Transforming Lives

# UPDATE: CHANGES HAVE BEEN MADE TO REQUIREMENTS REGARDING THE 2016 Low Acuity Budget Proviso since the distribution of the training.

***Please review carefully*.**

# History

In 2011, the Legislature enacted a bill to allow an adjustment to case mix scores for the 10 lowest RUG groups and the budget was adjusted accordingly. Due to legislative "hold harmless" provisions, these reductions have not been felt by nursing facilities (NFs). The legislative provisions insulating NFs from the adjustment will expire on June 30, 2016.

A bill was passed during the 2015 Legislative session, which created changes to NF rates making them facility specific with six components and the 2011 statute change reducing payment to the 10 lowest RUG groupings was changed in the statute. The 2016 legislative session budget includes a budget proviso* that exempts the five higher of the lowest ten RUG groups from the adjustment in rate and emphasizes **assisting 96 individuals in the lower acuity groups** (PA1-PC1) that are interested in relocating to community settings to do so.

*Proviso: Language in a budget bill that places limitations or provisions on the use of budget money.

# July UPDATE:

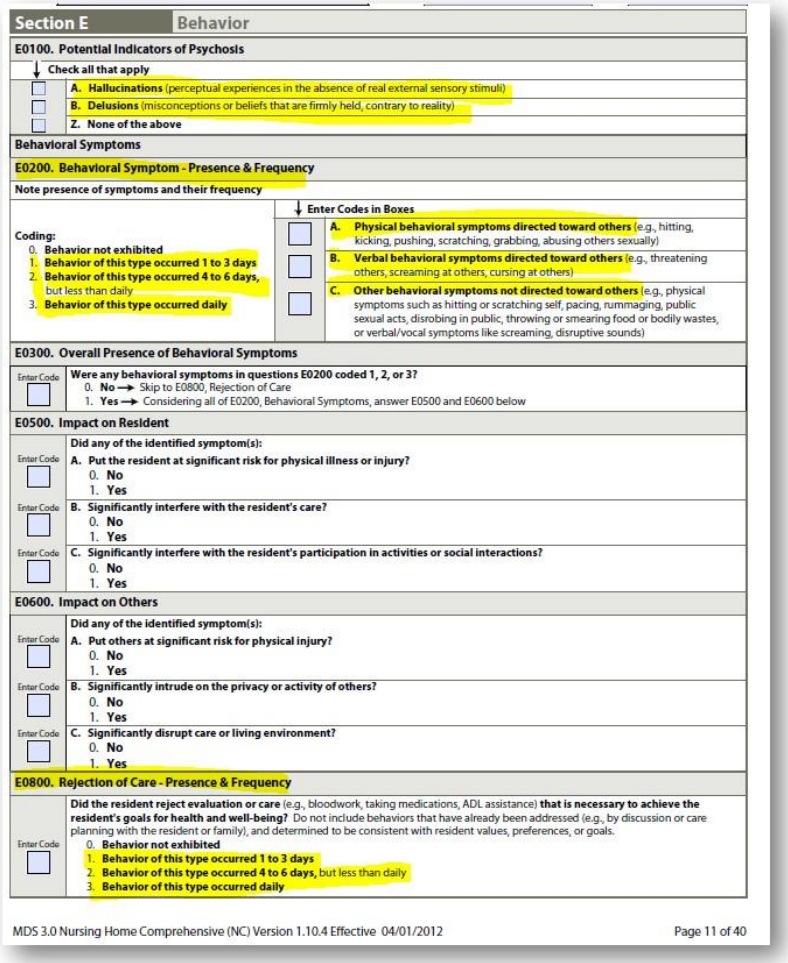
- **The following changes have been made to the requirements:**
  - **Exclude the PC1** group entirely from the penalty
  - **Exclude from the penalty those in the PA1, PA2, PB1 and PB2 who have identified behaviors** in the MDS assessment (see following slide for details).

# September UPDATE:

DSHS has evaluated the budget and determined no exclusions can be offered for those residents who choose to stay or those for whom a community setting could not be located. If we are unable to meet budgetary requirements, it will become necessary for the Department to reevaluate the viability of continuing to offer existing exceptions (PC1 and PA1-PB2 with behaviors).

# July UPDATE:

- For those in the PA1 –PB2 groups, behaviors excluded from the penalty are defined as a response coded greater than zero in any of the following MDS Fields (*0=Behavior not exhibited*):
  - E0100A Behavior: Hallucinations Code
  - E0100B Behavior: Delusion Code
  - E0200A Behavior: Physical Behavioral Code
  - E0200B Behavior: Verbal Behavioral Code
  - E0200C Behavior: Other Behavioral Code
  - E0800 Rejection of Care: Presence and Frequency
  - E0900 Wandering: Presence and Frequency



**Section E** Behavior

**E0100. Potential Indicators of Psychosis**

Check all that apply

- A. **Hallucinations** (perceptual experiences in the absence of real external sensory stimuli)
- B. **Delusions** (misconceptions or beliefs that are firmly held, contrary to reality)
- Z. **None of the above**

**Behavioral Symptoms**

**E0200. Behavioral Symptom - Presence & Frequency**

Note presence of symptoms and their frequency

Coding:
0. Behavior not exhibited
1. Behavior of this type occurred 1 to 3 days
2. Behavior of this type occurred 4 to 6 days, but less than daily
3. Behavior of this type occurred daily

Enter Codes in Boxes

- A. **Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
- B. **Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others)
- C. **Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

**E0300. Overall Presence of Behavioral Symptoms**

Enter Code — **Were any behavioral symptoms in questions E0200 coded 1, 2, or 3?**
0. **No** → Skip to E0800, Rejection of Care
1. **Yes** → Considering all of E0200, Behavioral Symptoms, answer E0500 and E0600 below

**E0500. Impact on Resident**

Enter Code — **Did any of the identified symptom(s):**
- A. **Put the resident at significant risk for physical illness or injury?** 0. No 1. Yes
- B. **Significantly interfere with the resident's care?** 0. No 1. Yes
- C. **Significantly interfere with the resident's participation in activities or social interactions?** 0. No 1. Yes

**E0600. Impact on Others**

Enter Code — **Did any of the identified symptom(s):**
- A. **Put others at significant risk for physical injury?** 0. No 1. Yes
- B. **Significantly intrude on the privacy or activity of others?** 0. No 1. Yes
- C. **Significantly disrupt care or living environment?** 0. No 1. Yes

**E0800. Rejection of Care - Presence & Frequency**

Enter Code — **Did the resident reject evaluation or care** (e.g., bloodwork, taking medications, ADL assistance) **that is necessary to achieve the resident's goals for health and well-being?** Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and determined to be consistent with resident values, preferences, or goals.
0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

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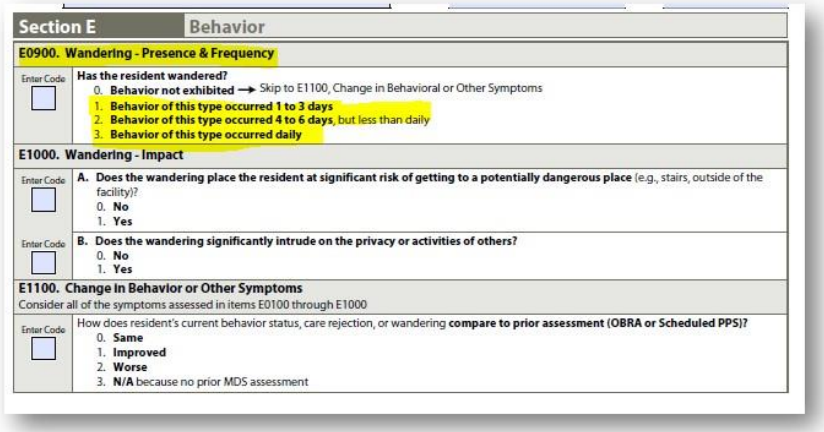


