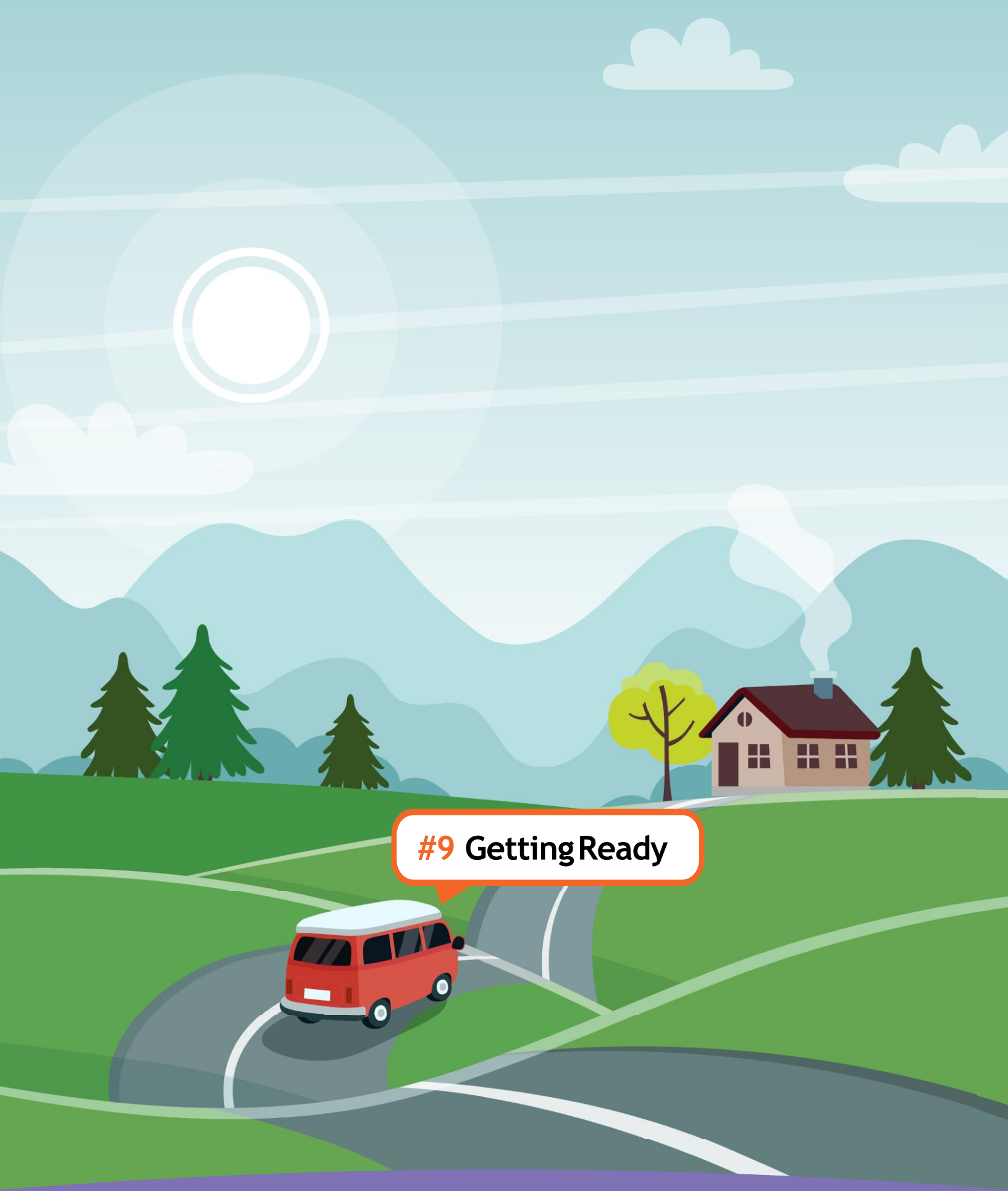

ADULT FAMILY HOME

ADMINISTRATOR STUDENT MANUAL

VERSION 5.2

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Module 9 – Getting Ready
Table of Contents

