## Residential Services

***Ask the Expert***

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

**Emily Watts** Assisted Living Facility Policy Program Manager

Emily.Watts1@dshs.wa.gov

Anna Cavanaugh Adult Family Home Policy Program Manager

 Anna.Cavanaugh@dshs.wa.gov

If you have questions or need clarification regarding authorization for bed holds, please contact:

**Jacquelyn Pinkerton**  Payment Policy and Systems Unit Manager

 Jacquelyn.Pinkerton@dshs.wa.gov

If you have questions or need clarification on Enhanced Services Facilities, please contact:

**JD Selby** Residential Support Waiver Program Manager

 James.Selby@dshs.wa.gov

Table of Contents

[Residential Services 1](#_Toc141347314)

[Licensing requirements for Residential Services 3](#_Toc141347315)

[Adult Family Home (AFH) 3](#_Toc141347316)

[Assisted Living Facilities (ALF): 3](#_Toc141347317)

[Enhanced Services Facilities (ESF): 3](#_Toc141347318)

[Contracts 3](#_Toc141347319)

[Contract Types 3](#_Toc141347320)

[Contract Requirements 5](#_Toc141347321)

[Facility requests to voluntarily withdraw a Medicaid contract 5](#_Toc141347322)

[Change of Ownership (CHOW) 5](#_Toc141347323)

[Expired Contracts 6](#_Toc141347324)

[Medicaid Contract Requirements in Residential Facilities 7](#_Toc141347325)

[Nursing Services Available in Each Licensed/Contracted Residential Setting 9](#_Toc141347326)

[Community Integration 11](#_Toc141347327)

[Determining program eligibility for residential setting 12](#_Toc141347329)

[SDCP Eligibility Criteria 13](#_Toc141347330)

Specialized Dementia Care Program Authorization 13

[Prior to referring a client to the Specialized Dementia Care Program 13](#_Toc141347345)

[Community Integration Eligibility Criteria in AFHs: 13](#_Toc141347331)

[Community Integration Reimbursement 15](#_Toc141347335)

[Community Integration Mileage Reimbursement 16](#_Toc141347336)

[Authorizing Services in Residential Setting 14](#_Toc141347333)

[Authorizing/Determining the payment rate for residential services 14](#_Toc141347334)

[Medical Mileage Reimbursement 17](#_Toc141347337)

[Medical Escort Fee 17](#_Toc141347338)

[Determining a client’s room and board, and client responsibility towards the cost of their personal care. 21](#_Toc141347341)

[Supplementing the Medicaid rate 21](#_Toc141347342)

[Case Managers/Social Service Specialists Responsibilities 23](#_Toc141347343)

[Assisting a client to move into a residential setting 24](#_Toc141347344)

[Assisting with community integration in AFHs 28](#_Toc141347346)

[Assisting client with relocation 29](#_Toc141347347)

[Monitoring changes in the client’s condition/significant change 32](#_Toc141347348)

[Reviewing the Negotiated Service Agreement/Negotiated Care Plan 33](#_Toc141347349)

[Client Rights 35](#_Toc141347350)

[Client Rights in HCBS Settings 36](#_Toc141347351)

[Documenting modifications to Client Rights: 36](#_Toc141347352)

[Exception to Rule 38](#_Toc141347353)

[Resident Choice Regarding ALF Room Exemptions 38](#_Toc141347354)

[Bed Hold for Medical Leave 40](#_Toc141347355)

[Authorizing Bed Holds 41](#_Toc141347356)

[What is the payment for Bed Hold? 42](#_Toc141347357)

[Summary on Bed Hold Policy: 43](#_Toc141347358)

[Social Leave 44](#_Toc141347359)

[Resources 48](#_Toc141347360)

[Revision History 49](#_Toc141347361)

[Appendix 50](#_Toc141347362)

[SDCP Guidelines 50](#_Toc141347363)

[Meaningful Day Checklist (link) 50](#_Toc141347364)

[AFH Providers FAQs about community integration 50](#_Toc141347365)

## Licensing requirements for Residential Services

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

The Residential Care Services Division (RCS) of Aging and Long Term Support Administration (ALTSA) is responsible for licensing and monitoring all Adult Family Homes, Assisted Living Facilities, and Enhanced Services Facilities in Washington State.

### Adult Family Home (AFH)

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

Adult Family Home may also be designated as a specialty home (on their AFH license) in one or more of the following three categories: Developmental Disability, Mental Illness, and Dementia when they meet all certification and training requirements. See [Chapter 388-76 WAC](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-76) for more information on Adult Family Home licensing requirements and [Chapter 388-112A](http://apps.leg.wa.gov/wac/default.aspx?cite=388-112A) for residential training requirements.

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

### Assisted Living Facilities (ALF)

A facility, for seven or more residents, with the express purpose of providing housing, basic services (assistance with personal care and room and board) and assumes the general responsibility for safety and well-being of the resident. See [Chapter 388-78A WAC](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-78A) for more information on Assisted Living Facility licensing requirements.

### Enhanced Services Facilities (ESF)

An Enhanced Services Facility provides 24-hour personal care and behavior support services to a maximum of sixteen residents who have complex personal and behavioral care needs that exceed the capacity of other residential settings. See Chapter [388-107 WAC](http://apps.leg.wa.gov/wac/default.aspx?cite=388-107) for more licensing requirements. For additional information on ESF please see [Chapter 7f](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.dshs.wa.gov%2Fsites%2Fdefault%2Ffiles%2FALTSA%2Fhcs%2Fdocuments%2FLTCManual%2FChapter%25207f.docx&wdOrigin=BROWSELINK) for information.

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

## Contracts

### Contract Types

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

The **Assisted Living Facility** (ALF) contract requirements are outlined in [Chapter 388-110 WAC](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-110). There are three types of assisted living contracts:

* [Adult Residential Care (ARC)](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-110-240)
* [Enhanced Adult Residential Care (EARC)](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-110-220)
* [Assisted Living Services (AL)](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-110-140)

There are three Assisted Living Subcontracts:

* [Enhanced Adult Residential Care - Specialized Dementia Care:](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-110-220)

EARC-SDC contracts are available only to Assisted Living Facilities with a designated separate dementia care unit and ALFs dedicated solely to the care of individuals with dementia that have been approved by ALTSA to deliver SDCP services.

The Specialized Dementia Care Program (SDCP) is based on Standards of Care specified in [WAC 388-110-220](http://apps.leg.wa.gov/wac/default.aspx?cite=388-110-220) (3). DSHS contracts with licensed and qualified assisted living providers throughout all regions in the State to provide Specialized Dementia Care Program in Assisted Living Facilities. Services are provided in:

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

For more information on the Specialized Dementia Care Program in EARC-SDC/ALF, go online to: <http://adsaweb.dshs.wa.gov/hcs/SDCP/>.

* Expanded Community Services (ECS) - see [Chapter 7f](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.dshs.wa.gov%2Fsites%2Fdefault%2Ffiles%2FALTSA%2Fhcs%2Fdocuments%2FLTCManual%2FChapter%25207f.docx&wdOrigin=BROWSELINK) for more information
* Community Stability Supports (CSS) – see [Chapter 7f](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.dshs.wa.gov%2Fsites%2Fdefault%2Ffiles%2FALTSA%2Fhcs%2Fdocuments%2FLTCManual%2FChapter%25207f.docx&wdOrigin=BROWSELINK) for more information

The **Adult Family Home** requirements are outlined in [Chapter 388-76 WAC](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-76). There are three types of Subcontracts in AFH:

* Expanded Community Services (ECS)
* Meaningful Day Activities (MDA) (see Chapter 8a)
* Specialized Behavior Support (SBS)

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

The **Enhanced Services Facilities** contract requirements are outline in Chapter [388-107 WAC](http://apps.leg.wa.gov/wac/default.aspx?cite=388-107) and [Chapter 7f](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.dshs.wa.gov%2Fsites%2Fdefault%2Ffiles%2FALTSA%2Fhcs%2Fdocuments%2FLTCManual%2FChapter%25207f.docx&wdOrigin=BROWSELINK).

### Contract Requirements

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

### Facility requests to voluntarily withdraw a Medicaid contract

If the residential facility is requesting to voluntarily withdraw their Medicaid contract, but continues to provide personal care services, the facility’s voluntary withdrawal from participation is not an acceptable basis for the transfer or discharge of residents of the facility. The facility is required to maintain a Medicaid contract as outlined in [**RCW 18.20.440**](http://app.leg.wa.gov/RCW/default.aspx?cite=18.20.440) to permit the following residents to remain in the facility and not transfer or discharge them:

* Residents who were receiving Medicaid on the day before the effective date of withdrawal (except as described in [**RCW 70.129.110**](http://app.leg.wa.gov/RCW/default.aspx?cite=70.129.110), Disclosure, transfer, and discharge requirements), and

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

To ensure the resident’s rights are protected, the contractor may not evict a resident without (1) complying with the transfer and discharge requirements under [**RCW 70.129.110**](http://app.leg.wa.gov/RCW/default.aspx?cite=70.129.110) and (2) using any appropriate legal processes, including but not limited to unlawful detainer in RCW [**Chapter 59.16**](http://app.leg.wa.gov/RCW/default.aspx?cite=59.16) prior to evicting a resident.

**Note:** If you receive a written or verbal request from a facility for a voluntary withdrawal of a Medicaid contract, forward a copy of the written request to the ALTSA Contract Unit or have the facility contact the ALTSA Contract Unit directly. By [RCW 18.20.440](http://app.leg.wa.gov/RCW/default.aspx?cite=18.20.440) (5), the facility must give the department and its residents 60 days’ advance notice of the facility’s intent to withdraw from participation in the Medicaid program.

