC that is sent from ACES to ProviderOne or an error will occur.

The functional RACs, also known as HCLA RACs, indicate what program and related services the dyad or individual is eligible to receive. They are as follows:

RAC Title	RAC	RAC Description
Medicaid Alternative Care (MAC)	3170	Care receivers are Medicaid eligible
Medicaid Alternative Care : Presumptive Eligibility (Pre-MAC)	3171	Care receivers have time limited presumptive eligibility both financially and functionally
Tailored Supports for Older Adults (TSOA)	3175	Care receivers meet TSOA financial eligibility which allows for a higher income and resources than Medicaid
Tailored Supports for Older Adults: Presumptive Eligibility (Pre-TSOA)	3176	Care receivers have time limited presumptive eligibility both financially and functionally.
Tailored Supports for Older Adults No Unpaid Caregiver (TSOA-No-CGR)	3177	Care receiver does not have an unpaid caregiver, meets TSOA financial eligibility which allows for a higher income and resources than Medicaid.
Tailored Supports for Older Adults No Unpaid Caregiver: Presumptive Eligibility (Pre-TSOA-NO-CGR)	3178	Care receivers without an unpaid caregiver have time limited presumptive eligibility both financially and functionally.
Not Presumptively Eligible for MAC and TSOA (NOPE)	3190	Used when care receiver was: ○ initially enrolled as presumptively eligible for either MAC or TSOA; ○ received paid services; and ○ was later found to be ineligible. • Once found ineligible for MAC or TSOA this RAC must be added to mirror the PE RAC dates to reprocess claims into the correct funding bucket in order to comply with federal reporting requirements.
State Only Adjustment of Payment (SOAP)	3490	This RAC should be used minimally and requires HQ pre-approval. This RAC is used only when a payment for services was made in error (the care receiver was not eligible to receive the services) and the payment

		must be made using state-only funds. The claim must be reprocessed by ProviderOne.

AAA staff must open the MAC/TSOA Service Enrollments section in GetCare and change the care receiver's RACs when they change from presumptive eligibility to fully confirmed eligibility or when adding the NOPE.

Typical RAC Timeframes

TSOA enrollees may or may not have financial eligibility at the time of their Presumptive Eligibility screening. Presumptive Eligibility TSOA RACs will begin on the date of the locked functional PE screening and end on the last day of the following month with one exception – if the care receiver submits a TSOA financial application within the PE period, the care receiver remains presumptively eligible until the HCS financial worker determines full financial eligibility.

MAC and TSOA Presumptive Eligibility (PE) and a locked care plan must be completed prior to any services being authorized.

If the TSOA care receiver did not previously have financial eligibility, the worker must wait to hear from HCS financial worker about their financial eligibility determination before moving the individual from PE to full eligibility. In this case, the full functional eligibility date spans one year from the date that the PE assessment was confirmed by HCS worker and may extend to the end of the month. For example:

- PE assessment NFLOC confirmed 10/29/24.
- Full financial eligibility confirmed 11/17/24.
- Full eligibility RAC start date = 12/01/2024; end date = 10/31/25.
- NFLOC reassessment must be completed WITHIN one year of initial PE or in this case, before 10/31/25.

MAC enrollees must have financial eligibility at the time of their Presumptive Eligibility screening. This means that functional eligibility confirmation is the last step in determining full eligibility for MAC care receivers. Due to this, MAC care receivers often do not have a PE RACs or the MAC PE RACs coverage dates are minimal. Full MAC eligibility will begin on the date functional eligibility is confirmed by HCS and end on the last day of the month one year later. Financial eligibility will be determined on a different cycle therefore Barcode and ACES should be monitored to ensure continued financial eligibility.

Managing RACs, Enrollments and Service Authorizations When Care Receiver is in Hospital, Rehabilitation Facility or Jail

If the care receiver is in the hospital, rehabilitation facility or jail for 30 days or less, you must do the following:

- Leave the functional RAC in place and do not change start or end dates
- Leave the enrollment in place and do not change start or end dates

- Change the end date of the P1 service authorization service line to match the date of admission into the hospital/facility. Notify paid providers and have services put on hold.
- If less than 30 days, The AAA staff should evaluate if there are any changes in the care receiver service needs and if so, complete a change in condition assessment and care plan.
- If the stay becomes longer than 30 days but the intent is still to return home with MAC or TSOA services, The AAA staff would need to complete the NFLOC, updated screening and assessment as well as a change in condition care plan prior to services being re-instated.
- AAA staff must lock the change of condition care plan prior to authorizing additional services.
- Verify care receiver remains active in ACES and Barcode
- Once the care plan is locked, the AAA Staff can create a new P1 service authorization line (no earlier than the date of discharge).

No services can be authorized (including services and supports being provided to the unpaid family caregiver, while the client is hospitalized, in a rehabilitation facility or in jail.

If the care receiver is in the hospital/facility for 30 days or more. The AAA staff would need to check the MAC or TSOA care receivers' financial eligibility coverage and communicate with financial as needed to ensure the appropriate financial RAC is opened prior to re-establishing paid services. The AAA Staff would then need to complete the NFLOC, updated screening and assessment as well as a new care plan prior to services being re-instated.

Managing RACs, Enrollments and Service Authorizations when there will be a temporary pause in services

If the MAC or TSOA care receiver is requesting to temporarily pause services, for 90 days or less (example: will be out of the country but the care receiver's intent is to return and re-engage in services), you must do the following:

- Ensure the duration of the pause will not span over a functional or financial eligibility review due date. If so, proceed with a voluntary disenrollment. Leave the functional RAC in place and do not change start or end dates
- Leave the enrollment in place and do not change start or end dates
- Notify paid providers and then change the end date of the P1 service authorization lines to match the date client is departing or is requesting to pause services
- The AAA staff would need to do the annual NFLOC upon client's return to determine that the care receiver still meets NFLOC. An updated screening, assessment and care plan would also need to be completed.
- Verify care receiver remains active in ACES and Barcode
- Once the care plan is locked. The AAA Staff can create a new P1 service authorization.