**Section E** Behavior

**E0900. Wandering - Presence & Frequency**

Enter Code — **Has the resident wandered?**
0. **Behavior not exhibited** → Skip to E1100, Change in Behavioral or Other Symptoms
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

**E1000. Wandering - Impact**

Enter Code — **A. Does the wandering place the resident at significant risk of getting to a potentially dangerous place** (e.g., stairs, outside of the facility)? 0. No 1. Yes

Enter Code — **B. Does the wandering significantly intrude on the privacy or activities of others?** 0. No 1. Yes

**E1100. Change in Behavior or Other Symptoms**

Consider all of the symptoms assessed in items E0100 through E1000

Enter Code — How does resident's current behavior status, care rejection, or wandering **compare to prior assessment (OBRA or Scheduled PPS)?**
0. **Same**
1. **Improved**
2. **Worse**
3. **N/A** because no prior MDS assessment

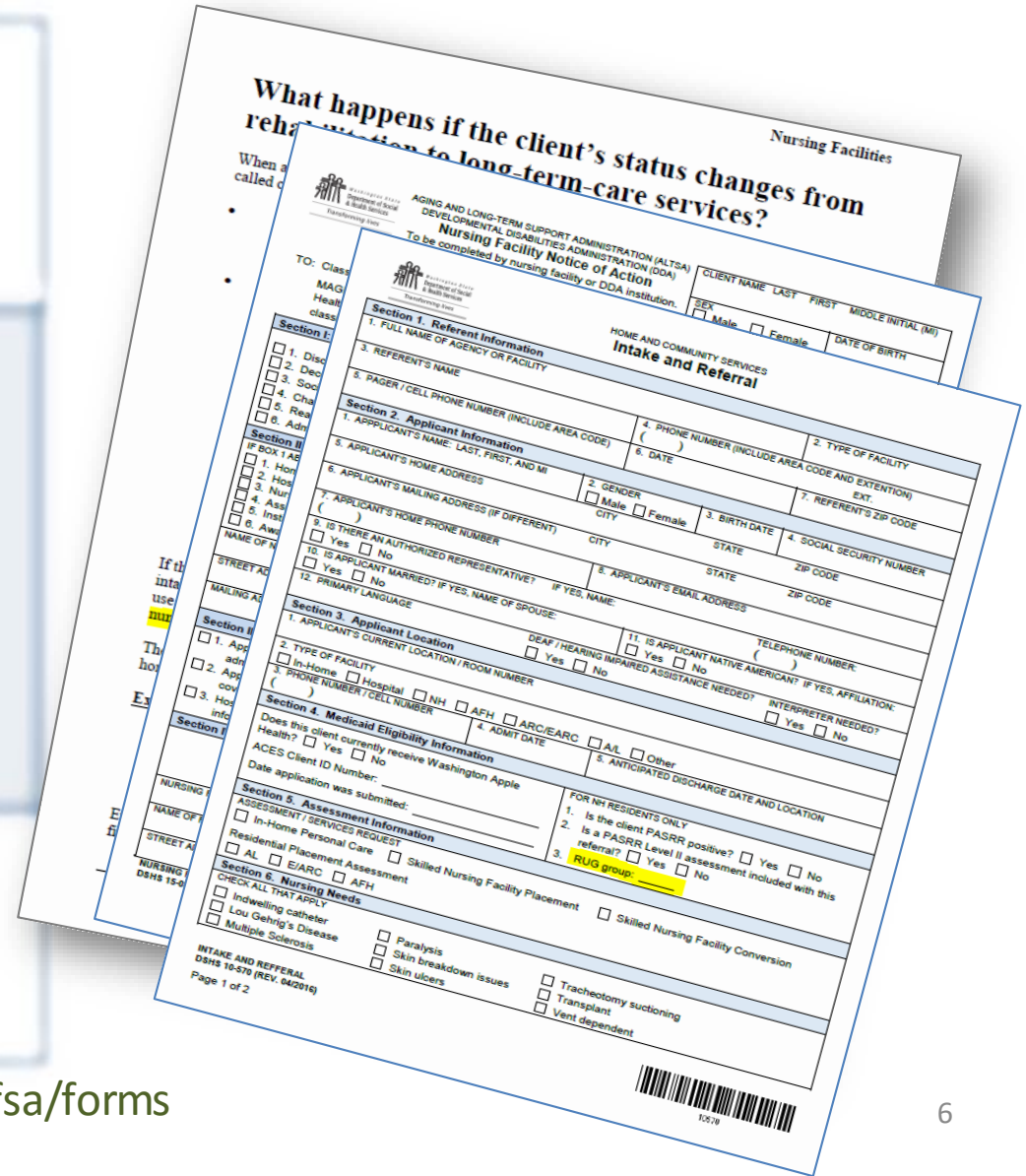
# September UPDATE:

- A referral must be submitted to HCS for all residents within the PA1-PC1 RUG groups regardless of behavior score or exclusion from penalty.
- NHs can prioritize the PA1-PB2 and those within the PC1 who have indicated interest in relocation.
- After those referrals are complete, the remainder of the PC1 referrals should be submitted. References have been updated throughout this presentation.

***As always, if an individual desires to learn more about community options, an Intake should be submitted regardless of RUG or behavior score.***

# UPDATE: Referral & Tracking: NFs

1. Nursing facilities will follow the referral process that is in the NH Provider Billing Guide [submit an Intake and Referral (10-570)]; this should occur within 30 days of a Medicaid client being identified in one of the FIVE lowest RUG groups (PA1-PC2 including those exempt from the penalty).
2. For clients who desire to discharge, a Notice of Action (DSHS form 15-031) must be faxed to DSHS per the NH Provider Billing Guide just prior to discharge.