Getting Ready to Admit a Resident

Introduction

Apple Health is Washington's Medicaid program. In this module we will discuss Apple Health Long-Term Services and Support. The Comprehensive Assessment Reporting and Evaluation (CARE) assessment determines functional and program eligibility. We will cover CARE definitions, rates, and categories. We will clarify Medicaid supplementation and the Exception to Rule (ETR) processes. Our Home and Community Services (HCS) and Developmental Disability Administration (DDA) Case Managers (CM) share a personal message with you with tips and recommendations. Many providers are anxious to fill their beds as soon as possible. A referral agency may be an option. We will discuss the pros and cons when considering a referral agency.

Learning Objectives

At the end of the module, you will be able to:

- Describe Medicaid and its programs and supports
- Explain the role of the assessment/preliminary care plans
- Identify the qualifications of a qualified assessor
- Summarize the role of the CM
- Discuss Medicaid payment, supplementation, and ETRs

What Do you Know?

- What do you know About Medicaid?

Medicaid

What is Medicaid?

> Medicaid allows me to receive service in the community, to choose where and with whom I want to live, and to make choices about my life.
>
> -- @AmySequenzia

Medicaid is a government health insurance program. To be Medicaid eligible, individuals must have very limited income and resources. Each state designs and administers its own Medicaid program according to federal requirements. Apple Health is the Medicaid program in Washington State. Centers for Medicaid and Medicare Services (CMS) is the federal Medicaid agency. CMS, together with the state, funds the state's Medicaid program. States must meet all CMS requirements to offer Medicaid. Apple Health Long Term Services and Support (Apple Health LTSS) pays for long-term care.

Medicaid Contracts

If you want to serve Medicaid residents, you must have an Adult Family Home Medicaid Contract. AFH contracts are legal agreements between the AFH (the contractor) and DSHS. The contract describes the legal obligations, responsibilities, and conditions for providing Medicaid services.

To apply for an Adult Family Home Medicaid Contract:

1. Email adsahqcontracts@dshs.wa.gov with your interest to have a Medicaid Contract. Include the following information:
    - Facility Name
    - Facility License Number
    - Facility Address

2. Contracts staff will enter your request into the Agency Contracts Database (ACD). Once in ACD, they email you the forms below to complete. To save time, you can complete them first and attach them to your contract request.
    - Contractor Intake Form
    - Medicaid Provider Disclosure Statement
    - W9

    Once the contract manager has processed your forms) they will email you a copy of the contract for review and signature. When you return your signed copy, contract staff will complete the contracting process and send you a copy.

Contract Distribution:

- The Health Care Authority manages all Medicaid payments using a system called ProviderOne (P1).
- P1 is automatically notified when there is a new Medicaid contract.
- P1 automatically sends you a letter with a "User Access Request". Once the Heath Care Authority receives the User Access Request back, they set up your business in the system. Once set up, you will be able to claim and receive payment for providing Medicaid services.
- You will learn more about ProviderOne at the end of the module.

Additional Contracted Medicaid Services or Programs

To use these specialized services or activities, they must be added to your Medicaid contract:

- Meaningful Day Activities (MDA)
- Expanded Community Services (ECS)
- Specialized Behavior Support (SBS)

AFH Sample Contracts

AFH Sample Contracts | DSHS (wa.gov)

- AFH Sample Contract
- AFH & Meaningful Day Sample Contract
- AFH & Expanded Community Services Sample Contract
- AFH & Private Duty Nursing Sample Contract
- AFH & Out of Home Respite Sample Contract
- AFH & Specialized Behavior Support Sample Contract

Medicaid Funding Sources

There are several funding options available to pay for personal care in an AFH setting. Selecting the best funding source depends on the client's eligibility and need.