### Change of Ownership (CHOW)

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

* [**RCW 18.20.440**](http://app.leg.wa.gov/RCW/default.aspx?cite=18.20.440) does not apply to assisted living facilities that change ownership.
* Instead, [**WAC 388-78A-2785**](http://apps.leg.wa.gov/wac/default.aspx?cite=388-78A-2785) requires the facility to give 90 days’ notice to the residents of a facility undergoing a change of ownership if the change is anticipated to result in the discharge or transfer of any residents.
* If the facility does not want to participate in a state Medicaid program, the CM/SSS’s will assist residents to move and terminate the Medicaid payment effective the day prior to the move or the same date as the contract termination date.
* If the new owner wants to participate in the Medicaid program; the facility will be asked to sign a Medicaid contract in order to be paid for Medicaid residents.

### Expired Contracts

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

Case Managers/Social Service Specialists who receive an error message in ProviderOne may need to review the taxonomy error in the ProviderOne authorization to determine whether an expiring contract is the cause of the payment error. If so, the CM/SSS will need to notify the contractor of their expiring contract and have the contractor renew their contract before payment can be re-authorized.

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

### Medicaid Contract Requirements in Residential Facilities

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

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

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

Assisted Living Facilities (ALF) are required by ([WAC 388-78A-2060](http://app.leg.wa.gov/WAC/default.aspx?cite=388-78A-2060)) to complete their own preadmission assessment using a Qualified Assessor ([WAC 388-78A-2080](http://app.leg.wa.gov/WAC/default.aspx?cite=388-78A-2080)) prior to admitting any resident and complete a full assessment ( [WAC 388-78A-2090](http://app.leg.wa.gov/WAC/default.aspx?cite=388-78A-2090)) at least annually or when the NSA no longer meets the resident’s care needs.

Adult Family Home (AFH) are required to obtain a written assessment that contains accurate information about the prospective resident’s current needs and preferences before admitting a resident to the home ([WAC 388-76-10330](http://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10330)). The AFH assessment must be completed by a Qualified Assessor ([WAC 388-76-10150)](http://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10150) or the department case manager/social service specialist for Medicaid residents ([WAC 388-76-10345](http://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10345))

Enhanced Services Facility (ESF) must have an initial person-centered service plan developed for each resident prior to admission to the ESF ([WAC 388-107-0110](http://apps.leg.wa.gov/wac/default.aspx?cite=388-107-0110)). The plan must include immediate specific support needs and directions to staff and caregivers relating to those needs. The resident must give written informed consent to the content of the plan. The initial comprehensive person-centered service plan must be completed within 14 days of the resident’s move-in date, as outlined in ([WAC 388-107-0120](http://apps.leg.wa.gov/wac/default.aspx?cite=388-107-0120)).

All residential contracted providers (except ESF) are required to update the assessment at least annually, when there is a significant change in client’s physical or mental conditions, when the NSA/NCP no longer reflects the current needs of the client, and at the client’s request ([WAC 388-78A-2100](http://app.leg.wa.gov/WAC/default.aspx?cite=388-78A-2100) (ALF) and WAC [388-76-10350](http://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10350) (AFH). ESF is required to update the assessment every 180 days ([WAC 388-107-0080](http://apps.leg.wa.gov/wac/default.aspx?cite=388-107-0080)) or when there is a significant change in client’s conditions.

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

All providers, except ESF, must develop and complete the NCP/NSA within 30 days of the client’s admission. The initial comprehensive person-centered service plan for ESFs must be developed and completed within 14 days of the client’s admission. The NCP/NSA must be reviewed and revised at least annually, when there is a significant change in client’s physical, emotional, mental, behavioral functioning; or any time it no longer addresses the needs and preferences of the client.

For detailed information regarding Adult Family Home Negotiated Care Plan refer to ([WAC 388-76-10355](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-76-10355) through [388-76-10385](http://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10385); Assisted Living Negotiated Service Agreement ([WAC 388-78A-2130](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-78A-2130) through [388-78A-2160](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-78A-2160)); and Person-centered service plan for Enhanced Service Facility ([WAC 388-107-0110](http://apps.leg.wa.gov/wac/default.aspx?cite=388-107-0110)  through [388-107-0130](http://apps.leg.wa.gov/wac/default.aspx?cite=388-107-0130))

**Note:** Medicaid payment will be made only for services identified in the CARE assessment and as required by contract.

### Nursing Services Available in Each Licensed/Contracted Residential Setting

|  |  |
| --- | --- |
| ***NURSING SERVICES AVAILABLE IN EACH LICENSED, CONTRACTED SETTING*** |  |
| **Services Provided** | **Assisted Living** | **ARC** | **EARC** | **AFH** | **ESF** |
| Intermittent NursingServices (INS)  | Yes | No | Yes | No | No |
| Nurse Delegation  | Optional | Optional | Optional | Optional | No |
| Waiver Skilled Nursing  | No | Yes | Yes | Yes | No |
| 24-hour Nursing Services | No | No | No | No | Yes |
| Nursing Services  | Yes | Yes | Yes | Yes | Yes |

***Intermittent Nursing Services***

Intermittent Nursing Services may include, but is not limited to: Medication administration, Administration of health treatments, Diabetic management, non-routine ostomy care, and Tube feeding.

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

***Nurse Delegation***

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

In Adult Family Homes (AFH), the cost of nurse delegation can be covered by the CFC program or the Residential Support Waiver for Medicaid residents or using state funds when a resident is not a Medicaid client. AFH providers may choose to admit or retain residents requiring nurse delegation. Nurse delegation can occur in ALFs and EARCs, but it is not a reimbursable function. Since ALF and EARC have intermittent nursing services by contract, their nursing staff may delegate if they choose ([WAC 388-110-150](http://app.leg.wa.gov/WAC/default.aspx?cite=388-110-150) and [WAC 388-110-220](http://app.leg.wa.gov/WAC/default.aspx?cite=388-110-220)).

|  |
| --- |
| **Note**: Refer to [LTC Manual Chapter 13](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/documents/Nurse%20Delegation%20Chapter.doc) for additional information regarding Nurse Delegation. |

***24-hour nursing services***

Enhanced Services Facility (ESF) is required to have a licensed nurse on-site at all times. A Registered Nurse is on-site in the facility 20 hours per week and on-call the remainder of the week to meet any specific nursing needs that cannot be addressed by the licensed nurse on-site ([WAC 388-107-0240).](http://app.leg.wa.gov/WAC/default.aspx?cite=388-107-0240)

***Waiver Skilled Nursing***

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

***Nursing Services***

Nursing services are available in all residential settings, when the service does not duplicate a service that is already provided by contract or another source. The frequency and scope of the nursing services is based on individual need as determined by the CARE assessment and additional collateral contact information ([WAC 388-106-0200](http://app.leg.wa.gov/WAC/default.aspx?cite=388-106-0020), [WAC 388-106-0300](http://app.leg.wa.gov/WAC/default.aspx?cite=388-106-0030), and [WAC 388-107-0070](http://app.leg.wa.gov/WAC/default.aspx?cite=388-107-0070) for ESF). Services include:

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

**Note:** For additional information regarding Nursing Services refer to LTC Manual [Chapter 24](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/documents/Chapter%2024.doc)

## Determining program eligibility for residential setting

All ALTSA clients in any residential setting must meet the functional and financial eligibility program requirements before being placed in the facility. Eligibility is determined simultaneously between the Public Benefit Specialist for financial eligibility and by CM/ SSS for functional eligibility. Individuals who do not qualify for CFC, the Residential Support Waiver or RCL can only be placed in contracted AFH or ARC. The following chart shows which residential facility types can be offered to client based on the financial program they are eligible for:

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

### Authorizing/Determining the payment rate for residential services

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

1. Prior to authorizing payment to a provider; the CM/SSS must obtain the client’s approval on the plan of care (Refer to LTC Manual [Chapter 3](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/documents/Chapter%203.doc)). The CARE Assessment is not complete until it is moved to current. This includes assessments that are completed for a client converting from private pay to Medicaid in a residential setting. The client must also be financially eligible for residential care services or on Fast Track.
2. The CM/SSS must verify the correct amount of the daily rate identified in the CARE Classification for the geographic location of the provider. Current payment rates for Adult Family Homes and Assisted Living Facilities can be found at: [*http://adsaweb.dshs.wa.gov/management/orm/All\_HCS\_Rates.xls*](http://adsaweb.dshs.wa.gov/management/orm/All_HCS_Rates.xls).
3. In addition to the CARE-determined payment rate, some ALFs with an assisted living contract may receive an additional payment amount called a Capital-Add-on Rate. The ALTSA Rates staff determines if an ALF qualifies for the Capital-Add-on rate annually, each July. The CM/ SSS will receive notification from headquarters of qualifying facilities and are responsible for adjusting the payment rates for Medicaid clients. ALFs may receive Capiral-Add-on Rate for both clients when in a shared room. Details on the Capital-Add-On program can be found in [*WAC 388-105-0035*](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-105-0035).. A current list of Capital Add-On providers can be found through the [Office of Rates Management](https://www.dshs.wa.gov/ALTSA/management-services-division/office-rates-management/) page under “Home and Community.”

Supplementation of the Medicaid rate is not allowed (only by exception in some limited circumstances). Please see the [*Supplementing Medicaid Rate*](#_Supplementing_the_Medicaid) part of this chapter

## Community Integration

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

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

* Be individualized and chosen by the resident based on their interests and preferences;
* Include opportunities to engage in the community with other community members; and
* Occur in the resident’s local community.