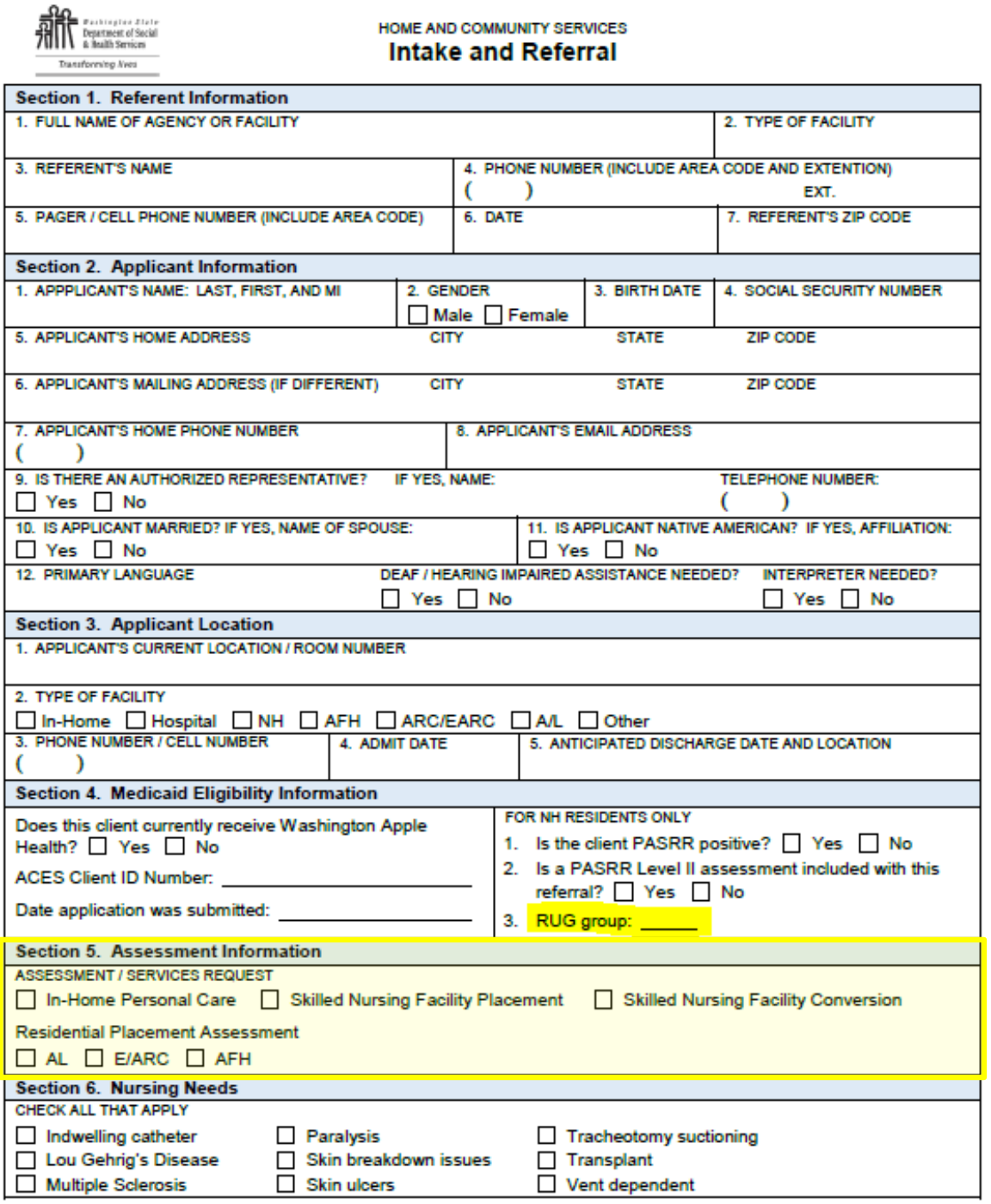



Forms can be found @ DSHS.wa.gov/fsa/forms

# Referral: NFs

**Not every section of the Intake Form will apply in every case:**

- Do not delay requesting a NF Level of Care (NFLOC) determination if RUG score has not been determined. Write "NA" for *Not Available*. Delaying could impact the Medicaid payment start date; see the NH Billing Guide for more information regarding payment start date.
- Once the RUG is determined for new admits, update the Intake and re-submitted it if the resident is assessed to be in the PA1-PC1 group.



Washington State Department of Social & Health Services
Transforming Lives

HOME AND COMMUNITY SERVICES
**Intake and Referral**

**Section 1. Referent Information**

1. FULL NAME OF AGENCY OR FACILITY
2. TYPE OF FACILITY
3. REFERENT'S NAME
4. PHONE NUMBER (INCLUDE AREA CODE AND EXTENTION) ( ) EXT.
5. PAGER / CELL PHONE NUMBER (INCLUDE AREA CODE)
6. DATE
7. REFERENT'S ZIP CODE

**Section 2. Applicant Information**

1. APPPLICANT'S NAME: LAST, FIRST, AND MI
2. GENDER ☐ Male ☐ Female
3. BIRTH DATE
4. SOCIAL SECURITY NUMBER
5. APPLICANT'S HOME ADDRESS — CITY — STATE — ZIP CODE
6. APPLICANT'S MAILING ADDRESS (IF DIFFERENT) — CITY — STATE — ZIP CODE
7. APPLICANT'S HOME PHONE NUMBER ( )
8. APPLICANT'S EMAIL ADDRESS
9. IS THERE AN AUTHORIZED REPRESENTATIVE? ☐ Yes ☐ No — IF YES, NAME: — TELEPHONE NUMBER: ( )
10. IS APPLICANT MARRIED? IF YES, NAME OF SPOUSE: ☐ Yes ☐ No
11. IS APPLICANT NATIVE AMERICAN? IF YES, AFFILIATION: ☐ Yes ☐ No
12. PRIMARY LANGUAGE — DEAF / HEARING IMPAIRED ASSISTANCE NEEDED? ☐ Yes ☐ No — INTERPRETER NEEDED? ☐ Yes ☐ No

**Section 3. Applicant Location**

1. APPLICANT'S CURRENT LOCATION / ROOM NUMBER
2. TYPE OF FACILITY ☐ In-Home ☐ Hospital ☐ NH ☐ AFH ☐ ARC/EARC ☐ A/L ☐ Other
3. PHONE NUMBER / CELL NUMBER ( )
4. ADMIT DATE
5. ANTICIPATED DISCHARGE DATE AND LOCATION

**Section 4. Medicaid Eligibility Information**

Does this client currently receive Washington Apple Health? ☐ Yes ☐ No

ACES Client ID Number: _____

Date application was submitted: _____

FOR NH RESIDENTS ONLY

1. Is the client PASRR positive? ☐ Yes ☐ No
2. Is a PASRR Level II assessment included with this referral? ☐ Yes ☐ No
3. RUG group: _____

**Section 5. Assessment Information**

ASSESSMENT / SERVICES REQUEST

☐ In-Home Personal Care ☐ Skilled Nursing Facility Placement ☐ Skilled Nursing Facility Conversion

Residential Placement Assessment

☐ AL ☐ E/ARC ☐ AFH

**Section 6. Nursing Needs**

CHECK ALL THAT APPLY

| | | |
|---|---|---|
| ☐ Indwelling catheter | ☐ Paralysis | ☐ Tracheotomy suctioning |
| ☐ Lou Gehrig's Disease | ☐ Skin breakdown issues | ☐ Transplant |
| ☐ Multiple Sclerosis | ☐ Skin ulcers | ☐ Vent dependent |

# Referral: NFs

**Not every section of the Intake Form will apply in every case:**

- Completing Section 5 for a current or new resident in the PA1-PC1 RUG group:
  - Skip Section 5 if you are unsure about the resident's goal regarding discharge.
  - If you know the resident is interested in d/c and you know their desired setting, check the appropriate box: In-home, AL, AFH, E/ARC.