- Community First Choice (CFC)
- Community Options Program Entry System (COPES) Waiver
- DDA Waivers
- Medicaid Personal Care (MPC)
- Residential Support Waiver (RSW)
- Roads to Community Living (RCL)
- State-funded Medical Care Services (MCS)

Medicaid Services and Supports

- All Medicaid services have different program and eligibility requirements
- Each resident's services are unique and based on their functional and financial eligibility and assessed needs as identified in their person-centered service plan
- A CM will only create an authorization for the services the resident has consented to in their plan of care
- To receive payment for any Medicaid service, it must be in the resident's person-centered service plan and authorized by their CM

Medicaid Services Summary

Some of the services listed below require an addition to your Medicaid contract and/or have a "$" at the end of their title. The "$" indicates there is an add on (additional amount) to the services AFH daily rate (Current DDA and HCS Rate Tables).

- The state is broken into Metropolitan Service Areas (MSA). Your rate and add-on amounts will depend on which county/MSA your home is located.
- An add-on may be a set amount. For example, Meaningful Day is a flat daily rate (See the Rate Tables linked above)
- A rate may increase due to an Exception to Rule (ETR).

NOTE: If you are authorized a rate different from what you were told, contact your CM right away.

The Service Summary prints the rates for most services. A few services such as Community Integration, Meaningful Day Activities, and Residential Support Waiver (ECS and SBS) are not included.

Adult Day Health (ADH)

- ADH is a supervised daytime program providing skilled nursing and rehabilitative therapy services in addition to the core services of Adult Day Care. Adult Day Health services are appropriate for adults with medical or disabling conditions that require the intervention or services of a registered nurse or licensed rehabilitative therapist acting under the supervision of the resident's physician or an Advanced Registered Nurse Practitioner (ARNP).

Adult Protective Services (APS)

- An individual can be placed in an AFH for up to 90 days to help protect the alleged victim from harm
- APS may move an individual to an AFH without regard to functional or financial status
- State funds pay up to the 90 days unless placed under Medicaid
- Can move to Medicaid funding if functional and financial eligibility are established

Bed Holds for Medical Leave

WAC 388-105-0045

You must hold the resident's bed for 20 days when:

- The resident discharges to a hospital or nursing home for medical reasons,
- The stay is expected to be short-term, and
- They are likely to return to the AFH.

To receive payment to hold a bed, you must report your resident's admission to a medical facility to your CM **within one working day**. You can report either by email, fax, or phone. The discharge must be to a nursing home or hospital and expected to be longer than 24 hours.

- Use the Adult Residential Care Services Notice of a Change (wa.gov) form (DSHS 05-249), to notify your CM of a bed hold. You can fax it to (855)635-8305 or send by mail as indicated on the form. For DDA, email the form to your CM.
- Timely notification of discharges and returns is critical in reducing overpayments

Authorization for payment occurs after validation that the resident returned or will not be returning to the AFH and is based on the number of days your resident is out of the home:

- Date of Discharge to the 7th Day: 70% of daily rate
- 8th day through the 20th day: $15 per day
- 21st day forward: You may seek a third-party payment or no longer hold the bed