If the MAC or TSOA care receiver is requesting to temporarily pause services for 90 days or more, you must do the following:

- Notify care receiver that AAA Staff will be completing a voluntary disenrollment.
- Provide instructions/contact #'s for client to call when wanting/needing services in the future

- Complete closure steps (See Checklist)

If the client would like to re-engage services after being disenrolled, The AAA Staff should start the re-enrollment process similar to a new enrollee. The AAA Staff and HCS MTP staff would need to complete the Presumptive Eligibility (PE) screening. If care receiver is determined NFLOC on the PE. AAA Staff should verify client still is open on the appropriate financial coverage group. If so, CM can proceed with completion of the screening, assessment and care plan. Upon completion of the necessary items per step level (see Step Chart), services can be re-instated. If the client's financial coverage group was closed, AAA CM should notify PBS and may need to assist with a new application depending on the circumstances (please use link to determine if a new LTSS app is needed). If the client has received PE services in the last 24 months; no services can be authorized until the full financial determination is made. If the client has not received PE services in the last 24 months; the AAA Staff may enter the appropriate PE RAC and establish services as outlined in the care plan under PE until the full financial determination is made.

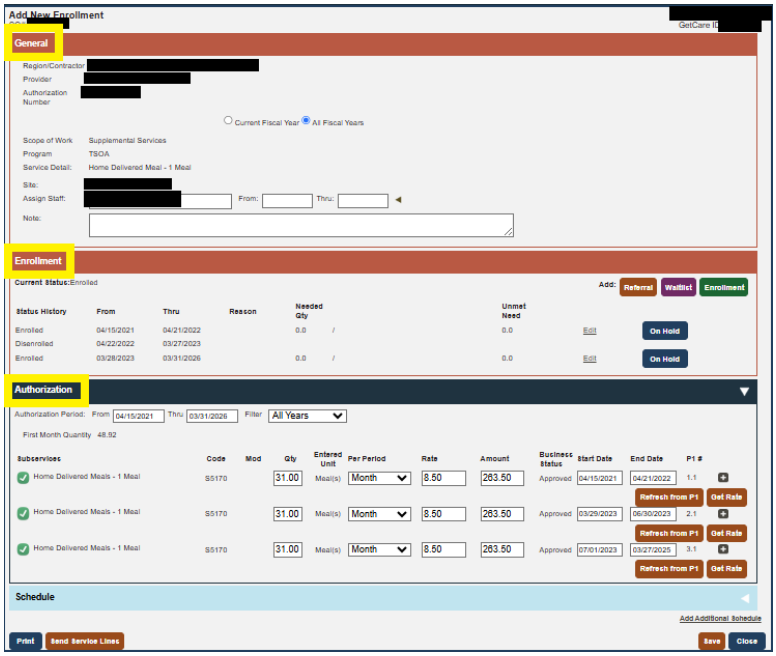
AUTHORIZATIONS

Authorizations for MAC and TSOA services will be completed by AAA staff through the GetCare system which interfaces with P1. Authorizations may be completed only after a P1 identification number has been obtained for the MAC or TSOA care receiver and the care plan has been completed and locked.

Prior to authorizing MAC or TSOA services, due to CMS rules, AAA staff must check for service coverage under Medicaid Apple Health, long-term care insurance, or other third parties such as private insurance. If the care receiver has LTC insurance, private insurance, Medicaid, Medicare or other federal/state programs that will cover the services requested under MAC or TSOA, then MAC or TSOA funds should not be authorized for those specific services. MAC or TSOA may be authorized for services that are not duplicative of services available under the other insurance benefit.

Note: Aid and attendant benefits through the Veterans Administration (this does not include Veterans Directed Care services) do not have an impact on the eligibility for MAC and TSOA services. The MAC or TSOA veteran can purchase additional in-home care services with their VA aid and attendant benefits, and it does not change the amount or type of services that can be purchased with MAC or TSOA funding. MTP should be the payor of last resort, by following that policy it prevents duplication and potential "stacking" or supplanting in services covered under private insurance, Medicare, state plan Medicaid, VAMC, or through other federal or state programs. Care receiver's cannot be enrolled in Veterans Directed Care while simultaneously enrolled in the MAC or TSOA programs.

Each authorization in GetCare has several elements: General, Enrollment, and the Authorization section. The General Section is where the Region, Provider, Authorization Number, Program, and details on the services are entered. The Enrollment section outlines the enrolled and disenrolled status of the care receiver. The Authorization section is where services are entered with corresponding service codes rates, business status, and dates.



Providers being authorized in ProviderOne to deliver MAC and TSOA services must meet certain qualifications and be contracted through the HCLA HQ or the local AAA prior to services being authorized. Each local AAA maintains a list of contracted, eligible providers for HCS and AAA.

As service lines are created in the authorization section, they are assigned a ProviderOne service line number and the ProviderOne systems confirms this is a service which can be covered under the services benefit package of the opened RAC. If a service is entered which is not configured with the appropriate RAC and error will occur.

Service authorizations created in GetCare for environmental modifications, Durable Medical Equipment (DME) and non-medical equipment and supplies should be entered in Reviewing status. Reviewing status allows the service line for these services to be submitted to ProviderOne, but not to be claimed or paid. After confirmation that the service is completed appropriately, the AAA staff can change the status of the authorization to "Approved" which will allow payment to be issued to the provider. A receipt in the GetCare Electronic File Cabinet (EFC) is also necessary.

More information on authorizations can be found in the GetCare MAC/TSOA Desk Manual in the Help Library.

Common Errors

Common errors refers to the process that occurs when ProviderOne does not recognize submitted information and stops the process of creating/modifying an authorization or allowing a claim to be made against an authorization. For MAC and TSOA, these stoppages will most commonly happen when an authorization header or a service line is submitted with information that conflicts with data that ProviderOne has already accepted. When such a stoppage occurs, ProviderOne will automatically

generate an error message letting the user know there is a problem. Each message is assigned a code by ProviderOne based upon the type of error that occurred. Below is a sample of common errors which occur in MAC and TSOA. For a more comprehensive list, please see the Get Care Help Library Common Issues and Error Codes, MTP Community Workspace, or the ProviderOne Social Services Appendix Common Errors Table.

MTP Related Error Codes in GetCare

GetCare users may see ProviderOne errors while working with authorizations for MAC & TSOA services. Here's a list of what the errors mean, what should be done, and by whom to resolve it.