Washington State Department of Social & Health Services
Transforming Lives

HOME AND COMMUNITY SERVICES
**Intake and Referral**

**Section 1. Referent Information**

| | | |
|---|---|---|
| 1. FULL NAME OF AGENCY OR FACILITY | | 2. TYPE OF FACILITY |
| 3. REFERENT'S NAME | 4. PHONE NUMBER (INCLUDE AREA CODE AND EXTENTION) ( ) EXT. | |
| 5. PAGER / CELL PHONE NUMBER (INCLUDE AREA CODE) | 6. DATE | 7. REFERENT'S ZIP CODE |

**Section 2. Applicant Information**

| | | | |
|---|---|---|---|
| 1. APPPLICANT'S NAME: LAST, FIRST, AND MI | 2. GENDER ☐ Male ☐ Female | 3. BIRTH DATE | 4. SOCIAL SECURITY NUMBER |
| 5. APPLICANT'S HOME ADDRESS | CITY | STATE | ZIP CODE |
| 6. APPLICANT'S MAILING ADDRESS (IF DIFFERENT) | CITY | STATE | ZIP CODE |
| 7. APPLICANT'S HOME PHONE NUMBER ( ) | 8. APPLICANT'S EMAIL ADDRESS | | |
| 9. IS THERE AN AUTHORIZED REPRESENTATIVE? ☐ Yes ☐ No | IF YES, NAME: | | TELEPHONE NUMBER: ( ) |
| 10. IS APPLICANT MARRIED? IF YES, NAME OF SPOUSE: ☐ Yes ☐ No | | 11. IS APPLICANT NATIVE AMERICAN? IF YES, AFFILIATION: ☐ Yes ☐ No | |
| 12. PRIMARY LANGUAGE | DEAF / HEARING IMPAIRED ASSISTANCE NEEDED? ☐ Yes ☐ No | INTERPRETER NEEDED? ☐ Yes ☐ No | |

**Section 3. Applicant Location**

1. APPLICANT'S CURRENT LOCATION / ROOM NUMBER

2. TYPE OF FACILITY
☐ In-Home ☐ Hospital ☐ NH ☐ AFH ☐ ARC/EARC ☐ A/L ☐ Other

| | | |
|---|---|---|
| 3. PHONE NUMBER / CELL NUMBER ( ) | 4. ADMIT DATE | 5. ANTICIPATED DISCHARGE DATE AND LOCATION |

**Section 4. Medicaid Eligibility Information**

Does this client currently receive Washington Apple Health? ☐ Yes ☐ No

ACES Client ID Number: _____

Date application was submitted: _____

FOR NH RESIDENTS ONLY
1. Is the client PASRR positive? ☐ Yes ☐ No
2. Is a PASRR Level II assessment included with this referral? ☐ Yes ☐ No
3. RUG group: _____

**Section 5. Assessment Information**

ASSESSMENT / SERVICES REQUEST
☐ In-Home Personal Care ☐ Skilled Nursing Facility Placement ☐ Skilled Nursing Facility Conversion

Residential Placement Assessment
☐ AL ☐ E/ARC ☐ AFH

**Section 6. Nursing Needs**

CHECK ALL THAT APPLY

| | | |
|---|---|---|
| ☐ Indwelling catheter | ☐ Paralysis | ☐ Tracheotomy suctioning |
| ☐ Lou Gehrig's Disease | ☐ Skin breakdown issues | ☐ Transplant |
| ☐ Multiple Sclerosis | ☐ Skin ulcers | ☐ Vent dependent |

# Referral: NFs

**Q: If a current resident is assessed and "RUGs Up" and is no longer in one of the impacted RUG groups, do we need to send an Intake notifying HCS of the change?**

**A: No.**

**Q: If a current resident is assessed and "RUGs down" and is now in one of the impacted RUG groups, do we need to submit an Intake notifying HCS of the change?**

**A: Yes.**

**Intake and Referral form for Social Services.**
**Barcode 10570 DSHS form 10-570**

**Purpose:** Communication to social services intake regarding an individual requesting a functional assessment for long-term services and supports (LTSS). Initial eligibility for LTSS is done concurrently by both the financial worker and the social worker/case manager.

**Instructions**

- Please type or print clearly and fill out as completely as you can to assist in processing the request for service.
- Fax form to the Home and Community Services office in your region for intake.
- If you have questions about submitting the form please contact your regional office at the number below.

**REGION 1N** – Pend Oreille, Stevens, Ferry Okanagan, Chelan, Douglas, Grant, Lincoln, Spokane, Adams and Whitman: 509-568-3767; **fax 509-568-3772**

**REGION 1S** – Klickitat, Kittitas, Yakima, Benton, Franklin, Walla Walla, Columbia, Garfield and Asotin: 1-855-636-5541; **fax: 509-575-2286**

**REGION 2N** – Snohomish, Whatcom, Skagit, Island, and San Juan 800-780-7094; **fax 425-339-4859;** Nursing Facility Intake, **fax 425-977-6579**

**REGION 2S** – King: 206-341-7750; **fax 206-373-6855**

**REGION 3** – Pierce, Kitsap, Thurston, Mason, Lewis, Grays Harbor, Pacific, Cowlitz, Clark, Clallam, Jefferson, Skamania and Wahkiakum: 800-786-3799; **fax 1-855-635-8305**

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**Section 1. Referent Information:** Include as much information as is known. If the referent is of relation to the applicant, include this information.

**Section 2. Applicant Information**

a. Fill out all known application information. Include all identifying information.
b. If there is an authorized representative complete this section

**Section 3. Applicant Location**

a) Please list the applicants currently location and fill out the box that most applies to the applicant's current setting.
b) Admit date: when was the applicant admitted to the current facility, not needed if in home.
c) Anticipated discharge date: complete if there is a discharge plan from the current location.

**Section 4. Medicaid Eligibility Information**

a) Washington Apple Health is the WA Medicaid program
b) ACES client id number can be found in a ProviderOne benefit inquiry and is also known as the DSHS number.
c) If the applicant is not eligible for WA Apple Health an application is necessary to receive services, please indicate the date the application was submitted.
d) PASRR information box should be completed only if the applicant is a current resident of a nursing facility. Check the "Yes" box if the applicant required and/or received a PASRR Level II assessment.

**Section 5. Assessment Information**

a) If the type of service being requested is known please complete this section.
b) If the applicant is requesting residential placement, and the type of placement is known please check the box.

**Section 6. Nursing Needs:**

a) Please check all boxes that apply to the applicant.

# Referral: NFs

**Q: The MDS is performed quarterly. Do we need to submit a new Intake for the same individual each quarter the RUG score is in the PA1-PC1 group?**

A: No. For the purposes of the budget proviso, an Intake is only sent the initial time the individual is identified as being in one of the RUG groups impacted. HCS will continue to have discussions regarding discharge with the resident without additional intakes.

However, the Intake continues to be the mechanism to communicate to HCS that a 1) a NFLOC is needed to verify eligibility, or 2) a resident is interested in hearing more about community service options, regardless of RUG score (see Intake instruction page).

**Intake and Referral form for Social Services.**
**Barcode 10570 DSHS form 10-570**

**Purpose:** Communication to social services intake regarding an individual requesting a functional assessment for long-term services and supports (LTSS). Initial eligibility for LTSS is done concurrently by both the financial worker and the social worker/case manager.

**Instructions**

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- Fax form to the Home and Community Services office in your region for intake.
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**Section 5. Assessment Information**

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b) If the applicant is requesting residential placement, and the type of placement is known please check the box.

**Section 6. Nursing Needs:**

a) Please check all boxes that apply to the applicant.

# Referral: NFs

**Q: What will happen after a referral is submitted by the SNF?**

A: HCS will have a conversation with each individual after an Intake and Referral has been received. For those residents who desire to transition into a community setting, HCS will perform an assessment. HCS will identify within 30 days whether an alternative setting is available to meet the resident's needs.

**Intake and Referral form for Social Services.**
**Barcode 10570 DSHS form 10-570**

**Purpose:** Communication to social services intake regarding an individual requesting a functional assessment for long-term services and supports (LTSS). Initial eligibility for LTSS is done concurrently by both the financial worker and the social worker/case manager.