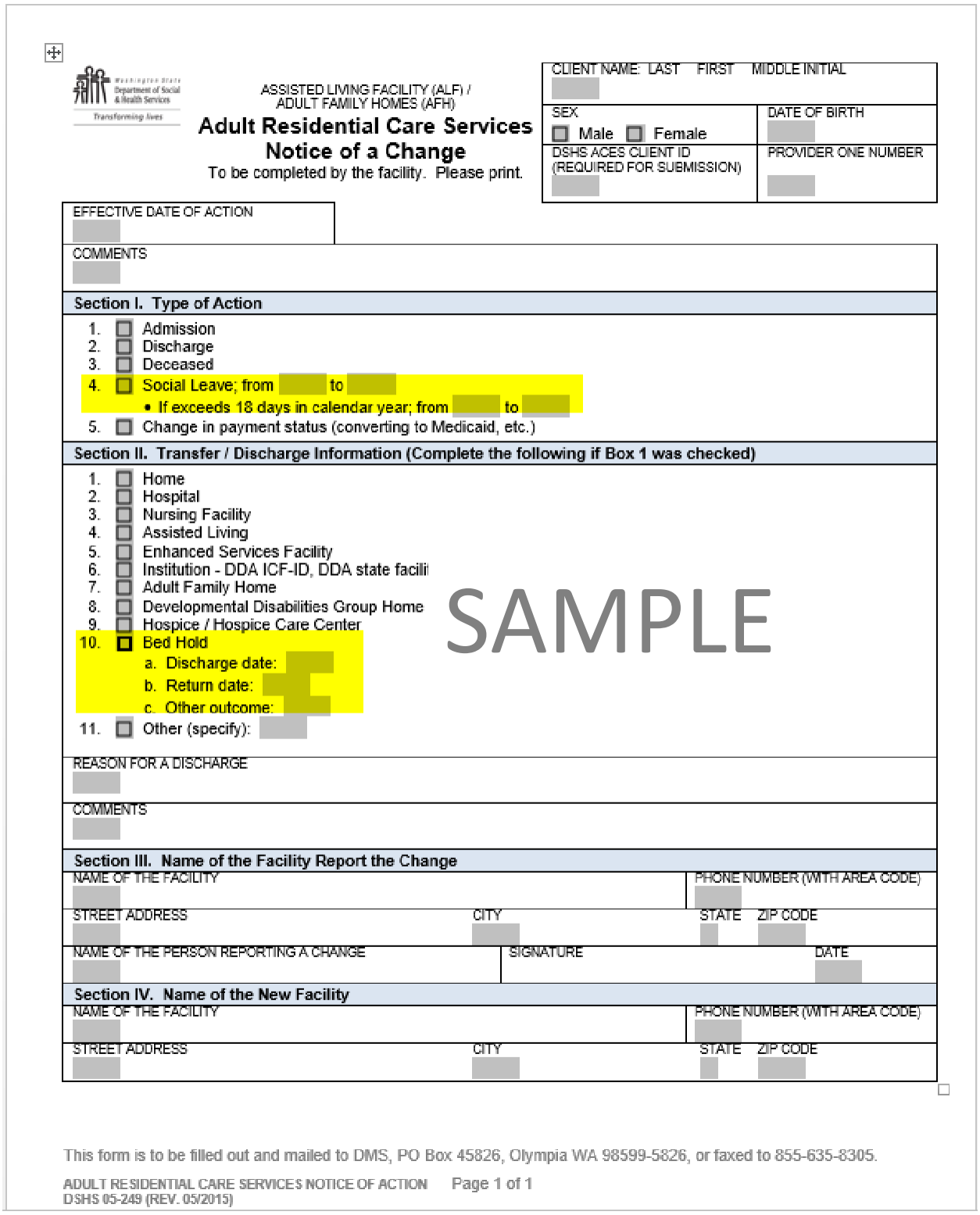
You may not seek third party payment during the first 20 days. After the 20th day, the provider may seek third party payment to continue to hold the bed. The third party payment cannot exceed the client's Medicaid daily rate paid to the facility at the time that the facility discharged the client to the hospital or nursing home (WAC 388-105-0045(10)).

After 20 days, the resident may wish to return to the AFH. If they continue to be eligible, they may return to the first available and appropriate bed.

Bed hold time frames if the resident returns home and discharges again

- Within 24- hours – Continue same 20-day bed hold
- After 24-hours – Start a new 20-day bed hold

You cannot claim for any services (personal care, nurse delegation, etc.) while the resident is in the medical facility.



ASSISTED LIVING FACILITY (ALF) / ADULT FAMILY HOMES (AFH)

Adult Residential Care Services
Notice of a Change

To be completed by the facility. Please print.