Error	Error Description	Action Needed	By Whom
Address Errors Invalid	The care receiver's address is invalid	Review, correct, and complete steps to update ProviderOne	AAA Staff
AREP (authorized representative) Warnings	The collateral contact or caregiver with the role of "P1 Client Letters" has an invalid address	Review, correct, and complete steps to update ProviderOne	AAA Staff
02255	Client not eligible for date of service	No action needed; will resolve when full eligibility RAC is added	AAA Staff
30988	Financial Eligibility Requirement	Determine if error should be "forced" and if so, refer to HCLA HQ for action*	AAA Staff and HCLA HQ staff
40061	Unexpected error occurred, please contact system administrator (fatal error)	Review service lines to see if unresolved errors exist. If unable to determine source of the error, post error into Issue Manager entitled as "MTP authorization error" for review by AAA supervisor and escalation by local System Admin*	AAA Staff and System Admins / CARE Help Desk
40065	Proc/Svc Code service duration exceeds the maximum allowed duration limit (fatal error)	Review service limits on Service Code Data Sheet (SCDS) and modify, if necessary	AAA Staff

*The local system administrator will review the error with respective AAA staff and, if it is determined there is a valid issue, it will be posted to Issue Manager in GetCare. Escalated errors will be pulled by State System Administrator for review. Issues will be updated as to resolution, or the next steps needed for resolution. Issue Manager tickets once resolved should be closed by either the AAA staff or the system administrator.

More information related to ProviderOne common errors is available on the DSHS/ProviderOne website.

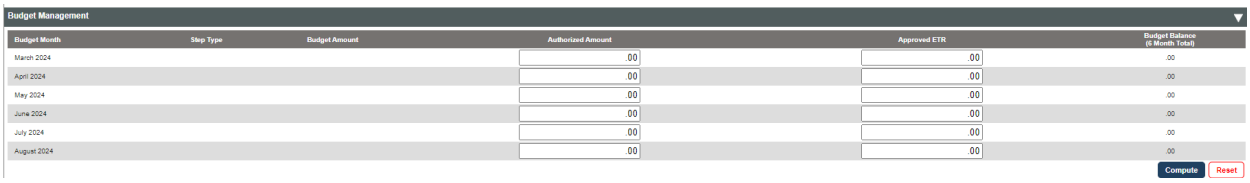
Tracking Benefit Expenditures

AAAs are responsible for tracking client expenditures to prevent over-expenditures based upon the step benefit levels identified in the table below:

Program	Step 1 Based on demographics & program eligibility; services may be received under PE	Step 2 Based on demographics, program eligibility, & results of a TCARE® or GetCare Screening; services may be received under PE	Step 3 Based on demographics, program eligibility, & results of a TCARE® or GetCare Assessment; services may be received under PE
MAC/TSOA Dyads	$250 one-time only	$500 annually minus any expenditures at Step 1	Avg. $844 monthly not to exceed $5064 in a six-month period*
TSOA Individual w/o CG	$250 one-time only	$500 annually minus any expenditures at Step 1	Avg. $844 monthly not to exceed $5064 in a six-month period*

*as of 7/1/2024. The Step 3 benefit level formula currently uses the home care agency hourly rate in it's calculation. Therefore, the Step 3 benefit level will change according to the rate determined by the rate setting board. Please see the "MAC-TSOA" tab on the HCS Rates website for the most current step 3 benefit level.

In the GetCare system, a budget management tool (calculator) is available to AAA staff to assist with managing the 6-month budget. It is located within the MAC/TSOA Service Enrollment section.



The 6-month budget period begins the month the PE assessment or annual NFLOC assessment is locked. Once the Initial or Annual care plan is locked, the 'Step Type', the related 'Budget Amounts' and 'Budget

Balance' will be automatically populate into the tool. Then as MTP services are authorized those will populate in the 'Authorized Amount' and will be subtracted from the 'Budget Balance'.

Authorizations for the Medicaid Unit Incentive (MUI), Pest Eradication, Specialized Deep Cleaning, and Nurse Delegation are funded by MTP's statewide aggregate funding and are not reflected in the 'Authorized Amount' or 'Budget Balance'.

Approved ETR amounts will populate into the 'Approved ETR' column and will calculate into the 'Budget Balance'.

PROVIDERS

In order to claim and be paid for services provided under MAC and TSOA programs, all providers, with the exception of Durable Medical Equipment (DME) providers, must have a DSHS signed contract, be registered or contracted in ACD (Agency Contracts Database), and be enrolled as a provider in ProviderOne. DME providers must have a core provider agreement with Health Care Authority (HCA) and be enrolled as a DME provider in ProviderOne.

All MAC and TSOA providers will be paid through the Health Care Authority's ProviderOne application, the Medicaid payment system.

When a service authorization is created and/or modified and sent to ProviderOne via GetCare, the provider will receive an Authorization Notice generated by ProviderOne. ProviderOne correspondence letters are sent when the following occur:

- A new authorization is created for a client/provider pair.
- An existing authorization service line is changed.
- A service line with a new service code is added.
- Adding or removing dates of service on a service line with an existing service code.
- Change in the amount of authorized units.
- Change in associated tasks.
- Change in the amount of client responsibility applied to the authorization service line.

Mailed ProviderOne correspondence will include the following:

- Names and ID's of provider and client
- Service Code, Modifier, Reason Code, Correspondence description
- Date ranges
- Number of units
- Dollar amount
- Client responsibility (Not applicable in the MAC and TSOA programs)
- Case worker name and phone number

A copy of the P1 Authorization Notice is also sent to the care receiver and for dyads to the unpaid family caregiver (ensure to select 'P1 Client letters' in the caregiver relationship role in GetCare). More information about ProviderOne correspondence can be found in the Social Services Authorization Manual.

Providers need to be added into GetCare with the appropriate ProviderOne number, Location Code and Service Sets. GetCare System Administrators should use Issue Manager in GetCare to request that new providers be entered once the provider has a signed contract in the ACD and been assigned a ProviderOne number.

In an effort in sustaining home care agency providers for MAC and TSOA programs, Community Partners in collaboration with HCLA created the Medicaid Utilization Incentive (MUI) rate (originally referred to as the "MTP Capital Add-On Rate"). The MUI service line should accompany a personal care or respite care service line and can be claimed by a home care agency who has provided at least 15 minutes of personal care or respite care services in that month of service. If two home care agencies are being utilized, both would be eligible for the MUI as long as at least 15 minutes of personal care or respite care was provided, in that month of service, by each home care agency. If only housework and errands is authorized, the provider is not eligible for the MUI.