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**Section 6. Nursing Needs:**

a) Please check all boxes that apply to the applicant.

# Referrals from NF: Section Q

Recent guidance from the [Department of Health and Human Services Office for Civil Rights](#) details how Section Q of the MDS is to be administered.

If an individual responds to Section Q of the MDS that they are interested in learning more about services in the community, the *Local Contact Agency (LCA)* referred to in the MDS is the local HCS office and you communicate the resident's interest via the Intake form.

GUIDANCE AND RESOURCES FOR LONG TERM CARE FACILITIES: USING THE MINIMUM DATA SET TO FACILITATE OPPORTUNITIES TO LIVE IN THE MOST INTEGRATED SETTING

*U.S. Department of Health and Human Services, Office for Civil Rights*
*May 20, 2016*

The U.S. Department of Health and Human Services' Office for Civil Rights (OCR) is issuing this guidance to help long term care facilities comply with their civil rights obligations by administering the Minimum Data Set (MDS) appropriately so that their residents receive services in the most integrated setting appropriate to their needs. Failure to properly administer the MDS places a facility's Medicaid and Medicare reimbursements in jeopardy.[1] Furthermore, inadequate administration of the MDS threatens the state and administrative agencies' compliance with civil rights laws. The state and state administrative agencies must provide services to residents in the most integrated setting. The unnecessary placement of a resident in a long term care facility may constitute discrimination under Section 504 of the Rehabilitation Act (Section 504) and Title II of the Americans with Disabilities Act, as interpreted by the U.S. Supreme Court in *Olmstead v. L.C.*[2]

OCR is responsible for enforcing Section 504 of the Rehabilitation Act as it applies to entities that receive HHS Federal financial assistance. Long term care facilities receive Federal financial assistance by participating in programs such as Medicare and Medicaid. Section 504 prohibits discrimination based on disability, including the unnecessary segregation of persons with disabilities. Unjustified segregation can include continued placement in an inpatient facility when the resident could live in a more integrated setting. This concept was set forth in the *Olmstead* decision which interpreted the same requirements in the Americans with Disabilities Act.

The MDS, a mandated quarterly assessment administered to all nursing home residents, has questions that can connect long term care residents with opportunities to live in the most integrated setting and assist the state in meeting its non-discrimination requirements under Section 504 and the Americans with Disabilities Act. Specifically, Section Q of the MDS provides a process that, if followed correctly, gives the resident a direct voice in expressing preference and gives the facility means to assist residents in locating and transitioning to the most integrated setting.

OCR has found that many long term care facilities are misinterpreting the requirements of Section Q of the MDS. This misinterpretation can prevent residents from learning about opportunities to transition from the facility into the most integrated setting. We are therefore providing a series of recommendations for steps that facilities can take to ensure

[1] See 42 CFR 483.1(b); 42 C.F.R. 483.20(b)(1)(xvi); and 42 C.F.R. 483.20(g)
[2] *Olmstead v. L.C.*, 527 U.S. 581 (1999).

**Q0600. Referral**

Enter Code ☐

**Has a referral been made to the Local Contact Agency?** (Document reasons in resident's clinical record)

0. **No** - referral not needed
1. **No** - referral is or may be needed (For more information see Appendix C, Care Area Assessment Resources #20)
2. **Yes** - referral made

# Referral & Tracking: HCS

1. Following all protocols and timelines, HCS will respond to referral received via Intake and Referral and discusses community options with resident to assess desire to transition to the community.
2. HCS NFCMs will assess those clients who are interested in relocating and within 30 days present an alternative setting based on the client's choice.
3. HQ and regional staff will follow up on all situations where no alternative setting was identified when a resident desires to move; conversations regarding community options will continue with the resident.
4. Information will be tracked by ALTSA HCS HQ.

# Nursing Facility Level of Care (NFLOC) has not changed (see WAC 388-106-0355)

- The determination that an individual meets functional eligibility for institutional care. In Washington State that means the individual:
  - Requires daily care provided or supervised by an RN or LPN; OR
  - Has a need for assistance with 3 or more ADLs; OR
  - Has a cognitive impairment AND a need for hands on assistance with 1 or more ADLs; OR
  - Needs 'hands-on' assistance with 2 or more ADLs.
- Individuals who meet nursing facility level of care are able to choose among available Medicaid settings which include nursing facilities, assisted living facilities, adult family homes and in-home.

# Association Key Points

- Budget Proviso:
  - Will require a high degree of collaboration between facilities, DSHS, and the Associations.
  - What impacts will there be in the future?
  - We need to better understand the barriers to DC that currently exist.

# Collaborative Association Efforts

- WHCA and LeadingAge Washington are working together to assist in the implementation of the budget proviso:
  - Collaboration with DSHS on program implementation and tracking of results.
  - Facility Training on key provisions of the program through webinars, written guides, and telephone support.
  - Data Gathering – Associations are collaborating on a system of collecting data that can be used to evaluate the effectiveness of the program in meeting the goals of reduction in nursing home stays for the target RUG level residents.

# Association Data Gathering

- Facilities will have the opportunity to submit information to the Associations that can be used to evaluate program successes and barriers.
  - Members will receive an email outlining how they may submit information to the Associations on residents interested in moving to the community.
  - Associations will use this information to seek to understand common barriers to discharge which could include lack of suitable housing, support structures, or program enhancement.
  - Associations and DSHS will share their information with the goal of coming up with priority lists of needed activities and best practices which could facilitate program successes.

# Long Term Services & Supports (LTSS)

- HCBS: *Home & Community-Based Services* are services and resources available to meet an individual's needs in the community.
  - HCS: *Home and Community Services Division*: the division of ALTSA that is responsible to promote, plan, develop and provide long-term care services responsive to the needs of persons with disabilities and the elderly.
  - DDA: *Developmental Disabilities Administration*: DDA is responsible to assist individuals with developmental disabilities and their families to obtain services and supports based on individual preferences, capabilities and needs.
  - AAA: *Area Agency on Aging*: AAAs help older adults plan and find additional care, services, or programs. They also provide case management for individuals on LTC HCBS in their home (not residential settings like adult family homes or assisted living).

# LTSS: Terms to Know

Medicaid is a program that provides medical assistance for certain individuals and families with low incomes and few resources. **Medicaid long-term care services** are offered under two different service packages based on functional and financial eligibility:

- **State Plan**: defines how WA State will meet the mandatory Medicaid requirements and which optional services the state will provide. Community First Choice (CFC) is a state plan service. MPC is another state plan service. Clients on CFC must meet NFLOC, but clients on MPC do not.
- **HCBS Waivers:** Medicaid's alternative to providing long-term care in institutional settings. COPES and New Freedom are examples of waiver services. Clients on HCS waiver services must meet NFLOC.

*The state typically receives about a 50/50 match from the federal Centers for Medicare and Medicaid (CMS) for our waiver services and some of our state plan services (CFC is a bit higher).*

# LTSS: Settings/Partners

- Nursing facilities, also known as skilled nursing facilities (NF or SNF)
- Hospitals (state mental or acute care hospitals)
- Community residential facilities: Adult family homes (AFH) and Assisted living facilities (AL or ALF, ARC, EARC)
- Community in-home: in the individual's own home or apartment either alone or with family members or others.