See [AFH Provider Community Integration FAQs](#_AFH_Providers_FAQs) for more information.

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

Activities Not Included Under Community Integration:

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

### [Community Integration Eligibility Criteria in AFHs:](#DeterminingEligibility)

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

**Note:**

* If the client’s current assessment does not reflect the need for assistance with community integration and the client is requesting assistance with community integration; the CM/SSS can create an Interim assessment to include the CI rate adjustment and CI mileage reimbursement prior to the next annual assessment due date.
* AFH Providers must include documentation of the client’s choice to participate in community integration activities in the client’s Negotiated Care Plan (NCP) when the need is also identified in the client’s CARE assessment.

### [Community Integration Reimbursement](#authorizing)

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

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

* Assisting the resident to select what they want to do and where they want to go in the community.
* Assisting the resident to plan how they will get to the activity.
* Assisting the resident before the activity to problem solve any issues that may come up.
* Assisting the resident to become members of community organizations that interest them.
* Assisting residents to identify other people in the community who can accompany them at the event or provide support with transportation.
* Arranging for or providing transportation to and/or from the activity.
* Accompanying the resident during the event to provide personal care assistance.
* Looking for additional opportunities in which the resident may want to participate.

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

* Specialized Behavior Support.
* Meaningful Day Activities.
* DDA Community Guide Services.
* Expanded Community Services (Refer to LTC Manual [Chapter 7f](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/documents/Chapter%207f.doc) when authorizing ECS).

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

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



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

* Does not need assistance because their informal supports provide all the CI assistance needed;
* Can independently access the community and does not need assistance; or
* Does not want to access the community.



* When community integration is assessed as a need in CARE, the CI adjusted rate will be automatically calculated when the authorization is created in CARE. ***Do not attempt to add rate manually (exception: if client is a resident in an approved HIV/AIDS AFH, case manager should add the CI rate to the published HIV/AIDS rate).***
* Community Integration rate adjustments and Community Integration mileage reimbursement is not available for PACE clients.

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

#### Community Integration Mileage Reimbursement

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

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

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

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

* + Does not need assistance because their informal supports provide allthe assistance needed;
	+ Can independently arrange for all transportation needs;
	+ Does not want to access the community; or
	+ Is not driven to and from chosen activities by the AFH provider or employee.

### Medical Mileage Reimbursement

Reimbursement is available to an Adult Family Home Provider who transports a resident to medical providers as outlined in the Department’s service plan generated by CARE. Reimbursement is available for up to 50 miles per month when brokerage transportation will not meet the resident’s needs.

* The AFH resident must have an assessed need for medical transportation as documented in the CARE service plan.
* Compensation will be paid on a per-mile-driven basis at the standard IRS mileage rate, up to a maximum of fifty (50) miles per month per resident.
* Mileage reimbursement for travel to medical appointments is different from Mileage reimbursement for community integration. Authorization for one does not preclude authorization for the other.
* Mileage reimbursement for travel to medical appointments is notavailable to AFH providers in the PACE program.

**Note:**

Medical mileage should be used **ONLY** when the resident has a medical need and the Medicaid brokerage transportation or other transportation resources are not available.

Medical Mileage can be authorized in addition to the Medical Escort Fee.

### Medical Escort Fee

AFH providers will be able to request reimbursement for providing a medical escort to a Medicaid resident when all other means of both escort and transportation have been exhausted. In accordance with the CBA, AFHs who provide transportation and accompany an individual resident to a medical appointment will receive a rate of eighteen dollars ($18.00) per hour, up to a maximum of twenty-four (24) hours per client per calendar year for medical escort reimbursement.

When a client has a need for transportation documented in CARE and the AFH provider submits a request for reimbursement, the request must include:

* Documentation of the medical appointment
* A denial from the Medicaid transportation broker
* Documentation that informal supports were unavailable
* The date the transportation was provided
* The actual start and stop time that was spent to provide an escort and transportation.

Upon receiving the request from the AFH provider, the CRM/SSS will:

* Note in an SER that the required documents have been received from the AFH provider including verification that informal supports were not available.
* Authorize payment for the amount of time spent escorting the resident to and/or from the medical appointment in ProviderOne using the Medical Escort Care code T1019 U5.
	+ The authorization for payment must be submitted after the service was provided.
	+ The Start Date and End Date must be the date the escort was provided.
	+ The authorization will result in an auto-generated payment to the AFH provider.
* Submit the Medicaid transportation broker’s written denial to DMS Hotmail for the client’s case record (ALTSA) or place in the client’s case file (DDA).

**Notes:**

* Non-emergency medical transportation is a covered service under Apple Health; therefore, if informal supports are not available to provide transportation, an AFH provider must not be authorized for medical transportation or escort if that service is available through the Medicaid transportation broker.
* An AFH provider must submit documentation of the medical appointment, a denial from the Medicaid transportation broker, and documentation that informal supports are unavailable for each appointment.
* The Medical Escort Care Fee is limited to 24 hours per calendar year. No duplicate authorizations are allowed.

## Specialized Dementia Care Program

### SDCP Eligibility Criteria

The eligibility for the SDCP program is defined in [WAC 388-106-0033](http://app.leg.wa.gov/WAC/default.aspx?cite=388-106-0033). To be eligible for the SDC program an individual must be:

* Financially eligible for CFC as defined in [WAC 388-106-0277](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-106-0277).
* Functionally eligible for CFC as defined in [WAC 388-106-0277](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-106-0277).
* Be assessed by the comprehensive assessment reporting evaluation tool (CARE) as having a cognitive Performance Score of 3 or above.
	+ Have a current qualifying Behavior listed in [WAC 388-106-0033](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-106-0033) or a self-performance code of supervision, limited assistance, extensive assistance or total dependence in eating.
* Have written or verbal confirmation from a health care practitioner of an irreversible dementia (such as Alzheimer’s, Multi-Infarct or Vascular dementia, Lewy Body, Pick’s, Alcohol-related Dementia, or Major Neurocognitive Disorder

### Specialized Dementia Care Program Authorization

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

Note: individuals must choose between enrolling in PACE and being authorized SDCP. They cannot participate in both.

**The approval process:**

* When approved or denied, the SDCP Program Manager will post SERs in CARE and will also notify CM/SSS via-email of the approval or denied.
* When CM/SSS received an approval for SDCP authorization; CM/SSS will need to send a copy of SDCP Eligibility Checklist form to DMS as part of client’s record.
* Send a Planned Action Notice to the client or his/her representative of approval for Specialized Dementia Care Program using the SDCP rate.
	+ - Mark as “Approved” and check “other” in reason
			* Write in SDC Program
			* In the “other comment” write “You are functionally approved for Specialty Dementia Care Program at a rate of $…..”
* Complete 14-443 to notify Public Benefit Specialist of SDCP authorization rate approval.

**SDCP Authorization Process:**

* When authorizing SDCP service in ProviderOne; CM/SSS will need to use SDCP approval rate with Service code of T1020\_U4 (Special Dementia Care Services).
* Select RAC Eligibility 3052 – CFC-Specialized Dementia Care Program.
* If a client transfers to another Specialized Dementia Care facility, the CM/SSS is not required to send another SDCP eligibility checklist. The CM/SSS will need to check if the facility has EARC-SDC contract and to check if the facility is in a High Cost or Standard Cost area of service. When authorizing SDCP rate for the new facility refer to this [SDCP Rates](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.dshs.wa.gov%2Fsites%2Fdefault%2Ffiles%2FALTSA%2Fmsd%2Fdocuments%2FAll_HCS_Rates_FY24.xlsx&data=05%7C01%7Cemily.watts1%40dshs.wa.gov%7C5f39a9789801477fdd3508db71d8574b%7C11d0e217264e400a8ba057dcc127d72d%7C0%7C0%7C638228946205144348%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=j427euuiNQSsPWQxszyfTgNN2HwnyNSD%2FWtlOoUDpQY%3D&reserved=0) sheet for approval rate in the service area.
* The department will not approve retroactive payments unless the client is converting from private pay to Medicaid, the assessment has been completed and in current showing the individual is eligible, and the individual was waiting for a Public Benefit Specialist eligibility determination that was delayed.
* It is permissible to authorize Fast Track on CFC with Specialized Dementia Care. When a client is eligible (and for Fast Track we are presuming eligibility), the client is eligible for all services he or she is assessed for.

The daily reimbursable rate for this service is set by the Legislature and based on an individual’s CARE Assessment Classification and the High Cost or Standard Cost Area they are receiving services. Refer to SDCP rate at: [SDCP Rates](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.dshs.wa.gov%2Fsites%2Fdefault%2Ffiles%2FALTSA%2Fmsd%2Fdocuments%2FAll_HCS_Rates_FY24.xlsx&data=05%7C01%7Cemily.watts1%40dshs.wa.gov%7C5f39a9789801477fdd3508db71d8574b%7C11d0e217264e400a8ba057dcc127d72d%7C0%7C0%7C638228946205144348%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=j427euuiNQSsPWQxszyfTgNN2HwnyNSD%2FWtlOoUDpQY%3D&reserved=0).