Documents Sent to Providers

Below is a table illustrating the specific documents that should be sent by the AAA staff to the provider:

Program	Service	Document
MAC and TSOA dyad • Step 1 and 2 • Step 3	Respite	• For step 1 and 2 - NFLOC assessment and care plan • For step 3 - TCARE® Respite Services Provider Assessment. If temporarily receiving out of home respite in an adult family home or assisted living facility you must also send the Respite Care Provider Addendum (DSHS 13-915).
TSOA Individual w/o CG • Step 3	Personal Care	• GetCare TSOA w/o CG assessment
MAC and TSOA dyad; TSOA individual w/o CG • Step 1 and 2 • Step 3	Adult Day Care Adult Day Health	• For step 1 and 2 – NFLOC assessment and care plan • For step 3 –GetCare TSOA w/o CG assessment or TCARE® Respite Services Provider Assessment
MAC and TSOA dyad • Step 2 and 3 TSOA individual • Step 2 only	Bath aide	• Dyads – send the TCARE® Respite Services Provider Assessment. • TSOA individuals – send the TSOA Individual w/o CG assessment.
MAC and TSOA dyad • Step 1, 2 and 3 TSOA Individual w/o CG	Nurse delegation	• Dyads – send the TCARE® Respite Services Provider Assessment. • TSOA individuals - GetCare TSOA w/o CG assessment

		• Copy of consent form (14-012) • ND Referral and Communication form (DSHS 01-212)

CONTRACTS

The Area Agencies on Aging (AAAs) will maintain a provider network to support the services available to MAC and TSOA enrollees. The AAAs also maintain the provider network for Family Caregiver Support Program (FCSP), traditional Medicaid programs such as CFC, MPC and COPES, and other supportive programs for older adults. MAC & TSOA programs for some services have specific MAC & TSOA contracts (example: Caregiver and Client Support or Behavior Support Services – MTP: Counseling) while other services are provided under already executed contracts held at the AAA (examples may include Personal Emergency Response Systems, Home Delivered Meals, Home Care Agencies, and Community Transition or Sustainability Services contracts). Most of the Medicaid and MAC/TSOA providers will have DSHS contracts executed and monitored by the AAAs. *(Please see the Benefit Categories/Services section for additional information about network adequacy).* When unpaid/no cost services are included in the care plan, a provider contract is usually not required.

Contracts in support of MAC and TSOA programs may be available via one of the following methods:

- Statewide contract through HCLA HQ Contract unit
- Core Provider Agreement (CPA) with Health Care Authority (DME providers)
- AAA or DSHS existing contracts
- FCSP services contracts that have the necessary Medicaid language included and the contract has been registered in the Agency Contracts Database maintained by HCLA.

The contracts that are executed and maintained by the contracts unit in HCLA Headquarters are:

- Specialized Equipment and Supplies (SES)
- Nurse Delegation (ND)
- Assistive Technology (AT)
- Adult Family Home (AFH - Respite)
- Assisted Living Facilities (ALF - Respite)
- Nursing Facilities (Respite)

For more information about contracting and network adequacy requirements see MB H17-043.
Refer providers who want more information about contracting to be a service provider to HCLA internet website.

CHECKLIST FOR CLOSING A MAC OR TSOA CASE

When a care receiver no longer wants or needs to be enrolled in the MAC or TSOA program it is important to complete several tasks in order to officially close the case. Completion of the tasks is especially important if the care receiver is transitioning to another ALSTA program like CFC or

CFC+COPES as it may impact the ability of the receiving case manager to add the new program RAC and create service authorizations for the new program.

The tasks to be completed include the following:

- Send a 14-443 to financial informing the Public Benefits Specialist (PBS) of the program end date and reason for closing case (such as withdrawing from services, moving to another program, passed away, etc.),
- Send MTP Service Notice (DSHS 15-492) to care receiver to provide formal notice of program/service termination (allow at least 10 days' notice for adverse actions, MTP Service Notice is not needed if the client passed away, as financial sends the condolence notification),
- Notify providers and change the end date of all service authorizations to match effective date of the MTP Service Notice or last date of service, if earlier
- Change the end date of the enrollment to match effective date of the MTP Service Notice (or date of death, when applicable)
- Change the end date of the functional RAC to reflect the last day of enrollment on the program
- Enter a progress note in CLC/ GetCare indicating reason for case closing

EXCEPTIONS TO RULE/POLICY

Before authorizing any exceptions to rule (ETR) or exceptions to policy (ETP), you must receive local or headquarters (HQ) approval, depending on the type of request. An ETR request means you are asking to make an exception to a rule (WAC). An ETP request means you are asking to make an exception to policy published in the LTC Manual or a management bulletin (MB).

CMS approved 1115 Waiver Policy and Procedures cannot be overridden with an ETP.

ETRs that require local approval include:

- Exceeding Step 2 benefit level of $500/annually up to $1,000
- A caregiver or TSOA individual who is in crisis and needs to be served with step 2 or 3 services without first completing a screening or assessment. A care plan must be completed prior to receiving services. The screening and/or assessment must be completed within 30 days if ongoing services are needed.
- Request for respite services in the rare instance when a dyad asks for respite services and the TCARE® assessment does not result in a recommendation for this service.
- When excess of 2 home delivered meals per day for the caregiver or care receiver is being requested (Excess of 62 meals per month for the caregiver or 62 meals per month for the care receiver is being requested).
- Exceeding Step 3 benefit level allowed in a six-month period for MAC and TSOA dyads
- For TSOA without a caregiver, when the six-month benefit level will be exceeded due to home delivered meals, PERS service (PERS service (install, monthly fee, and add-on features such as fall

detector, medication reminders, etc.), and requests to purchase Durable Medical Equipment (DME) and care supplies when the ETR request is $500 or less.

- Allowing Step 3 services when the assessment is only showing eligibility for Step 2 services.
- Annually, if a TSOA individual care receiver is also identified as an unpaid family caregiver for another MAC/TSOA care receiver.
- Exceeding $2,500 for Pest Eradication and Specialized Deep Cleaning.

NOTE:
ETRs may not be used to exceed the Step 1 benefit level of $250.