CLIENT NAME: LAST	FIRST	MIDDLE INITIAL
SEX ☐ Male ☐ Female		DATE OF BIRTH
DSHS ACES CLIENT ID (REQUIRED FOR SUBMISSION)		PROVIDER ONE NUMBER

EFFECTIVE DATE OF ACTION

COMMENTS

Section I. Type of Action

1. ☐ Admission
2. ☐ Discharge
3. ☐ Deceased
4. ☐ Social Leave; from ____ to ____
   - If exceeds 18 days in calendar year; from ____ to ____
5. ☐ Change in payment status (converting to Medicaid, etc.)

Section II. Transfer / Discharge Information (Complete the following if Box 1 was checked)

1. ☐ Home
2. ☐ Hospital
3. ☐ Nursing Facility
4. ☐ Assisted Living
5. ☐ Enhanced Services Facility
6. ☐ Institution - DDA ICF-ID, DDA state facili
7. ☐ Adult Family Home
8. ☐ Developmental Disabilities Group Home
9. ☐ Hospice / Hospice Care Center
10. ☐ Bed Hold
    a. Discharge date:
    b. Return date:
    c. Other outcome:
11. ☐ Other (specify):

SAMPLE

REASON FOR A DISCHARGE

COMMENTS

Section III. Name of the Facility Report the Change

NAME OF THE FACILITY			PHONE NUMBER (WITH AREA CODE)
STREET ADDRESS	CITY	STATE	ZIP CODE
NAME OF THE PERSON REPORTING A CHANGE	SIGNATURE		DATE

Section IV. Name of the New Facility

NAME OF THE FACILITY			PHONE NUMBER (WITH AREA CODE)
STREET ADDRESS	CITY	STATE	ZIP CODE

This form is to be filled out and mailed to DMS, PO Box 45826, Olympia WA 98599-5826, or faxed to 855-635-8305.

ADULT RESIDENTIAL CARE SERVICES NOTICE OF ACTION Page 1 of 1
DSHS 05-249 (REV. 05/2015)

Residential Care Services Behavior Health Support Team (RCS BHST)

The Residential Care Services Behavioral Health Support Team is available to support providers who have residents that exhibit exceptional behaviors. Their services are available in AFHs and other residential settings.

Thoughts on Successful Admissions from the
Residential Care Services Behavior Health Support Team (RCS BHST)

The RCS BHST wants your AFH to be successful. The number one challenge many AFHs face is understanding and addressing difficult behaviors. A resident may exhibit behaviors for a multitude of reasons. Dementia, mental health, and developmental disability are a few examples. Consider some of the following questions and strategies before you admit a resident.

To be successful, it's critical that you make thoughtful admission decisions. Consider asking yourself the following questions as you consider a resident for admission.

- Do you have all the information you need to make a good choice?
- Is this resident someone you can realistically care for, day in and day out, for the coming months? Can you meet them at their current need or their highest level of need without expectation that they will improve?"
- Will this resident be a good fit for your staff and any other residents who already live here?
- Does your home already have residents with intensive needs? If so, can it handle another without it having a negative impact on the other people already living here?

Once you've made your decision, start coming up with a plan for how you'll provide care to them once they move in. Consider asking yourself the following questions as you prepare for admission.

- Will you have enough staff to cover 24 hours/7 days a week?
- What's the best way to share space within the home?
- How will staff respond to any known behaviors?
- How will your new resident's preferences impact the preferences of others? What accommodations do you need to make?

Residents who have had difficulties in other settings may have difficulties with you too. Perhaps your home will be their third move this year as they discharge from a long-term hospital stay. Or they're about to finish a course of treatment in a mental health hospital. The RCS BHST is available to provide you with guidance as you make these important decisions and plans, especially for residents who have a history of engaging in challenging behaviors. The RCS BHST may be able to help you get things off to a good start.

The RCS BHST wants to help you and your resident be successful in the long term. We can help you with:

- Developing strategies for obtaining all the information you can about a person before admission
- Understanding how the regulations may apply to your situation
- Preparing your home and staff for when the new resident admits

To request assistance, please send an email to RCSBHST@dshs.wa.gov.