#### Prior to referring a client to the Specialized Dementia Care Program

* By CFR §441.301 (4), before making any modification to a Medicaid resident’s rights, including using restrictive interventions, such as delayed egress in the Specialized Dementia Care Program; other methods must have been tried and documented that did not work.
* To document the modification of the resident’s rights for SDCP:

The Alzheimer’s/dementia special care program must be selected in the CARE/Treatment screen with the following documentation on the comment section explaining:

* + The specific client’s need that is being addressed by moving the resident to an area with delayed egress.
	+ The positive interventions and supports that were used prior to deal with this need before placing the client in an area with delayed egress that did not work.
	+ The informed consent of the resident/guardian agreeing to living in a setting with delayed egress.
* Verify that the Assisted Living Facility has a current EARC-SDC contract using the ALF Look-Up.
* **Note:** For more detailed information regarding modifications to a Medicaid resident’s rights and where to document modifications to resident rights in CARE; refer to the [*Client Rights in HCBS Settings*](#_Client_Rights_in) in this chapter.

**SDCP Case Manager/Social Service Specialist Responsibilities:**

* When a facility requests an SDCP approval for an existing Medicaid client or a conversion from private pay that resides in the part of the facility that is contracted as EARC-SDC, and meets the eligibility criteria; the client must not be referred for the SDC program until:
* A facility provides a copy of the NSA or NCP with clear documentation explaining what positive interventions and supports were used prior to placing a resident in an area that is restricted. An explanation of less intrusive methods of meeting the need were tried that did not work.
* Document approval from the client or legal guardian to continue to reside in the SDC facility.
* If a facility did not provide a copy of the NSA or NCP; CM/SSS will need to request a copy.
* The CM/SSS must review the NSA or NCP to make sure that the facility is following §441.301(4) federal rules regarding the resident’s rights and has documented any restriction or modification in the resident’s Negotiated Service Agreement or Negotiated Care Plan. Sign and date the NSA or NCP when the required documentation is in place. Send the original back to the facility and a copy to DMS.
* CM/SSS will need to complete initial CARE assessment for a conversion with documentation explaining what less intrusive methods and positive interventions of meeting the resident’s needs that have been tried but did not work.
* If an Interim assessment is created to add required documentations results in a change in CARE classification a face-to-face Significant Change assessment will need to be completed.
* CARE Assessment must be in current status to be approved.
* Send the SDCP eligibility checklist form [DSHS 14-534](http://asd.dshs.wa.gov/FormsMan/formDetails.aspx?ID=12961) to SDCP@dshs.wa.gov
* When the CM/SSS receives an approval for SDCP authorization, the CM/SSS will need to send a copy of SDCP Eligibility Checklist form to DMS as part of client’s record.
* Send a Planned Action Notice to the client or his/her representative of approval for Specialized Dementia Care Program using the SDCP rate.
* Complete 14-443 to notify Public Benefit Specialist of SDCP authorization rate approval.

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

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

## Determining room and board

### Determining a client’s room and board, and client responsibility towards the cost of their personal care.

For MAGI clients in residential setting (AFH, ARC, EARC, and AL), CM/SSS will need to determine the amount of R&B. The Client Responsibility Notice (DSHS 18-720) must be completed and sent to clients or client representatives.

The HCS MAGI Room and Board Calculator can be found under Resources on the [Affordable Care Act Resources.](http://intra.altsa.dshs.wa.gov/ACA/)

For more information with R&B calculation refer to [Social Services Authorization Manual](http://intra.dda.dshs.wa.gov/ddd/P1ServiceCodes/documents/SSAM/Social%20Services%20Authorization%20Manual.docx).

**Note:** Clients are required to pay towards the cost of their room and board and may be required to pay towards the cost of their personal care services. Clients may keep a personal needs allowance (PNA) for clothing and personal, incidental items. Refer to [Social Services Authorization Manual](http://intra.dda.dshs.wa.gov/ddd/P1ServiceCodes/documents/SSAM/Social%20Services%20Authorization%20Manual.docx) and <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/hcb-waivers-room-and-board-etrs-and-bed-holds> for detailed information regarding the determination of client’s PNA, room and board, and client responsibility towards the cost of their personal care for CFC, CFC+COPES, MPC, and RSW clients in residential settings.

#####

## Supplementing the Medicaid rate

* Supplementation of the Medicaid daily payment rate is an additional payment requested from a Medicaid recipient or a third-party payer by an Adult Family Home (AFH) contractor or a licensed Assisted Living (AL) contractor with a contract to provide adult residential care (ARC), enhanced adult residential care (EARC), assisted living (AL) services, or an enhanced services facility (ESF).

By federal rule ([42 CFR 447.15](http://www.gpo.gov/fdsys/pkg/CFR-2006-title42-vol4/pdf/CFR-2006-title42-vol4-sec447-20.pdf)), the state must limit participation in the Medicaid program to only providers who accept the Medicaid state payment and client participation as payment in full.

**Supplementation for services or items**

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

1. Under licensing [Chapter 388-76 WAC](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-76), [Chapter 388-78A WAC](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-78A), Chapter [388-107](http://apps.leg.wa.gov/wac/default.aspx?cite=388-107), and/or
2. In accordance with his or her contract [Chapter 388-110 WAC](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-110) with the department; and
3. As outlined in the resident’s CARE plan.

**Supplementation for a unit or bedroom**

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

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

Adult Family Homes are required to provide a minimum of 80 square feet for single occupancy rooms. Double occupancy rooms must be at least 120 square feet. More information on bedroom space in Adult Family Homes can be found in [WAC 388-76-10690](https://apps.leg.wa.gov/WAC/default.aspx?cite=388-76-10690).

Sleeping rooms within EARCs and ARCs must be no less than 80 square feet for a one-person room and no less than 70 square feet per person for a two-person room. Private units within an ALF must be a minimum of 220 square feet. More information on Resident Units can be found in [WAC 388-78A-3010](https://apps.leg.wa.gov/WAC/default.aspx?cite=388-78A-3010).

**When a contractor may request supplemental payment**

1. Before a contractor may request supplemental payments for items **not covered in the Medicaid** **rate**, the contractor must have a supplemental payment policy that has been given to all applicants at admittance and to current residents. The policy must be in accordance with [WAC 388-105-0050](http://apps.leg.wa.gov/wac/default.aspx?cite=388-105-0050) and [388-105-0055](http://apps.leg.wa.gov/wac/default.aspx?cite=388-105-0055) and must follow the department contract per [WAC 388-76-10205](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-76-10205) and [WAC 388-105-0050](http://app.leg.wa.gov/WAC/default.aspx?cite=388-105-0050). The Contractor may not request supplemental payment of a Medicaid recipient's daily rate for services, items covered by the Medicaid daily rate, move-in fees, and/or refundable or non-refundable deposits, in accordance with Chapter [388-76](http://apps.leg.wa.gov/wac/default.aspx?cite=388-76) WAC, [RCW 70.129.030(4),](http://apps.leg.wa.gov/RCW/default.aspx?cite=70.129.030) [RCW 74.39A.901](http://apps.leg.wa.gov/rcw/default.aspx?cite=74.39A.901), this Contract, and the Client’s NCP.
2. The Contractor must disclose in the Admission Agreement per [WAC 388-76-10540](http://apps.leg.wa.gov/wac/default.aspx?cite=388-76-10540) and the ‘Policy on accepting Medicaid as a payment source’ [WAC 388-76-10522](http://apps.leg.wa.gov/wac/default.aspx?cite=388-76-10522), any changes that could occur if a resident becomes eligible for Medicaid funding. The Contractor shall refund to the Client, on a prorated basis, the amount prepaid for care of that Client in the event that the Client becomes eligible for Medicaid funding or moves out of the home before the end of the month.
3. If a family member or friend purchases additional items or services through the contractor that are not provided for under the Medicaid contract, he or she must pay the Contractor directly to avoid jeopardizing the resident’s financial eligibility.
4. In all cases of supplementation, the contractor is required to notify the department case manager of the additional charges, what they are for, and who is paying them. Violations of the supplementation rules will be reported to the RCS Complaint Resolution Unit. The CRU will investigate and refer to the Medicaid Fraud Unit if appropriate. The Complaint Resolution phone number is: **1-800-562-6078.**

**Examples of supplementation**

1. If a residential room is approved by RCS for double occupancy and a Medicaid resident’s family wants to pay extra for a private room, the contractor can charge extra if the facility has included this in their supplementation payment policy. The exception would be when the facility agreed in the NSA/NCP to provide a private room in order to meet the resident’s needs. If the room is a single occupancy room, the provider is not allowed to charge extra for the room. The extra fee associated with a double occupancy room should be a reasonable amount. If the resident or family feels it is not a reasonable amount, they should be directed to call the RCS Complaint Resolution Unit. If the family chooses to pay this extra amount, they must pay the provider directly.
2. In the case of a Medicaid client who is assigned participation greater than the cost of care, and the individual wishes to use their excess income to purchase additional care and/or services from the provider, the resident can use his own financial resources to hire additional assistance following the same guidelines for supplementation.  The services must be above and beyond what the facility is already contracted to provide for any resident in the facility under their Medicaid contract. The facility cannot stop providing any current level of services to the resident nor have the person hired by the resident take over any services required under the contract and the client’s CARE plan.
3. If resident prefers a brand name incontinent brief rather than the generic brand the home provides. The client would be expected to pay the difference in price.