ETRs that require HCS HQ approval are:

- Exceeding Step 2 benefit level greater than $1,000
- For TSOA without a caregiver, exceeding Step 3 benefit level allowed in a six-month period for any items not outlined in the local ETR process.
- DME/Bathroom equipment for care receivers who have Medicaid Apple Health or Medicare benefits that may also cover the requested piece of bathroom equipment. See MB H24-067 for more details, tools and instructions.
- Home modifications and repairs exceeding $500 or when the modification or repairs will cause the MAC/TSOA dyad or TSOA individual to exceed their 6-month benefit level.
- Exception to Policy requests, if not specified under local approval.
- Community Choice Guiding Services – If costs will exceed Step 3 benefit level OR if initial 160 units/40 hours for first 3 months was not sufficient and additional 160 units/40 hours for additional 3 months is needed.

ETR Process

All ETR requests and approvals/denials for MAC and TSOA should be completed in the ETR/ETP section of GetCare.

Both local and ATLSA HQ ETR and ETP requests must include the following details:

1. Request description
    a. What item/service is being requested
    b. Justification for request
    c. Alternatives explored before considering ETR request
    d. Cost of the request (e.g., hours, dollars, quantity, etc.)
2. Start and end date of request
3. WAC # or policy to which the exception applies

Complete the Medicaid Transformation Project Notice of Action Exception to Rule DSHS form #05-255 in GetCare and save letter (the 'Save Letter' option will automatically save the document to the care

receivers GetCare Electronic File Cabinet). Then send to the care receiver informing them of the decision.

Detailed instructions for using the ETR/ETP functionality in GetCare can be found in the GetCare Desk Manual located in the GetCare Help Library.

Complaint Procedure for denial of initial ETRs

Initial ETRs do not have administrative hearing rights. However, care receivers do have the right to make a complaint to the Department. For complaints related to initial ETR decisions made by AAA at the field level, follow your AAA Grievance Policy.

Complaints related to initial ETR decisions made by HCS Headquarters will be reviewed as follows:

1. The care receiver may make a complaint in writing to the HCS or State Unit on Aging (SUA) Office Chief. The Office Chief will make a decision about the written complaint within ten days of the date it was received and send a letter informing the client of the decision and that the decision may be reviewed by the HCS Director at the client's request.
2. If the client makes a written request asking the HCS Director to review the Office Chief's decision, the Director will make a decision about the complaint within ten days of the date it was received and send a letter informing the client of the final decision.

When responding to a complaint it is important to address, at a minimum, the specific concern perceived by the client and explain how all of the pieces of information were reviewed (e.g. screening, assessment, any additional information provided in the complaint, or information from other relevant sources) in order to make a decision. The AAA staff may want to discuss the care plan with the care receiver in order to identify service gaps that may be addressed using other available resources.

COLLABORATION WITH ADULT PROTECTIVE SERVICES (APS)

AAA/MTP staff are considered Mandated Reporters of abuse, abandonment, neglect, and financial exploitation of vulnerable adults.

If information is reported to the AAA staff about a care receiver or other vulnerable adult and the person providing the information to the AAA staff indicates they have already made a report to APS, the AAA staff may consider the following to determine if they too, should make a report to APS:

- An additional report by the AAA staff is not required if verified that the report was made. This must be done by asking the reporter for a reporting confirmation or intake number or contacting APS to verify a report was made. These steps must be documented in the GetCare progress notes.
- A mandatory reporter takes a personal risk and a risk to the agency they work for if they choose not to make a report to APS and there is a negative outcome for the vulnerable adult that was not reported to APS.
- See Adult Protective Services policy and procedure and Chapter 74.34 RCW for detailed information about mandated reporting, including consequences of failure to report.

All APS and RCS information is subject to confidentiality laws:

- Do not disclose the existence of an APS or RCS report or investigation to anyone,
- APS documents should not be placed in the ECR,
- Contact your public disclosure coordinator when:
  - You receive a request for records or information about an APS or RCS report or investigation. Do not acknowledge the existence of an investigation.
  - Your client requests to review his/her services record that contains documented APS or RCS activity. All APS and RCS related information must be redacted.

After receiving the intake notice, AAA staff should go to the APS/RCS ribbon in GetCare and do the following:

- Review the intake details,
- Do not divulge this information to anyone,
- Collaborate with the APS or RCS investigator, if contacted,
- Allow the investigator to complete his/her work before contacting the client, unpaid caregiver or anyone else unless directed to do so by the investigator,
- Document all communications and coordination activities in a progress note.
  - Use the following criteria when documenting:
    - ✓ Keep all progress notes pertinent and succinct.
    - ✓ Do not cut and paste emails or documents involving APS or RCS information (e.g., an APS outcome notice) into the progress note.
    - ✓ Summarize activities and communications in a progress note and document if you placed a printed email or document in the electronic file cabinet (e.g., "Received email from [name of person] on this date. See electronic file cabinet.").

The APS or RCS investigator will contact the AAA staff if more information is needed during the investigation or if action is needed by the AAA staff during the investigation.

Refer to APS section on the HCLA intranet site for more information.

DSHS FORMS AND NOTICES

The forms and notices below will be used for dyads and individuals enrolled in the MAC and TSOA programs.

All of these forms will be utilized by the AAA MTP staff. These forms can be accessed on the DSHS Internet forms site. Forms must be sent to care receivers in their primary language.

AAA staff will be able to complete the rest of the details in the form and save it in the care receiver's Electronic File Cabinet in GetCare. The case worker will then print the form/notice and provide it to the care receiver and obtain their signature (note that not all of the forms/notices require a signature).

As forms are submitted into the Electronic Filing Cabinet, the newest (most recent) submitted form supersedes any previously submitted versions. Therefore, it is important to ensure that all documents submitted to the Electronic Filing Cabinet are completed appropriately.