# Roles: Hospital Discharge Planner

- The person in the hospital responsible for ensuring patients are released from the hospital to the proper environment that can best care for the individual as they recuperate; the discharge planner functions as a consultant for the discharge planning process.

# Roles: Nursing Facility Social Worker

- WAC and CFR require that:
  - When a resident's health improves sufficiently and the resident no longer meets level of care, the resident can be discharged, with appropriate notice. The NF must provide sufficient preparation time to ensure a safe transition.
  - The facility conducts initial and periodic comprehensive assessments (timeframes are in federal rule), including discussing with the client if they have a goal of discharging to the community or if they would like to speak with someone about relocating (however, residents can opt out of this discussion).
  - The care plan must include a post discharge plan. The NF SW works collaboratively with the HCS NF case manager (NFCM) or AAA case worker to provide and ensure a smooth transition for residents who desire to transition to the community.

# Roles: Residential and In-home Case Managers

- Work with current clients, family members, informal supports, nursing facility staff when placement is less than 30 days (unless discharge is imminent; transfer time is based on professional judgement).
  - AAA Case Manager: Provides on-going case management when individuals on HCBS services receive in-home services.
  - HCS Residential Case Manager: Provides on-going case management for clients who reside in a community residential setting such as an adult family home (AFH) or assisted living facility (AL).

# Roles: Health Home Care Coordinator

- Available for eligible high risk clients with chronic conditions-not every client will have a HH Care Coordinator
- The HH Care Coordinator follows their caseload across all settings.
- Integrates services across all systems and works with professionals and collaterals.
- Contracted by the Managed Care Organizations in the state.
- Care Transitions is one of six health home services and includes:
  - Ensuring that follow up appointments are made with the doctor
  - Assisting to reconcile medications
  - Providing necessary client and family education and coaching
  - Developing or revising the Health Action Plan (HAP)

# Roles: Nursing Facility Case Manager

## NFCMs:

- Verify NFLOC (functional eligibility) within 10 days and perform a face-to-face visit with each newly admitted Medicaid client within 30 calendar days to begin to dialog about community options and desires for discharge.
- Document NFLOC and all work towards discharge goals.
- Provide information to clients, family and facility staff regarding what services the resident is eligible to receive.
- Work with clients, family members, informal supports, nursing facility staff, the client's physician, and community providers to assist the client to discharge to the setting of the individual's choice and access community services.

# Discharge Planning: Nursing Facility Case Management (NFCM) and Relocation

## Philosophy

- Most people want to live as independently as possible for as long as possible.
- ALTSA embraces the belief that clients with high care needs can be cared for and supported in the community in a variety of settings by offering waiver and state plan services that provide alternatives to nursing facility care.
- Goal: Offer options to individuals requiring long-term care services in the least restrictive setting while honoring client choice and preference.

## Purpose

- Assist residents of NFs who have the desire to move to another setting, by providing information regarding community long-term care options, identifying barriers to discharge then working with the resident, his/her family, NF staff and others to remove or address the barriers (discharge planning) and assessing, care planning, authorizing services and making referrals as necessary with other community and informal supports.

# Outreach and Education

- The NFCM:
  - Begins the discussion regarding the option of returning to the community when the NFLOC is performed at admit.
  - Determines and documents an individual's goals related to relocating to a community setting.
  - Assists in exploring all community options, including:
    - Returning to their own home
    - Adult family home
    - Assisted living centers (including enhanced adult residential care facilities, etc.)

# WA State's Standardized Assessment: CARE

- Comprehensive Assessment Reporting Evaluation (CARE) tool
- Single assessment tool used across aged and disabled populations. The assessment performs the following functions:
  - Functional eligibility determination for state plan and waiver services
    - Medical
    - Psych/social
    - ADLs/IADLs
  - Identification of service plan needs
  - Client notification
- Service Episode Record (SER): case notes
- Client Details (demographics and case management tools)
- Included are other assessments such as the Mini-mental Status Exam, Iowa Depression Scale, Cognitive Performance Scale, an alcohol/substance abuse screening tool and the Supports Intensity Scale.
- Does not crosswalk directly with RUG score, but both are measures of acuity.

Helping people who desire to transition back to the community is something HCS has done successfully for a long time. It is one of ALTSA's goals in the [DSHS Strategic Plan.]

## Aging and Long-Term Support Administration

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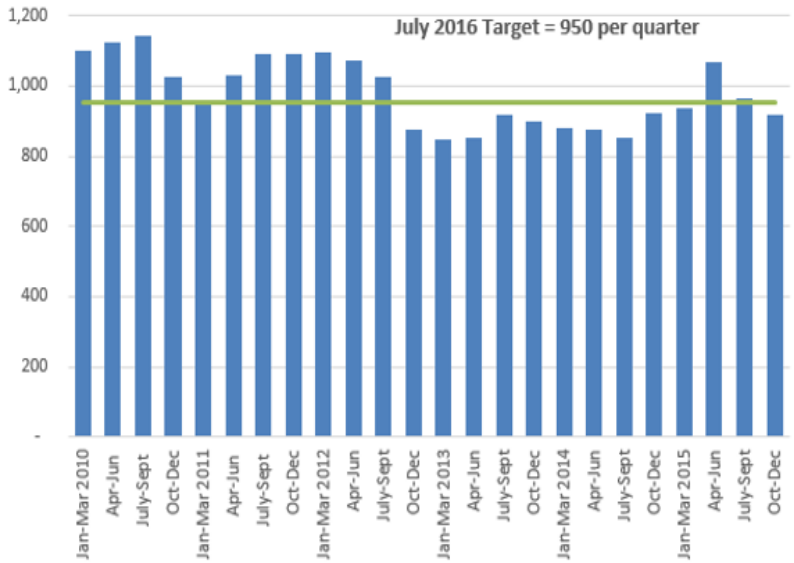
**Goal 4: Quality of Life - Each Individual in Need will be Supported to Attain the Highest Possible Quality of Life**

Number of people assisted to transition to home and community-based settings from nursing homes




**SUMMARY**

- This measure supports ALTSA Strategic Objective 2.2: Increase the number of individuals ALTSA is able to assist in transitioning to their homes or the community from nursing homes.
- Background: Federal match is maximized by utilizing the federal Money Follows the Person/Roads to Community Living (RCL) program to help people who choose to relocate. RCL participants report greater satisfaction with life after transition. Lack of affordable housing and complex medical or behavioral health needs can be barriers to relocation.
- Importance: The majority of individuals who require support choose to receive help in their home or a community-based setting.
- Success Measure: Increase the average number of individuals transitioned from nursing homes quarterly to 950 by July 2016.
- Action Plan: The updated action plan for this measure is located in the ALTSA Strategic Plan.

On average, HCS assists 4000 individuals per year move to the community.

**Data Source:** CARE
**MEASURE DEFINITION:** The count of clients who are actively assisted to relocate by DSHS staff from Nursing Facilities to Home and Community Based Settings. Programs are: NFCM: Nursing Facility Case Management & Relocation (NFCM); Road to Community Living (RCL; also called Money Follows the Person); Washington Roads (WA Roads).