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

## Case Managers/Social Service Specialists Responsibilities

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

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

**NOTE: If a copy of the NCP or NSA has not been returned within 30 days but has been requested by the CM/SSS, make a report to the Complaint Resolution Unit (CRU) by phone at 1-800-562-6078 or** [**online**](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Ffortress.wa.gov%2Fdshs%2Faltsaapps%2FOCR%2FpublicOCR.PubRptInputReporterInformation.executeLoad.action&data=05%7C01%7Cemily.watts1%40dshs.wa.gov%7Cb657f816182846660f1d08dbe14b2eac%7C11d0e217264e400a8ba057dcc127d72d%7C0%7C0%7C638351485238677469%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=AYFATDBj11GKm%2Fys7%2BQnuMfCuNzp2RQKhFM2KcJi72E%3D&reserved=0)**.**

### Assisting a client to move into a residential setting

**Prior to the move the CM/SSS must:**

* Complete a CARE Assessment to determine functional eligibility.
* Discuss/Review with the client, and/or his/her representative the Client’s Rights and Responsibilities form (DSHS 16-172) and answer any questions about the client’s rights and responsibilities. Have the client or the client’s representative sign two copies of the form when completing the initial CARE assessment. File one copy in DMS and give the other copy to the client.
* Discuss with the client, and/or his/her representative, client’s rights in HCBS settings and Long-Term Care Resident’s rights as outlined in [Chapter 70.129 RCW](http://apps.leg.wa.gov/RCW/default.aspx?cite=70.129) and [the Client’s Rights section of this chapter.](#HCBSSettings)
* Discuss with the client, and/or his/her representative about Medical/Social Leave Policy as outlined in [WAC 388-105-0045](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-105-0045) and [**WAC 388-110-100**](http://apps.leg.wa.gov/wac/default.aspx?cite=388-110-100)**.**  For detailed information, refer to the Bed Hold and Social Leave Policy section of this chapter ([Bed Holds for Medical Leave](#_Bed_Holds_for_1)).
* Provide information to clients so they can make informed choices about residential options.
* Discuss with the client his/her preferences identified on the Care Plan screen in the CARE assessment and then assist the client in selecting a residential setting that will meet his/her needs. Document in the SER the client’s choice of long-term care setting and provider.
* Ensure that the client meets the functional and financial eligibility for HCS programs.
* Coordinate with the HCS residential CM/SSS assigned to the facility. For details information refer to LTC Manual [Chapter 5](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/documents/Chapter%205.doc).
* Review and provide copies of the Assessment Details and Service Summary to the provider prior to a client’s admission and document in SER.
* Have the client approve and sign the Department’s plan of care and inform the client and/or their representative of any client responsibility and room and board. Document plan approval in the SER. For addition information refer to LTC Manual [Chapter 3](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/documents/Chapter%203.doc).
* Verify if the AFH/ALF is licensed and contracted by clicking the following link:
* [AFH Lookup](https://fortress.wa.gov/dshs/adsaapps/lookup/AFHAdvLookup.aspx)
* [ALF Lookup](https://fortress.wa.gov/dshs/adsaapps/lookup/BHAdvLookup.aspx)
* Verify Specialty Designation. Clients who have a developmental disability, mental illness, or dementia can only be served in facilities with a specialty designation. Case Managers/Social Service Specialists are required to verify if the provider has the correct Specialty Designation training by going to the RCS “AFH Look-Up” to verify if the provider has completed the Specialty Designation training. This look-up is not always up to date. If the provider has proof of a certificate but is not listed on the lookup as having completed the specialty designation, follow these steps:

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

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

* On Find a Training Class Section
* Check both boxes in the Mental Health and Dementia Specialty section, then clicks on **Find Instructors box** (at the bottom)
* Once you click on Find Instructors box; you will find the list of approved instructors in the training class search results section.
* Review the list to verify the name of the instructor who signed the certificate.

**2. To check for Development Disability Specialty Training:** To find Development Disabilities Specialty Training, please go [here](http://www.dshs.wa.gov/dda/dda-specialty-training).

* ***Adult Family Homes/Assisted Living Facilities Specialty Training Requirements must be the Manager Specialty Training****.* Manager specialty training is required for assisted living facility administrators (or designees), adult family home applicants or providers, resident managers, and entity representatives who are affiliated with homes that serve residents who have one or more of the following special needs: developmental disabilities, dementia, or mental health per RCW [18.20.270](http://app.leg.wa.gov/RCW/default.aspx?cite=18.20.270) and [70.128.230](http://app.leg.wa.gov/RCW/default.aspx?cite=70.128.230) ; WAC [388-112A-0400](http://app.leg.wa.gov/WAC/default.aspx?cite=388-112A-0400).
* ***If a resident develops special needs while living in a facility without a specialty designation*** the provider, entity representative, resident manager and facility administrator (or designee) has 120 days to complete manager specialty training or developmental disability caregiver training, and demonstrate competency per WAC [388-112A-0490](http://app.leg.wa.gov/WAC/default.aspx?cite=388-112A-0490).
* ***Providers serving residents with different specialty needs.*** When providers serve two or more residents with different specialty needs, they must obtain a separate specialty designation for each of the specialty needs. CM/SSS are required to verify if the provider has the correct Specialty Designation training.
* ***Providers serving residents that have more than one special need.*** When a provider serves a resident that has needs in more than one of the special needs areas, by WAC [388-112A-0410](http://apps.leg.wa.gov/wac/default.aspx?cite=388-112A-0410), the AFH, ALF, or ESF must determine which of the specialty training classes will most appropriately address the overall needs of the resident and ensure that the appropriate specialty training class is complete. If additional training beyond the specialty training is needed to meet all of the resident’s needs, the AFH, ALF, or ESF must ensure additional training is completed.
* If a resident has more than one specialty needs, CM/SSS must document in SERs which specialty training the AFH, ALF, or ESF has determined to meet all of the resident’s needs.

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

**Note:** Assisted Living Facilities are required by ([WAC 388-78A-2060](http://app.leg.wa.gov/WAC/default.aspx?cite=388-78A-2060)) to do their own preadmission assessment prior to admitting any resident. Adult Family Homes are NOT required to do the same. AFH providers are however required to obtain an assessment completed by the CM/SSS, or a qualified assessor that documents the prospective client’s needs and preferences before admitting the client to the home, ([WAC 388-76-10330](http://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10330))

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

1. Help coordinate the client’s move, if needed.
2. Notify the Public Benefit Specialist of the date of admission, the program authorized, and any other pertinent information using the [14-443](http://asd.dshs.wa.gov/forms/wordforms/adobe/14_443.pdf).
3. When client’s responsibility and room and board is determined, authorize the payment in ProviderOne to the provider effective the day the client actually moves into the facility. Refer to [Social Services Authorization Manual](http://intra.dda.dshs.wa.gov/ddd/P1ServiceCodes/documents/SSAM/Social%20Services%20Authorization%20Manual.docx).
4. Notify the receiving CM/SSS of the admission date to the new facility. Inform the receiving CM/SSS that a 30-day contact is required within that timeframe. Refer to LTC Manual [Chapter 5](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/documents/Chapter%205.doc) for additional clarification on when a 30 day visit is required instead of a telephone contact within 30 days of admission.
5. CM/SSS must complete the Individuals with Complex Behaviors (DSHS 10-234a) form for clients with challenging behaviors (assaultive, destructive, self-injuries, inappropriate sexual behaviors, or history of misdemeanor behavior). Refer to LTC Manual [Chapter 5](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/documents/Chapter%205.doc); under resources for additional information.
6. Transfer the client’s file and CARE assessment using instructions found in the Assessment Chapter of the LTC Manual [Chapter 3](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/documents/Chapter%203.doc).

**Note: (DSHS 10-234a) form apply to HCS and DDA clients in all residential settings.** Send the original copy of the Individual with Challenging Support Issues (DSHS 10-234a) form to the provider and a copy to the Hub Imaging Unit (HIU) to become part of the client’s record.

### Assisting with community integration in AFHs

CM/SSS responsibilities include:

* Assessing the need for assistance with community integration;
* Assessing the need for assistance with community integration mileage reimbursement for AFH providers;
* Authorizing community integration mileage reimbursement for AFH providers; and
* Completing Planned Action Notices.

### Assisting client with relocation

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

##### RCS responsibilities

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

1. Issue a statement of deficiency.
2. Stop the admission of new residents in facilities. When RCS determines the need for a Stop Placement, they will notify appropriate local entities and governmental organizations of the decision.
3. Suspend or revoke a facility’s license. When RCS decides to revoke or suspend the license of a facility, both HCS and RCS work together to ensure the transfer of Medicaid clients to another residential setting.
4. Close a facility.

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

### HCS responsibilities

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

* 1. The Long-Term Care Ombudsman Program;
	2. The regional RCS staff assigned to that facility;
	3. The RCS Complaint Resolution Unit;
	4. Your supervisor or Regional Administrator; and
	5. The headquarters Residential Program Manager.

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

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

1. Work with the facility staff.
2. When eligible, consider using the discharge resources if the client is moving to a less restrictive setting. See the LTC Manual [Chapter 10](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/documents/Chapter%2010.docx) more information on relocation resources.
3. Coordinate with other CM/SSSs, if necessary (e.g., DDA or BHA).

When a provider wants a client to move

1. Review or complete an assessment and review the current Negotiated Service Agreement/Negotiated Service Plan/ Person Centered Service Plan to determine if there is a legitimate reason for the move that is consistent with [RCW 70.129.110](http://apps.leg.wa.gov/RCW/default.aspx?cite=70.129.110). If after reviewing/completing the assessment and reviewing the NSA/NCP/PCSP:
	1. You find the facility has tried to reasonably accommodate the client's care needs and the care needs still exceed the license or contract limit of the facility; you will need to coordinate the relocation of the client to a different setting. If necessary, contact the RCS District Manager to obtain clarification of any license or contract requirements.
	2. You find there is no valid reason for discharge and the client wants to stay, try to resolve the issue with the provider. If you are unable to resolve the conflict, consult with your supervisor about referring the case to the Residential Care Services Complaint Resolution Unit at: **1-800-562-6078.**  Also, let the client know he/she can contact the Ombudsman or file a complaint with RCS.