TYPE	DSHS form #	PROGRAM	PURPOSE
Acknowledgement of Services	14-225	MAC	To document care receiver's choice to receive MAC services in the community rather than in a nursing facility. A signed copy must be scanned into the care receiver's electronic file cabinet in GetCare upon initial enrollment, when disenrolled and then returning to the MAC program, or at the next annual NFLOC assessment following a form revision
DSHS Notice of Privacy Practices for Client Medical Information	03-387	MAC & TSOA	To notify clients of their Health Insurance Portability and Accountability Act (HIPAA) privacy rights. Form must be distributed to both care receivers and the unpaid family caregiver, if part of a dyad, upon initially enrolling in the MAC and TSOA programs. Upon providing the form to the care receiver and the unpaid family caregiver (if applicable), a Progress Note should be entered stating the form was provided. There is no signature requirement so the form does not need to be placed in the Electronic Filing Cabinet (EFC).
Medicaid Transformation Project Notice of Action Exception to Rule (ETR)	05-255	MAC & TSOA	To provide notification to the care receiver of an ETR approval/denial or notice that request for ETR was not initiated. This form should be used for initial ETR requests or when the request does not **immediately precede** a current ETR.

			A completed copy of form must be scanned into the care receiver's electronic file cabinet in GetCare.
Consent	14-012	MAC & TSOA	To obtain consent from care receiver and caregiver to gather & share information for care planning purposes (Note: a separate consent form must be signed by the caregiver and by the care receiver.) A copy signed by the CR must be scanned into the care receiver's electronic file cabinet in GetCare. This form is valid for a maximum of one year and should be completed annually. A copy signed by the CG must be scanned into the caregiver's electronic file cabinet in GetCare.
Your Rights & Responsibilities when You Receive MAC or TSOA Services Offered by ALTSA	16-247	MAC & TSOA	To inform care receiver of their rights and responsibilities when receiving services from HCLA/AAA. A signed copy must be scanned into the care receiver's electronic file cabinet in GetCare. This form should be completed upon initial enrollment, when disenrolled and then returning to the MAC program, or at the next annual NFLOC assessment following a form revision.
Medicaid Transformation Project Service Notice	15-492	MAC & TSOA	To inform care receiver of: • actions (approval, denial, reduction, and termination) taken regarding their services; which includes decisions made on ETR extension requests that **immediately precedes** the current ETR and • Administrative Hearing rights

			A copy must be scanned into the care receiver's electronic file cabinet in GetCare. NOTE: You do not need to send a 15-492 when a client passes away. ACES/PBS sends out a condolence letter that includes termination of service language. AAA staff should send a 14-443 to financial when they become aware of a MAC or TSOA care receiver's death.
MTP TCARE® Information for Respite Care Service Providers	N/A	MAC & TSOA dyads	To provide necessary information about the care receiver's needs while receiving respite services.
Information for Respite Care Services Providers: Addendum to TCARE® Assessment (ALTSA)	13-915	MAC & TSOA dyads	To provide additional information, required by the facility's license, about the care receiver's needs during their respite stay in an adult family home or assisted living facility A completed copy of form must be scanned into the care receiver's electronic file cabinet in GetCare.
Housing Modification Property Release Agreement	27-147	MAC & TSOA	Must be completed for modifications to the residence of individuals enrolled in an Home and Community Living Administration (HCLA) program, including the installation of necessary equipment, that directly affects the interior or exterior of the dwelling.
Notice and Consent of Communication via Text or Unencrypted Email	27-156	MAC & TSOA	Have the care receiver and/or caregiver, when applicable, sign when they indicate they would like to receive communication by text messaging or via unencrypted email. Place signed copy in the care receiver's electronic file cabinet in GetCare.
Voter Registration (ABVR) forms	ABVR	MAC & TSOA	At least annually, during in-person visits, or when a change in address occurs. Continue to ask the care receiver if they would like to register to vote and if they need assistance

			with filling out the form. Use Agency Based Voter Registration (ABVR) forms and complete the voter registration section in GetCare.

The top eight languages available besides English are:

- Spanish
- Korean
- Somali
- Russian
- Laotian
- Cambodian
- Chinese
- Vietnamese

Instructions: Saving Documents and Forms to the GetCare Electronic File Cabinet.
To scan and send a document or form to the electronic file cabinet in GetCare:

- Scan signed document
- Email scanned document to AAA staff or other worker's email address
- Save email as title of document, name of client – follow internal security policy for PHI
- Open client record in GetCare
- Open electronic file cabinet in client's file
- Select "Browse"
- Select "Add attachment"
- Find the location of the file you saved
- Select appropriate file
- Select "Open"
- In GetCare, see the add attachment pop up and select "Save".

If care receivers do not return documents such as the Consent and Rights & Responsibilities form, this is not cause for terminating the client from the program. The AAA staff should use person-centered strategies to encourage the return of the signature and document their efforts in a Progress Notes. Documenting these efforts is an important component related to the Quality Assurance and CMS signature requirement if the signed document is never returned.

When the care receiver doesn't return the signed Consent form, services should continue but there may be certain entities to whom we cannot share information. However, the "covered entities" that are most important are typically covered under HIPAA and a signature is not required.

ADMINISTRATIVE HEARING (AKA FAIR HEARINGS)

Care receivers have the right to an administrative hearing when the department (HCS/AAA):

a. Sends a notice that approves, denies, reduces, or terminates a service or eligibility (at least 10 calendar days before the effective date of the action);
b. Determines a client received more benefit than they were eligible for and an overpayment was issued;

c. Reduces or terminates an ongoing service such as respite or in-home personal care that was initially approved through an ETR; and
d. Denies or terminates financial eligibility (Note: these hearings are facilitated by HCS financial staff).

Requesting an Administrative Hearing

Hearing requests must be made within a specific timeframe. The care receiver must request a hearing (aka as an appeal) to Office of Administrative Hearings (OAH) within 90 days of the date the service notice was received.

A care receiver or their representative may request a hearing in any of the following ways:

a. Verbal request. Department staff or their designee must notify OAH of any verbal request from the client, preferably in writing.

b. Written request (of any kind). Department staff or their designee must notify OAH of any written request that doesn't go directly to OAH.

c. The Request for Hearing form that accompanies every Service Notice (15-492). This form can be completed by the care receiver and mailed or faxed to OAH. The care receiver may also ask department staff or their designee to help them complete and submit the hearing request to OAH.

Administrative hearings related to financial eligibility decisions (full eligibility not PE) are handled by the financial staff.

Hearings related to decisions for services and functional eligibility (full eligibility not PE) are handled by AAA staff. Each AAA will designate who completes this work.

For more details about administrative hearings (AH), the AH process, and roles of the AAA staff/case manager and AH coordinator see Ch. 26 of the LTC Manual.