TO DATA: http://www.dshs.wa.gov/data/metrics/AAH.2.xlsx

WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES
*We transform lives*

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FEBRUARY 2016
SP 2.2 (AAH.2)

# Discharge Resources

- **Housing Maintenance Allowance (HMA):** Income a clients is allowed to keep to maintain his/her housing. A physician must certify the client is likely be in the institution no more than 6 months. (Authorized by NFCM)

- **Assistive Technology:** limited funds available to help purchase assistive devices and services which have no other funding source. (Authorized by NFCM)

- **Client Intervention Services/Independent Living Consultation:** limited funding available for specific, short-term, client intervention services needs that are not available through Medicaid or waiver services. (Authorized by NFCM)

- **Social/Therapeutic Leave:** A Medicaid resident is allowed up to 18 days per calendar year up for social/therapeutic. The NFCM does not need to authorize this. See the NH Billing Guide for more information.

# Discharge Resources

## Community Transition Services (CTS)

- Funds used to purchase one-time, set-up expenses necessary to help relocate clients discharging from an institutional setting (such as a NF) to a home and community-based setting AND will be receiving CFC services upon discharge. Services may include:
  - First month's rent, deposits, safety deposits and/or utility set-up fees or deposits
  - Health and safety assurances, such as pest eradication, allergen control, or one-time cleaning fees prior to occupancy
  - Moving fees
  - Furniture, essential furnishings, and basic items essential for basic living outside the institution
- Maximum limit is **$850**. Limit can be exceeded by a HQ ETR (or local ETR when client is enrolled in RCL or WA Roads).
- Providers must hold a contract with DSHS (all contracting is performed by the local AAA).

# Discharge Resources

## Residential Care Discharge Allowance (RCDA)

- **One-time only state funds** used to help eligible clients relocate from institutional (NF or hospital) and other residential settings (AFH or AL) to a less restrictive setting. Can be used for clients with a DDA determination only if they are moving from a NF.
- Similar to CTS, services may include:
  - First month's rent, deposits, safety deposits and/or utility set-up fees or deposits
  - Health and safety assurances, such as pest eradication, allergen control, or one-time cleaning fees prior to occupancy
  - Moving fees
  - Equipment, furniture, essential furnishings, and basic items essential for basic living outside the institution.
- **Can be used to fund trial visits to less restrictive settings.**
- Maximum limit is **$815**; all providers must be contracted.
- Because it is state funded (no federal match), other services must be used first, if available.

# Discharge Resources

## Roads to Community Living (RCL)

- The statewide, demonstration project funded by the federal "Money Follows the Person" grant.
- Eligibility criteria:
  - Must be admitted **3 months or longer** into a hospital, nursing facility, or Intermediate Care Facility for the Intellectually Disabled (ICF-ID), OR
  - A continuous stay of 3 months or longer in a psychiatric hospital and be under age 22 years or over age 65 year;

  AND each of the following:
  - Receiving Medicaid-paid inpatient services immediately prior to discharge;
  - Interested in moving to a qualified community setting (home, apartment, assisted living or adult family home with 4 or fewer unrelated individuals);
  - On the day of discharge, RCL participants must be functionally and financially eligible for waiver (COPES) or state plan services (CFC or MPC or Fast Track), but participants are not required to receive services.

# Discharge Resources

## Roads to Community Living (RCL) *(cont.)*

- RCL services are available prior to discharge and for 365 days after the client leaves the institution.
- After 365 days in the community, the client transfers ongoing services to CFC, CFC + COPES or MPC for HCS or a community waiver for DDA.
- RCL services include those available under CFC or CFC+COPES, such as:
  - Personal care in a home or a qualified residential setting (AFH or AL)
  - Environmental modifications
  - Skilled nursing services
  - Personal Emergency Response System
  - Informal Caregiver Supports

# Discharge Resources

## Roads to Community Living (RCL) *(cont.)*

- There are some RCL services that are *not* currently available through the waiver or state plan (known as demonstration services):
  - Community Choice Guide (CCG)
  - Professional Therapies such as: OT/PT, speech/communication therapy, dietitian/nutritionist, transitional behavior consultation and technical assistance (available only after other resources have been used)
  - Adult Day Health Trial (available while client is a resident in the SNF)
  - Substance Abuse Services
  - Demonstration Transition Goods
  - Assistive Technology and Vehicle Adaptions

*The state receives extra match from CMS for most RCL services. (75/25)*

# Discharge and Stabilizing Resource

- Washington Roads
  - A state funded program intended to fill specific gaps to provide transitional and stabilizing services to support community living for ALTSA clients.
  - WA Roads is used to supplement existing available services when needed.
  - There are three distinct eligibility groups for WA Roads:
    - Cohort I are residents of an institution who do not meet the federal eligibility criteria for RCL but who need transitional goods or services not offered through CTS or RCDA. Clients must be:
      - People age 18 and older with a continuous 30-day or longer stay in a hospital or nursing facility; and
      - Medicaid recipients in the institution for at least one day; and
      - Eligible for home and community based services (HCBS).

# Discharge and Stabilizing Resource

## Washington Roads *(cont.)*

- Cohort II are individuals who live in the community who are functionally and financially eligible for waiver/state plan HCBS AND have unstable residential or in-home settings, frequent institutional contacts, frequent turnover of caregivers or multiple systems are involved (DOC, psychiatric institutions, etc.). **This can be used to help break the revolving door cycle some residents experience with the NF.**
- Cohort III are individuals living in subsidized housing that have been coordinated through ALTSA (including NED, Bridge, 811, etc.).

Most of the RCL demonstration services are available through WA Roads, as well as two additional services only available through WA Roads:

- Emergency Rental Assistance: one-time payment for emergency rental assistance to maintain or stabilize community placement
- Bridge Subsidy: housing option for individuals discharging to the community from an institution who are on a wait list for subsidized housing (available through contracted vendors for up to 24 months. For more information see your regional HCS Housing Specialist; phone numbers are available through your local HCS office).

# Discharge and Stabilizing Resource

## Washington Roads *(cont.)*

- WA Roads services are meant to supplement existing waiver and state plan services and should only be used when:
  - Community Transition Services (CTS) did not cover all the services or items necessary for an individual to relocate to the community from a nursing facility or hospital and the client is not eligible for RCL (CTS may be used in combination with WA Roads, when necessary).
  - All the other options have been tried and the client is at risk of losing their community setting. All other resources must be explored and maximized before authorizing WA Roads.
  - Unlike Roads to Community Living, these services provide no ongoing services like personal care after discharge.

# LTC Programs: State Plan Services

- Community First Choice (CFC):
  - Must meet NFLOC and financial eligibility
  - Services available include:
    - Personal and Relief Care
    - Nurse Delegation
    - Skills Acquisition Training
    - Personal Emergency Response Systems (PERS)
    - Assistive Technology
    - Community Transition Services
    - Caregiver Management Training
    - Annual Limit (used to purchase Skills Acquisition Training and/or AT)

# LTC Programs: State Plan Services

- Medicaid Personal Care (MPC)
  - Not required to meet NFLOC but must meet financial eligibility
  - Services include:
    - Personal care
    - Nurse delegation in residential settings (ARC, AFH)
    - Caregiver Management Training

# LTC Programs: Waiver Services

## Community Options Program Entry System (COPES)

- Must meet NFLOC and financial eligibility
- COPES is not longer a stand-alone program; it will always be linked with CFC (known as CFC + COPES)
- Services available include:
  - Adult Day Care
  - Adult Day Health
  - Client Support Training/Wellness Education
  - Environmental Modifications
  - Home Delivered Meals
  - Home Health Aide
  - Nursing Services
  - Specialized Medical Equipment and Supplies
  - Skilled Nursing
  - Transportation