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

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

1. Client wants to move from the facility and the family/alternate decision maker does not want the client to move, or
2. Family or alternate decision maker wants the client to move and the client desires to remain in the facility. In these situations, refer the situation to the Ombudsman for resolution.

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

1. The department does not pay for the last day of service if a client moves out of the facility unless the last day of service is the date of death.
2. The CM/SSS must terminate the P1 authorization line using the date before the client moved out of the facility.
3. Notify the Public Benefit Specialist via the electronic [DSHS 14-443](http://asd.dshs.wa.gov/forms/wordforms/adobe/14_443.pdf) of the change in client residence, circumstance, date of the action and other pertinent information.

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

[WAC 388-76-10615](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-76-10615); [RCW 70.129.110](http://app.leg.wa.gov/RCW/default.aspx?cite=70.129.110); [RCW 18.20.440](http://app.leg.wa.gov/RCW/default.aspx?cite=18.20.440).

1. For facilities that have a large number of clients, develop a plan with the Regional Administrator to locate new facilities and relocate the clients. This effort may involve several CM/SSSs from around the region.
2. Work with the facility staff when transferring/moving a client.
3. If a client is moving to a less restrictive setting, consider using the residential discharge allowance for relocation. Follow the discharge allowance procedures outlined in LTC Manual [Chapter 10](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/documents/Chapter%2010.docx).
4. If the client is case managed by DDA or BHA, coordinate the move with other CMs.

**Note:** For additional information regarding termination of a Medicaid contract; refer to section [*II* ***Contract Types***](#_Contract_Types) of this chapter.

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

1. The CM/SSS will need to coordinate with RCS to ensure the clients move in a timely manner.
2. Provide assistance in relocating private pay residents if they request it.

##### **When there is a Stop Placement:**

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

##### **Provider responsibilities**

Before transferring or discharging a client, the provider must:

1. First, attempt, through reasonable accommodations, to avoid the transfer or discharge, unless agreed to by the client.
	1. In SDCP contracted facilities, a provider is required to have a policy to obtain consultative resources to address behavioral issues for residents prior to discharge.
2. Notify the client, and representative, and make a reasonable effort to notify, if known, an interested family member of the transfer or discharge and the reasons for the move in writing, and in a language and manner he/she understands, 30 days prior to the discharge date, unless:
3. There is an emergency per [RCW 70.129.110](http://apps.leg.wa.gov/RCW/default.aspx?cite=70.129.110); or
4. The client has been in the facility less than 30 days.
5. Record the following in the client's record:
6. The reason for transfer or discharge;
7. The effective date of transfer or discharge; and
8. The location to which the client is transferring or discharging.
9. Refund any unspent participation within 30 days of the client’s move. The provider and the client will receive correspondence from ProviderOne notifying them of the change in client responsibility. Providers are required to refund the difference between the amount paid and the new amount identified in correspondence to the client.

**Note:** If the client or client’s family notifies you that they have not received the expected refund, report the incident to the RCS Complaint Resolution Unit at: 1-800-562-6078.

### Monitoring changes in the client’s condition/significant change

A Significant Change assessment is required when requested by the resident or when there has been a change in the client’s cognition, ADLs, mood and behaviors, or medical condition that will affect the care plan; the change may be an improvement or a decline. Refer to LTC Manual [Chapter 3](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/documents/Chapter%203.doc) for additional information that a significant change assessment must be completed within 30 days of notification of the change.

**Residential Facilities, including ESFs, are required to:**

1. Document the significant changes in a client’s condition in the NSA, NCP and PCSP and provide a copy of the NSA, NCP, and/or PCSP to the department CM/SSS.
2. Notify a resident's next of kin, guardian, or other individuals or agencies responsible for, or designated by, the resident as soon as possible regarding:
	1. A serious or significant change in a resident's condition.
	2. The relocation of a resident to a hospital or other healthcare facility.
	3. The death of a resident. In case of death, the facility must notify the coroner, if required by [RCW 68.50.010](http://apps.leg.wa.gov/RCW/default.aspx?cite=68.50.010).
3. Notify the CM/ SSS if there has been a Significant Change in client’s care needs, whether or not related to a medical discharge.

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

1. If requested by an ALF, AFH, or ESF, prior to completing a significant change; the CM/SSS should request a copy of the NSA, NCP, and/or PCSP from the facility with documentation of the changes in the client’s care needs. The CM/SSS will need to review the client’s NSA, NCP, or PCSP to determine if the changes meet the criteria of a significant change as defined in [WAC 388-76-10000](http://apps.leg.wa.gov/wac/default.aspx?cite=388-76-10000) for AFH, [WAC 388-78A-2020](http://apps.leg.wa.gov/wac/default.aspx?cite=388-78A-2020) for ALF, and [WAC 388-107-0060](http://app.leg.wa.gov/WAC/default.aspx?cite=388-107-0060) for ESF.
2. Perform a Significant Change assessment if there has been a change in the client’s condition that warrants a new assessment.
3. If the new assessment results in a change to the daily rate, remember that the new payment cannot be earlier than the new current assessment date. Also, staff cannot authorize payment until they have obtained the client’s [consent](http://asd.dshs.wa.gov/forms/wordforms/adobe/14_012.pdf) and the assessment is in **Current status**.

**Note:** Refer to [LTC Manual Chapter 3](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/documents/Assessment%20Chapter.doc) for additional information regarding Significant Change Assessments and Getting Approval on the Plan of Care.

Reviewing the Negotiated Service Agreement/Negotiated Care Plan

##### *Negotiated Plans between the resident and the facility*

**ALF:**

* The Assisted Living Facility (ALF) per [WAC 388-78A-2130(2)](http://app.leg.wa.gov/WAC/default.aspx?cite=388-78A-2130) is required to develop a negotiated service agreement (NSA) for each resident using the resident’s preadmission/full assessment and using the CARE assessment for Medicaid residents, within 30 days of the resident’s admission. The NSA must include a list of the care and services to be provided, with details on the resident’s preferences and choices, and how services will be delivered to accommodate these preferences and choices.
* The Assisted Living Facility (ALF) per [WAC 388-78A-2120](http://app.leg.wa.gov/WAC/default.aspx?cite=388-78A-2120) is required to review and update each resident’s negotiated service agreement (NSA) annually, when there is a significant change in resident’s physical, mental, or emotional functioning, or when the negotiated service agreement no longer adequately addresses the resident’s current care needs and preferences. The Assisted Living Facility (ALF) must involve the resident, the resident’s representative to the extent he or she is willing and capable, the department’s case manager/social service specialist for a Medicaid resident, and facility staff when developing the resident’s negotiated service agreement.

**AFH:**

* The Adult Family Home (AFH) per [WAC 388-76-10355](http://apps.leg.wa.gov/wac/default.aspx?cite=388-76-10355), is required to develop the negotiated care plan (NCP) by using the resident assessment, or CARE assessment for Medicaid residents. The NCP must include a list of the care and services to be provided, with details on the resident’s preferences and choices, and how services will be delivered to accommodate these preferences and choices.
* Per [WAC 388-76-10360](http://apps.leg.wa.gov/wac/default.aspx?cite=388-76-10360), the AFH must ensure the negotiated care plan (NCP) is developed and completed within 30 days of the resident’s admission. When developing the NCP per [WAC 388-76-10370](http://apps.leg.wa.gov/wac/default.aspx?cite=388-76-10370), the AFH must involve the resident, the resident’s representative, professionals involved in the care of the resident, and the department case manager/social service specialist for Medicaid clients. Per [WAC 388-76-10375](http://apps.leg.wa.gov/wac/default.aspx?cite=388-76-10375), the AFH must ensure that the negotiated care plan is agreed to and signed and dated by the resident and AFH provider.
* The Adult Family Home (AFH) per [WAC 388-76-10380](http://apps.leg.wa.gov/wac/default.aspx?cite=388-76-10380) is required to review and update each resident’s negotiated care plan (NCP) annually, when there is a significant change in the resident’s physical, mental, or emotional functioning, or when the negotiated care plan no longer adequately addresses the resident’s current care needs and preferences, or at least every twelve months.
* For Medicaid clients ([WAC 388-76-10385](http://apps.leg.wa.gov/wac/default.aspx?cite=388-76-10385)), the Adult Family Home must give the department case manager/social service specialist a copy of the negotiated care plan each time the plan is completed or updated, and after it has been signed and dated. The AFH has 30 days from the time the assessment is moved to current to return the NCP, regardless of the reason for the update. The AFH provider can send a copy of their negotiated care plan through email or fax to the department case managers/social service specialists.

**ESF:**

* The Enhanced Service Facility (ESF) must develop an initial Person-Centered Service Plan (PCSP) as a replacement for the Negotiated Service Agreement/Service Plan for each resident prior to the admission as outlined in [WAC 388-107-0110](http://apps.leg.wa.gov/wac/default.aspx?cite=388-107-0110), a Comprehensive Person-Centered Service Plan within 14 days of the move-in date per [WAC 388-107-0120](http://apps.leg.wa.gov/wac/default.aspx?cite=388-107-0120), upon significant change in the client’s condition, upon the client’s request, or at least every 180 days if there is no significant change in condition per [WAC 388-107-0130](http://apps.leg.wa.gov/wac/default.aspx?cite=388-107-0130).

**Case Managers/Social Service Specialist are required to:**

* Review the NSA/NCP/PCSP for Initial, Annual, and Significant change assessments and compare it to the current CARE assessment. If the NSA/NCP/PCSP does not address all of the client’s current care needs, the CM/SSS must have a discussion with the Assisted Living Facility staff, Adult Family Home provider, or Enhanced Services Facility staff regarding how the client’s current care needs will be met.
* If there are changes in the client’s needs that would affect the CARE classification and/or change to the caregiver instructions, the CM/SSS must complete a Significant Change Assessment.