WAIT LIST

The state has client numbers and expenditure limits for each year of the 1115 demonstration waiver. It is possible that a wait list will be required if it appears that the limit will be reached. The renewal waiver, also deemed as MTP 2.0, has been approved from July 1, 2023 to June 30, 2028.

In the event that a wait list is implemented, the MAC and TSOA programs will stop conducting presumptive eligibility (PE) determinations. Dyads or individuals receiving services under presumptive eligibility established prior to implementation of the wait list will be able to continue receiving services until their PE period ends or their final eligibility determination is completed whichever comes first.

If additional funds become available, dyads or individuals may be removed from the wait list on a first come, first served basis.

During the time a wait list is in place, dyads or individuals should be referred to other options such as FCSP, local community resources, or other Medicaid long-term care services (CFC, MPC, New Freedom, Residential Support Waiver, COPES, etc.).

CONFLICT FREE CASE MANAGEMENT

Background

Federal requirements for the Community First Choice program, COPES, New Freedom, Residential Supports Waiver, and the Medicaid Transformation Project require Home and Community Living Administration (HCLA) to ensure that conflict of interest safeguards are in place for all Medicaid participants. These safeguards outline provider qualifications, require a strategy for solving conflict and outline clear conflict-of-interest guidelines per Washington State MTP, Special Terms and Condition (STC) #52. Conflict of Interest, § 42 CFR 441.301(c)(1)(v)(vi), § 42 CFR 441.730, and § 441.555 (c).

In some areas of the state, it is challenging for HCLA and Area Agencies on Aging (AAA) to recruit and enroll providers of evidence-based services or other services with a low demand such as support groups. This can be especially true when looking for culturally or linguistically appropriate providers or when serving a minute population spread across a vast frontier area or tribal reservation. Yet often these are the exact services that a participant needs and desires at the time they are assessed.

HCLA and the AAAs are committed to providing needed services at the time and location that is right for the participant. Both entities acknowledge there may be occasions when safeguards are needed to protect participants from conflict of interest. This policy details the safeguards that must be in place when an AAA provides assessment and/or service planning and is the only qualified and willing entity available to be authorized to provide a home and community-based service.

Area Agency on Aging Requirements

AAA's must attest (see attached sample attestation form below) that they will adhere to the following conflict of interest policies:

1. The AAA will ensure that participants:
    a. As part of the assessment and authorization process, receive information about the full range of services available to the participant and not just the service furnished by the AAA; and
    b. Are supported in exercising their right to free choice of providers; and
    c. Are informed of their opportunity to identify other qualified and willing providers available in the participant's geographic area to provide the service.

2. The AAA's grievance resolution process must refer the participant to DSHS if they wish to dispute the assertion that there is not another qualified and willing entity available in the participant's geographic area to provide the service.
3. Where the AAA attests it is the only willing and qualified provider, the AAA must request HCLA approval prior to authorizing service provision by an AAA employee. The approval shall be in effect as long as these policies are followed and until an alternative provider is identified. HCLA will verify AAA is the only willing and qualified provider by:
    a. Reviewing the AAA provider recruitment efforts and results annually; and
    b. Confirming there is no available contracted provider in the State's contract database, ACD.
4. The development of the service plan is administratively separated, from the provision of authorized services. With the functions ideally accomplished by separate units.
5. Where service provision and/or assessment and service planning functions are provided by the same AAA employee because the only available qualified provider of the service is also the AAA staff/case manager who assists the client with service planning, supervision must be provided separately from the assessment and/or service planning functions. For this purpose, supervision means verifying that the requirements of this Conflict-of-Interest policy are being met as services are being delivered and that authorization levels are consistent with what is typical for the service.
6. That the AAA staff will remain unbiased and impartial during the development of the person-centered service plan.
7. That the AAA will include the service in its process for continuous recruitment and open enrollment of qualified providers required by Chapter 6 of the AAA policy and procedures manual.
8. That the AAA staff training includes these policies prior to providing services along with training on confidentiality, ethics and grievance procedures.

Home and Community Living Administration Requirements

HCLA will provide oversight and monitoring of the conflict-of-interest safeguards for Medicaid participants when service provision and service planning are provided by the same AAA employee. The results of the activities will be reported to the State Medicaid Agency at the quarterly waiver management committee meeting. Monitoring and oversight activities will include an annual review of:

1. AAA compliance with these policies and adherence to the AAA attestation.
2. AAA efforts to enroll service providers.
3. A comparison of service utilization patterns where the AAA is the direct provider with utilization that is typical for comparable services provided by contracted providers.

4. A comparison of rates paid to the AAA with rates paid to contracted vendors for comparable services.



Conflict of interest attestation form.doc›

QUALITY ASSURANCE

As part of the special terms and conditions with the 1115 demonstration waiver, the state developed a Quality Improvement System (QIS) which includes:

a. Performance measurement and reporting in accordance with the quality reporting and review standards outlined in Modifications to Quality Measures and Reporting in 1915(c) Home and Community-Based Waivers guidance issued March 12, 2014, and reporting timelines outlined in Revised Interim Procedural Guidance issued February 6, 2007.

   Performance measures should address the following areas:

   i. Identification of needs and goals, and access to services (Level of Care/Functional assessment and Person-Centered Plan of Care at least annually);
   ii. Services are delivered in accordance with the Person-Centered Plan of Care
   iii. Providers meet required qualifications;
   iv. Settings meet the home and community-based setting requirements for those services that could be authorized under 1915(c) and 1915(i);
   v. Number of substantiated incidents of neglect, exploitation or abuse and average time to resolution;
   vi. The State Medicaid Agency (SMA) retains authority and responsibility for program operations and oversight; and
   vii. Washington State Medicaid Transformation Project 2.0 Section 1115(a) Demonstration Approval Period: July 1, 2023 through June 30, 2028 Page 45 of 154 vii. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1115 participants by qualified providers.

b. Ongoing quarterly/annual reporting that includes:

   i. Number of LTSS beneficiaries broken out by program (MAC and TSOA);
   ii. Number of new MAC and TSOA person-centered service plans;
   iii. Percent of MAC and TSOA level of care re-assessments annually; and
   iv. Number of people self-directing services under employer authority.