# LTC Programs:

- Other Waivers:
  - New Freedom (only available in limited areas)
  - PACE (only available in limited areas)
  - Residential Support Waiver
  - Expanded Community Services (for eligible individuals with a mental health diagnosis)

- State Funded Services (less frequently used)
  - CHORE (group of clients grandfathered into program that ended in 2001)
  - Medical Care Services (limited eligibility and services in certain residential settings)
  - State-funded LTC for Non-Citizens (limited number of slots)

# Discharge Resources

## Long-term Care Ombuds Program (LTCOP)

- Included in the Medicaid State Plan and the federal Omnibus Budget Reconciliation Act (OBRA) of 1987 which included nursing home reform law which created the Residents' Bill of Rights and assured access to the state's LTCOP.
- LTCOP is a resource to protect resident rights regarding admission, discharge and transfer:
  - Resident's who meet NFLOC have the right to remain in the SNF if they choose.
  - Residents who meet NFLOC and choose to discharge to a community setting must be provided a safe discharge.
  - Residents who no longer meet NFLOC must be given:
    - Adequate notice of discharge (30 days)
    - Safe and orderly discharge
    - Notice of right to appeal the decision
    - Contact information for the LTCOP and Disability Rights Washington.

# Discharge Planning:

- The NF SW and the NFCM should work collaboratively with the resident to create a safe discharge plan.
- Early and consistent communication between all involved in the discharge process is key.
- The NFCM will authorize LTC services for eligible residents as needed to discharge safely to the community.
  - Most residents will not need every discharge service available.
- Functional and financial eligibility will determine a resident's LTC program and services at discharge.

# FAQ

Q: How do we know the RUG score? We only get our RUG report quarterly.

A: Most facilities use software that provides this information almost instantaneously. It is prudent to explore getting this information on a more regular basis.

Q: What if the resident doesn't want to leave?

A: The client can choose to stay.

Q: How do nursing homes work collaboratively with a client that has poor decision making skills and no family or legal representatives to assist with placement? How do we get clients like this someone to help advocate for them?

A: Contact the nursing facility case manager assigned to the facility. The LTC Ombuds is another resource.

# FAQ

Q: Who submits an Exception to Rule (ETR) if the SNF feels the resident's benefit amount will not cover the client's care need?

A: All authorizations are initiated by the NFCM. The results of the CARE assessment is reviewed by the case manager. If the NFCM feels the client's situation differs from the majority of others individuals in their CARE classification, the CM can submit an ETR for their supervisor's review. If their supervisor agrees that exceptional criteria is met, the ETR is submitted to HCS HQ for review.

Q: What if HCS CM does not feel the need for an ETR but the SNF does; what is the process to pursue an ETR?

A: If the client does not agree with the ETR outcome, the client may request a review of the decision.

Q: When an AFH decides to discharge the resident back to the NH within the first 30 days of admission, per WAC 388-76, will the NH be required to accept the resident-client back?

A: No WAC has been changed due to the budget proviso.

# FAQ

Q: Will there be any webinars towards adult family homes or assisted living facilities to request them to engage with nursing homes so that it can become known that this need exists?

A: The NF Associations and DSHS are working collaboratively with the AFH association and AL providers to educate community residential providers.

Q. When will the penalty be felt by SNFs?

A: Case mix is adjusted twice each year. The adjustment will impact January 1, 2017 rates.

Q: What if there is a lack of resources in an area such as a lack of Medicaid beds in less restrictive settings?

A: This will be closely tracked by both HCS and the nursing home associations. HCS HQ will be in touch with regional administrators to look for possible solutions when this occurs.

# FAQ

Q: Are there additional HCS workers that will be available to help meet these timelines?

A: No. The legislation did not fund additional DSHS FTE.

Q: How will the NFCM present this information without it looking like the SNF is requesting them to leave?

A: NFCMs are used to presenting all the service options to residents. This is their regular business. There has been made available an "Informational Bulletin" that can be given to residents regarding their right to decide where they live. This can be left with the resident in case questions arise from family or loved ones.

Q: If a client has a protective payee and funding is sent directly to the SNF, does APS need to intervene to set this up in the community?

A: No; the NFCM can arrange this. They might bring in a CCG to assist with the paperwork, etc.

# FAQ

Q: There have been issues with ordering equipment. Have the issues been resolved?

A: Yes. On June 17th a Management Bulletin was released changing the process to order bathroom equipment when it is needed for independent living. This process may take a couple of weeks to get to the field workers through their unit meetings, etc.

Q: How is equipment that is only necessary post discharge, such as a hospital bed, obtained? Do we use rental equipment?

A: Items such as hospital beds can be authorized while the resident is in the SNF, but the vendor may only claim after the resident is in the community and it has been confirmed that the item has been received by the client.

Q: Does the discharge of a resident in these RUG groups that occurred after the legislation but before July 1 count towards the 96?

A: No. But supporting lower acuity individuals who desire to move transition to the community will impact your case mix.

# FAQ

Q: I work in a facility that specializes in Alzheimer's and much of our population fall into these lower RUG scores. Is there going to be changes in the MDS to help capture the needs of residents with higher ADL scores that don't qualify for the behavior RUGs?

A: The MDS is a federal assessment that WA State cannot influence. Changes have been made to exclude those with certain behaviors from the requirement (see slide 4).

Q: I have a question regarding participation for residents who discharge. Is that changing?

A: No, participation isn't changing. See the Nursing Facility Billing Guide for information.

Q: Has the Business Rules for MDS Payor Source been updated since COPES has changed?

A: Yes, it was updated on June 23, 2016.

# FAQ

Q: Who should facilities contact if a DDA client is identified in the lower RUG groups; is there someone specifically identified to work with DDA clients at HCS?

A: Submit your Intake the same way; the HCS NFCM and the DDA Case Resource Manager will work together to coordinate discharge for clients enrolled in DDA who desire to move to a community setting.

Q: The hospitals are already having trouble discharging residents in these low RUG groups and the BB RUGs; how is this going to affect the hospitals, and have you talked to them about this?

A: HCS is working on developing a strategy to divert more individuals from discharging from acute care hospitals to nursing homes. HCS is working on providing more information to hospital discharge planning regarding community care options.

Q: Is each facility expected to discharge 96 residents or is the 96 across all NFs across the state?

A: 96 discharges is a statewide benchmark.

# FAQ

Q: Does the RUG scores affect the AFH they go to?

A: No, although the rate for the AFH is based on acuity level so some AFHs may choose not to accept the daily rate for some of the lower CARE classification levels.

Q: Who would a nursing home contact if the nursing home social worker or case manager have not responded timely to an Intake?

A: Take your concerns to the NFCM's supervisor. If they don't respond, discuss the issue with the local Field Services Administrator.

Q: When is an Intake due for current residents in these RUGs?

A: By July 30, 2016. Then, as additional residents are identified as being in these RUGs, the NF has 30 days from the date of identification to notify HCS. For example, if an MDS assessment is completed on August 1st and a new individual is identified as being in the PA1-PC1 RUG group, the SNF has until August 31, 2016 to notify HCS.

# FAQ

Q: Is there a resource I can use to share with a resident a success story or two of people who have moved successfully to the community?

A: Yes! You can find an RCL Video Presentation @ https://www.youtube.com/watch?v=778HOXbrRD4

Transforming Lives

Questions should go to your NH Association.

whca Washington Health Care Association

LeadingAge Washington