**Send NSA/NSP/PCSP** **to the HIU:**

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

Send the copy of the NSA/NCP/PCSP to the Hub Imaging Unit (HIU) to become part of the client’s record.

**Note:** Additional information regarding Residential Case Management Responsibilities can be found in [LTC Manual Chapter 5](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/documents/Case%20Management%20Chapter.doc) – Case Management.

## Client Rights

All residents living in licensed assisted living facilities and adult family homes are protected by the rights granted in [Chapter 70.129 RCW](http://apps.leg.wa.gov/RCW/default.aspx?cite=70.129), Long-Term Care Residents Rights***.*** SSS/CMs need to be familiar with the rights outlined in[Chapter 70.129 RCW](http://apps.leg.wa.gov/RCW/default.aspx?cite=70.129). As an SSS/CM, you are responsible for reportingany significant or repeated resident rights violations to the RCS Complaint Resolution Unit (CRU) for review and investigation. A provider’s failure to respect these rights is a violation of licensing requirements.

ESF residents have specific rights, as outlined in [WAC 388-107-0190](http://apps.leg.wa.gov/wac/default.aspx?cite=388-107-0190).

**Abuse, Neglect, Abandonment, or Exploitation**

All DSHS employees are mandatory reporters. When you have reasonable cause to believe that abuse, neglect, abandonment, or financial exploitation of residents in facilities that are currently licensed/contracted (or required to be licensed/contracted) has occurred, you must report the concern to CRU. Residential Care Services (RCS) is responsible for the intake, screening, and investigation. In addition, under certain circumstances you are also required to call law enforcement. See the Adult Protective Services of the LTC Manual [Chapter 6](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/documents/Chapter%206.doc)  for more information about mandatory reporting requirements.

**Client Rights Violations**

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

## Client Rights in HCBS Settings

##### The federal rules regarding Home and Community Based Settings mandate basic participant rights in all home and community-based settings. These are the rights listed in the federal rule:

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

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

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

### Documenting modifications to Client Rights:

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

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

|  |
| --- |
| **Note:** Prior to moving a resident to a facility or an area within a facility with delayed egress, the Case Manager/Social Service Specialist must ensure that all the conditions above are met and documented. If a facility is requesting the move, request a copy of their Negotiated Service Agreement (NSA), Negotiated Care Plan (NCP), or Person-Centered Service Plan (PCSP) indicating the changes of client’s care needs with the above documentation in the NSA/NCP/PCSP. Before signing the NSA/NCP/PCSP, the CM/SSS must review it to make sure the conditions above met and documented. The CM/SSS must also document the reason for the move in the CARE assessment as described below. |

**Where to document modifications to Client Rights in CARE:**

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

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

**Review the Plan and a need for modification:**

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

The plan must be reviewed and revised at least:

* Every 12 months, or
* When the client’s circumstances or needs change, or
* At the client’s request

Facilities must document the following in the annual Negotiated Care Plan, Negotiated Service Agreement, or Person-Centered Service Plan (and as indicated by a significant change in the resident’s condition) that the facility has reviewed the need for and effectiveness of the restriction or modification with the resident; and

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

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

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

## Exception to Rule

You may need to request an Exception to Rule (ETR) for some of your clients. ETRs for increases in the daily rate related to personal care, must be approved by the HQ ETR committee. For related policy see [LTC Manual Chapter 3](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/documents/Chapter%203.doc). All requests related to a daily rate increase must be completed on the ETR/ETP screen in the Client Details folder of CARE and processed electronically for review and approval. For instructions related to the functionality in CARE refer to the [Assessor's Manual](http://intra.altsa.dshs.wa.gov/CA/documents/PolicyHandouts/Assessor%20Manual.doc).

**Note:** For AFH provider post card notices about ETR requests; refer to [LTC Manual Chapter 3.](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/)

When needed, an ETR for a bed hold can be requested; please submit ETR requests to the Payment Policy and Systems Unit Manager for consideration. For more information, see the [Bed](#_Bed_Holds_for) Hold section of this chapter.

## Resident Choice Regarding ALF Room Exemptions

**Physical Plant Exemptions in an AL Room**

RCS may grant an exemption to the requirements provided in [WAC 388-110-140](http://apps.leg.wa.gov/wac/default.aspx?cite=388-110-140) in accordance with [WAC 388-78A-2820](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-78A-2820).

* According to [WAC 388-110-140 (2)](http://apps.leg.wa.gov/wac/default.aspx?cite=388-110-140), (a), and (b) a facility with an AL contract is required to provide each resident a private apartment-like unit that is a minimum of 220 square feet.

 **Examples of exemptions in Assisted Living settings are included below:**

* Residing in a room that does not meet the physical plant requirements identified in WAC 388-110-140; or
* Residing in a room that has been granted an exemption from RCS when the client is converting from private to public assistance

The provider must offer the client a choice of units that meets contract requirements. The request to remain in a unit that does not meet the contract requirements or to share a unit must be the client’s choice. The client must be advised of the physical requirements (under WAC 388-110-140) that they are entitled to have.

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

|  |
| --- |
| **Note:** Only RCS is authorized to grant exemptions under this process and only HCS is authorized to have the discussion with the client documenting the client’s choice regarding residing in a room that has been granted an exemption. If any of the items listed on WAC 388-110-140 are not present in the Medicaid resident’s room, and an exemption has not been granted by RCS, report this to the CRU. |

**Sharing an AL Room**

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

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

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

**Documenting Resident Choice:**

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

Use Form 15-447 – “Resident Choice Regarding ALF Room Requirements” to document your discussion with a client and the client’s choice regarding:

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

When completing the Form 15-447:

1. Enter the specific room number.
2. For a room that does not meet physical plant requirements:
3. Check which of the listed items are missing from that room.
4. Select the client’s choice to remain in a room that does not meet the contract requirements for an AL under WAC 388-110-140 (listed on the back of the form)
5. When a client wishes to share an AL room with another resident:
6. Select the name of the resident that will be sharing the room
7. If two Medicaid residents are wishing to share a room, separate forms will need to be completed for both clients.
8. Have the client sign the document.
9. Send the form to HIU to be placed in the client’s file.

The 15-447 only applies only to the specific room number and only for the resident(s) listed on the form. The agreement does not permit other Medicaid residents to occupy the room, nor does it permit the residents listed on the form to be relocated to another “non-qualified” room. If either resident chooses to relocate within the facility listed, arrangements should be made for each of them to move into a room that meets the Assisted Living Facility physical plant requirements.

**Documenting the client’s approval in CARE:**

 1. Enter the room number in “ALF/ESF Room #” box located on the Residence screen in CARE.

 2. For clients, including married couples, wishing to share an AL room, select “Shared Room in AL” Category and Type in the ETR/ETP screen. This selection documents the client’s approval.

 3. Submit the ETR request to the supervisor or SHPC for field review and approval.

 4. Document in the SER the actions taken and the client’s approval.

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

**Note:** If a facility wants to request more money for non-contracted room; please follow the [supplementation policy](#_Supplementing_Medicaid_rate)

## Bed Hold for Medical Leave

Per [WAC 388-105-0045](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-105-0045) (2), residential facilities (ESF, AFH, ARC, EARC, or AL) are required to hold a client’s bed for 20 days when the client is discharged for medical reasons to a nursing home or hospital.

Per [WAC 388-105-0045](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-105-0045) (6), a Medicaid resident’s discharge for a short stay in a hospital or SNF must be longer than 24 hours before a bed hold can be authorized.  This only applies to the following residential facilities: ESF, ARC, EARC, and AL.

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

Per [WAC 388-105-0045](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-105-0045) (8), if a resident is discharged back to the facility and returns to the hospital, the Medicaid resident must be back in the facility for 24 hours prior to being discharged again on medical leave to begin a new 20-day hold period.

**Notification Process for Medical Leave and Return**

* According to [WAC 388-105-0045 (7),](http://apps.leg.wa.gov/wac/default.aspx?cite=388-105-0045) residential facility (ESF, AFH, ARC, EARC, or AL) contractors must notify the Department Case Manager/Social Service Specialist by e-mail, fax, or telephone within one working day whenever the resident is discharged from the facility for more than 24 hours on medical leave to a nursing home or hospital.
* Facilities may use the [Adult Residential Care Services Notice of a Change](http://forms.dshs.wa.lcl/formDetails.aspx?ID=14984) form (**DSHS 05-249**), to notify the CM/SSS of a client’s discharge and return to the facility. This form can be faxed to (855)635-8305 or mailed to DMS at P.O. Box 45826 Olympia, WA 98599-5826.
* Timely notification of discharges and returns remains critical in reducing overpayments.

### Authorizing Bed Holds

When the department Case Manager/Social Service Specialist received notification from a facility reporting that the client has been discharged to the hospital or nursing home; within two working days of learning of a client’s discharge, the CM/SSS must determine whether or not the client is likely to return to the residential facility by verifying with the hospital staff or nursing home staff if hospital or nursing home stay may be less than 20 days.

If the client will likely return to the facility, the Residential CM/SSS will:

1. End Date residential services service line in P1.
2. End Date other open service lines in P1. Please note special instructions exist in the SSAM for Wellness Education, PERS Units/Add-ons, and Nurse Delegation.
3. Use DSHS 14-443 to send required notification to the Public Benefit Specialist.
4. Document all related bed hold actions in SER.
5. Once the client’s outcome is known (meaning they have returned to the residential facility, died, or discharged to an alternate setting) then authorize the bed hold.