All MAC and TSOA AAA staff are eligible for a Quality Assurance review, regardless of length of employment. The HCLASocial Service Quality Assurance unit will complete statewide monitoring using a statistically valid sample size when pulling cases for review.

During the annual Quality Assurance review, PSA's should complete the following:

i. Review any completed Initial Process Review and make corrections indicated for specific questions and their associated "no" responses.
ii. Correct the items identified in the Initial Process Review within 30-calendar days.
Note: AAA/HCS social service staff must lock any care plans and/or return any scanned copies of corrected documents required by the deadline to the HCLA QA Lead. Original documents should still be sent to the Electronic File Cabinet.
iii. Correct items identified in the 30-day review by the 60-day due date.
iv. Any questions that did not meet or exceed the proficiency standard at the Initial Process Review and are not already being addressed in the HQ Proficiency Improvement Plan (PIP), will need to be included in each area's PIP.
v. E-mail PIPs, based on Initial Process Review findings, to headquarters within 30 calendar days of receiving the area Final Report.

RESOURCES

Related LTC Chapters

Chapter 3	Assessment and Care Planning
Chapter 4	Social Service Intake
Chapter 5	Case Management Chapter - Challenging Cases Protocol
Chapter 11	Consumer Directed Employer
Chapter 12	Adult Day Services
Chapter 13	Nurse Delegation
Chapter 15A	Communicating with Individuals with LEP & SD, Guidance for AAA Staff
Chapter 15B	Communicating with Individuals with LEP & SD Guidance for HCLA and DDA Staff
Chapter 20	Transportation
Chapter 23	Quality Assurance and Improvement
Chapter 26	Administrative Hearings
Chapter 28	Medicaid Fraud
Chapter 30A	Intro to Medicaid Transformation Project

Related WACs

Functional WAC 388-106- 1900 thru 1990
Financial WAC – MAC 182-513-1600 and 1605, and 182-513-1660
Financial WAC – TSOA 182-513-1610 thru 1655, and 182-513-1660

Acronyms

AAA	Area Agency on Aging
ABP	Alternative Benefit Plan
ACD	Agency Contracts Database
ACES	Automated Client Eligibility System
ADLs	Activities of Daily Living
AFH	Adult Family Home
AH	Administrative Hearing
ALF	Assisted Living Facilities
ALTSA	Aging and Long-Term Support Administration (Being replaced by HCLA)
APS	Adult Protective Services
AREP	Authorized Representative
AT	Assistive Technology
CARE	Comprehensive Assessment Reporting and Evaluation
CDSME	Chronic Disease Self-Management Education
CFC	Community First Choice
CG	Caregiver
CLC	Community Living Connections
CM	Case Manager
CMS	Centers for Medicare and Medicaid Services
CN	Categorically Needy
COPES	Community Options Program Entry System
CPA	Core Provider Agreement
CR	Care Receiver
CS	Community Spouse
DME	Durable Medical Equipment
ECR	Electronic Case Record
EFC	Electronic Filing Cabinet
ER	Eligibility Review
ETP	Exception to the Policy
ETR	Exception to the Rule
FBR	Federal Benefit Rate
FCSP	Family Caregiver Support Program
GPS	Global Positioning System

HCA	Health Care Authority
HCLA	Home and Communitly Living (Replacing ALTSA)
HCS	Home and Community Services
HDM	Home Delivered Meals
HQ	Headquarters
IADLs	Instrumental Activities of Daily Living
ID	Identification
IP	Individual Provider
LTC	Long Term Care
LTSS	Long Term Services and Supports
MAC	Medicaid Alternative Care
MMIS	Medicaid Management Information System
MN	Medically Needy
MPC	Medicaid Personal Care
MSP	Medicare Savings Program
MTP	Medicaid Transformation Project
MUI	Medicaid Unit Incentive
ND	Nurse Delegation
NFLOC	Nursing Facility Level of CARE
NOPE	Not Presumptively Eligible for MAC and TSOA
OAH	Office of Administrative Hearings
P1	ProviderOne
PBS	Public Benefits Specialist
PE	Presumptive Eligibility
PERS	Personal Emergency Response Systems
PSA	Planning Service Area
RAC	Recipient Aid Category
RCS	Residential Care Services
RCW	Revised Code of Washington
RDAD	Reducing Disability in Alzheimer's Disease
RU	Reporting Unit
SCDS	Service Code Data Sheet
SES	Specialized Equipment and Supplies
SIPC	Spousal Impoverishment Protections Community
SOAP	State Only Adjustment of Payment
SSI	Supplemental Security Income
SSN	Social Security Number
STCs	Special Terms and Conditions
SUA	State Unit on Aging
TIVA2	Tracking Incidents of Vulnerable Adults
TSOA	Tailored Supports for Older Adults
WAC	Washington Administrative Code

WHO Warm Hand Off

Outreach & Marketing Materials

MAC & TSOA Brochure
Publications, rack cards, poster

Other

For AAA Staff/MTP Case managers

HCLA Intranet – HCS Medicaid Transformation Project
ProviderOne Social Services Authorization Manual for case managers
Service Code Data Sheets (SCDS) for ProviderOne authorizations
Health Care Authority – MTP Website
TCARE® – Caregiver Assessment and Planning

For Care receivers and Caregivers

HCLA Internet – Caregiver Resources

For Potential Providers/Contractors

HCLA internet – Potential Service Providers

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
12/2019	Debbie Johnson	1. Moved to new template 2. Incorporated QA section 3. Updated content 4. Added policy decisions from 2017 & 2018 MBs 5. Added policy info from Community WorkSpace 6. Modified policy related to sending DSHS 15-492 to	H19-0xx

		GetCare electronic file cabinet rather than DMS	
4/2025	Resa Lee-Bell	1. Added policy decision from 2019-2024 MBs 2. Added policy info from Community WorkSpace 3. Added policy info from GetCare Help Library 4. Incorporated language from June 2023 CMS Approval/STC's 5. Added Acronyms 6. Style Formatting Update	H24-009 H23-093 H23-091 H23-057 H23-029 H21-079 H21-012 H20-033 H19-053 H19-049 H19-020
4/2026	Resa Lee-Bell	1. Replaced references to ALTSA with HCLA. 2. Added updated form and policy clarification. 3. Added more related chapters. 4. Added general policy clarifications.	H25-056