If the client has already returned to the facility, the Residential CM/SSS will:

1. Split the residential services service line in P1 as of the last full day prior to admission in the institution, then remove the dates the client was institutionalized.
2. Split other open service lines in P1. Please note special instructions exist in the SSAM for Wellness Education, PERS Units/Add-ons, and Nurse Delegation.
3. Authorize the bed hold.
4. Use DSHS 14-443 to send required notification to the Public Benefit Specialist
5. Document all related bed hold actions in SER.

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

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

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

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

Per federal HCBS rules, a client is entitled to the same eviction rights as any renter residing in a private unit. This is called out in HCBS settings rule- 42 CFR § 441.530, Section (a)(1)(vi)(A). [RCW 70.129.110](http://app.leg.wa.gov/rcw/default.aspx?cite=70.129.110) requires a provider to meet before discharging or transferring a resident, including first making an attempt through reasonable accommodations to avoid the transfer or discharge and giving at least 30 days’ notice before the transfer or discharge.

**Note**: The CM/SSS will be responsible for determining and processing an overpayment if the client does not return to the facility and the providers continue to claim for services. For detail information on an overpayment process; refer to [Social Services Authorization Manual](http://intra.dda.dshs.wa.gov/ddd/P1ServiceCodes/documents/SSAM/Social%20Services%20Authorization%20Manual.docx).

### What is the payment for Bed Hold?

|  |  |
| --- | --- |
| **From the:** | **The department:** |
| Date of discharge through the 7th day | Pays 70% of the daily rate for ARC, EARC, ALF, and AFH. ([WAC 388-105-0045](http://apps.leg.wa.gov/wac/default.aspx?cite=388-105-0045)) (4), (5) |
| 8th through the 20th day | Payment reduced to $11.66 per day for ARC, EARC, and ALF. $15 per day for AFH, except ESFs, which are paid at 70% of the daily rate for days 1-20 ([WAC 388-105-0045](http://apps.leg.wa.gov/wac/default.aspx?cite=388-105-0045)) (3). See current rates on the [ALTSA website](http://adsaweb.dshs.wa.gov/management/orm/). These rates are subject to legislative action. |
| Date of discharge through the 20th day | Pays 70% of the daily rate for ESF (WAC 388-105-0045 (3). |
| 21st day forward | No longer pays for the bed hold. The provider may seek a third-party payment or no longer hold the bed |

|  |
| --- |
| **Note:**  The date of discharge entered in the bed hold data base is the date the client left the residential facilities (AFH, EARC, ARC, ALF or ESF) on medical leave.* Bed Hold days are not processed until there is an outcome.
* In case of client’s death, the last date of payment for bed hold is the day of death.
* Client Responsibility is never counted toward bed hold days.
 |

### Summary on Bed Hold Policy:

**Who determines if the bed holds ends during the 20 days of bed hold?**

[WAC 388-105-0045(9)](http://apps.leg.wa.gov/wac/default.aspx?cite=388-105-0045) states: A department case manager/social service specialist determines whether the Medicaid resident’s hospital or nursing home stay is not short term, and the Medicaid resident is unlikely to return to facility. The department will cease paying the day the case manager/social service specialist notifies the contractor of his/her decision.

**The provider may not seek third party payment during the first 20 days.**

If the 20-day bed/unit hold has expired, no third-party payment is available, the facility has not held the client’s unit, and the client wishes to return to the facility, the client may return to the first available and appropriate bed or unit, if the criteria are still met (e.g., level of care, contract and licensing).

**Exceptions to Rule (ETRs) for payment to hold a client’s bed/unit after the 20-day.**

Department-paid bed holds are not permitted past the 20th day (per [WAC 388-440-0001](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-440-0001) and [RCW 18.20.290](http://apps.leg.wa.gov/RCW/default.aspx?cite=18.20.290)). However, the provider may seek a third-party payment, as long as it does not exceed the client’s Medicaid daily rate paid to the facility at the time that the facility discharged the client to the hospital or nursing home.

ALTSA Headquarters will consider exceptions to rule [WAC 388-105-0045](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-105-0045) only when a residential client discharges to an RSN-funded mental health bed or licensed Hospice Care Center on temporary medical leave from facilities that are not licensed hospitals or skilled nursing facilities. State-contracted Alcohol and Substance Abuse Residential Treatment Programs may also be considered for ETR. Client’s receiving services under RSW are not eligible for ETR.

## Social Leave

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

* ALTSA permits Social Leave in all residential settings. Social Leave is limited to no more than **18 days per calendar year per** [**WAC 388-110-100**](http://apps.leg.wa.gov/wac/default.aspx?cite=388-110-100) (2).
* Residential Facilities are responsible for self-reporting and self-tracking Social Leave for their clients.

**When do I authorize this service and for how long?**

If a client takes Social Leave, the residential facilities are required to notify the department Case Manager/Social Service Specialist within **one working day**. Upon receiving the notification from the residential facilities; CM/SSS must:

* Maintain the current P1 authorization.
* Evaluate the need for social leave beyond 18 calendar days per year.
* Discuss with the provider how the client’s personal care needs will be met while the client is out of the facility on social leave. Document in the SER actions taken relating to social leave.

**Note:** Facilities should use the [Adult Residential Care Services Notice of a Change](http://forms.dshs.wa.lcl/formDetails.aspx?ID=14984) form (DSHS 05-249), to notify the CM/SSS of a client’s discharge and return to the facility from social leave.

**Are ETR’s allowed for Social/Therapeutic Leave?**

Evaluate whether there is a need for an ETR and consider the following questions:

* Do the additional days meet the client's needs and desires?
* Is there a person willing and able to meet the client's care needs while the client is out of the facility?
* Is there a temporary service plan in place to meet the client's needs during his/her absence?
* If you determine the need for additional days, submit an ETR in CARE for your Appointing Authority (FSA/RA) for review/approval.
* Evaluate if the client’s continued residence in the AFH, ALF, or ESF is the most appropriate option.

## Resources

[Rules and Policies](#RulesPolicy)

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

|  |
| --- |
| **RCW** |
| [Chapter 70.129 RCW](http://apps.leg.wa.gov/RCW/default.aspx?cite=70.129) | LONG TERM CARE RESIDENT RIGHTS |
| [Chapter 70.128](http://app.leg.wa.gov/rcw/default.aspx?cite=70.128) RCW | ADULT FAMILY HOMES |
| Chapter 70.97 RCW | ENHANCED SERVICES FACILITIES |
| [Chapter 43.190 RCW](http://apps.leg.wa.gov/RCW/default.aspx?cite=43.190) | LONG TERM CARE OMBUDSMAN PROGRAM |
| **WAC** |
| [Chapter 388-76 WAC](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-76) | ADULT FAMILY HOMES MINIMUM LICENSING REQUIREMENTS |
| [Chapter 388-78A WAC](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-78A) | ASSISTED LIVING FACILITY LICENSING RULES |
| [Chapter 388-105 WAC](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-105) | MEDICAID RATES FOR CONTRACTED HOME AND COMMUNITY RESIDENTIAL CARE SERVICES |
| [Chapter 388-106 WAC](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-106) | LONG TERM CARE SERVICES  |
| [Chapter 388-110 WAC](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-110) | CONTRACTED RESIDENTIAL CARE SERVICES |
| [Chapter 388-112 WAC](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-112) | RESIDENTIAL LONG TERM CARE SERVICES (TRAINING) |
| [Chapter 182-515 WAC](http://app.leg.wa.gov/wac/default.aspx?cite=182-515) | ALTERNATE LIVING – INSTITUTIONAL MEDICAL  |
| [Chapter 182-527 WAC](http://app.leg.wa.gov/wac/default.aspx?cite=182-527) | ESTATE RECOVERY |
| [Chapter 388-107 WAC](http://app.leg.wa.gov/wac/default.aspx?cite=182-527) | ENHANCED SERVICES FACILITIES |

## Revision History

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Made By** | **Change(s)** | **MB #** |
|  | Emily Watts | * Update staff assigned
* Removal of Meaningful Day
* Reformatting to move SDCP items into one section.
* Update on share ALF rooms
 |  |
| 7/30/2023 | Emily Watts | * Revised formatting, including moving some items to the Appendix
* Updated service area information for SDCP
* Community Stability Supports (CSS) information added
* Clarified SDCP Referral Process
* Clarified HIV/AIDS rate information, including for Community Integration
* Clarified Meaningful Day Process
* Added Revision History
 | TBD |
| 6/14/2023 | Emily Watts | * Updated contact information
 | H23-039 |
| 3/28/2023 | Natalie Lehl | * Clarify room sizes
* Update SDC guidance
 | H23-017 |
| 12/22/2022 | Natalie Lehl | * Updated contact information
* Added additional language to “Social Leave”
 | H22-064 |
| 9/14/2022 | Natalie Lehl | * Updated guidance on Specialized Dementia Care Program referrals
* Title change for MPC Calculator
* Enhanced Services Facilities (ESF) subject matter expert name and contact information updated
 | H22-042 |
| 6/21/2022 | Natalie Lehl | * Removed use of “placement” throughout the chapter
* Updated Specialized Dementia Care Program instructions
 | H22-028 |
| 4/12/2022 | Natalie Lehl | * Adding Meaningful Day Program Manager
* Update process for Meaningful Day approval (VI, E)
* Meaningful Day Checklist added
 | H22-020 |

## Appendix

###

### SDCP Referral Process



### AFH Providers FAQs about community integration