Do you have...

...a resident who is difficult to care for due to behaviors?

...staff who want training about mental health, how to handle behaviors, regulations...or something else?

...regulatory questions, especially when it comes to caring for residents with challenging behaviors?

Are you...

...preparing to admit a new resident with challenging behavior history?

...struggling to come up with new ways to care for a resident with challenging behaviors?

...feeling overwhelmed by a residents' behavioral health needs?

The RCS Behavioral Health Support Team Is Available!

WE'RE HERE TO HELP

Frequently Asked Questions:

How do I make a referral to your team?
- All we need is an email with the resident name, date of birth, the name of the Adult Family Home, the name & phone number of the best point of contact at the Home, & if you are referring on behalf of an Adult Family Home– indication that you've spoken to the owner about making a referral & that they're okay with you talking to someone from our team.

Does anyone on the team investigate complaints or inspect facilities? Do you issue fines or citations?
- **No**. Nobody on the team has the authority to do these things. If we see a potential rule violation we will bring it to your attention, & may report to the appropriate authority. This is because everyone on the team is a mandated reporter - like all DSHS employees.

Is the information your team provides guaranteed to be 'citation proof?'
- We can't guarantee this, as there are too many factors that impact each situation. However, please know that ***we work hard*** to ensure that what we provide is also in alignment with the regulations. This includes staffing with the individuals who write those policies & other regulatory subject matter experts when we're not sure about something.

What if I'm not sure you can help?
- Reach out to us anyway! We'll do the best we can to help you, & if we can't then we'll try to get you pointed in the direction of someone who can.

Are team members experienced in working with behavioral health issues?
- **Yes**. Members include licensed social workers, licensed mental health counselors & more – with experience working at Western State Hospital, the Special Commitment Center on McNeil Island, community mental health agencies, Home & Community Services, local courts & behavioral health crisis units. We are able to help providers address a range of challenges, including disruptive behaviors, wandering, aggression, substance use, refusal of care, symptoms of psychosis...the list goes on.

Does a resident have to have a specific mental health diagnosis before we can make a referral?
- **No**. It doesn't matter to us if the resident has a cognitive issue like dementia, a mental health diagnosis like schizophrenia, a developmental delay or no diagnosis at all - so long as the resident engages in a challenging behavior, it's a referral we can take!

Can a provider receive support for individual residents & receive training for staff?
- **Yes**. A provider is welcome to both of these services. Also, please note that training is ***free***.

Does a resident have to be on Medicaid, or does the facility have to accept Medicaid in order for you to help?
- **No!** So long as the facility is a Nursing Home, an Assisted Living Facility, an Adult Family Home or a Supported Living Home that is licensed or certified by RCS, it's a referral we can take!

Does your team provide mental health counseling to residents?
- **No**, this is outside of our team's scope. However, if mental health services are needed, we are happy to help you find local resources to meet that need.

OPEN **We'd love to hear from you! Make a referral or ask us a question by sending an email to: RCSBHST@dshs.wa.gov** OPEN

Client Training-Behavior Support

This waiver service provides training to the resident and AFH provider through the development of a behavior support plan. The goal of this plan is to develop positive interactions and outcomes which help facilitate a successful care plan.

Client Training-Behavior Support cannot replace services available through the resident's Apple Health benefit. If the resident may benefit from additional behavioral health services offered through a resident's Apple Health benefit, the CM can make a referral to the local mental health agency.

To access a behavior support provider, your CM will make a referral for an assessment. The behavior support provider will complete an assessment of the causes, triggers, and purposes behind the behavior within 90 days. The behavior support plan will address things such as:

- Factors that increase the likelihood of challenging and positive behavior.
- Recommendations for:
    - Improving the resident's quality of life
    - Strategies, techniques, and environmental changes to decrease the challenging behavior and increase positive behavioral changes
    - Work with the resident to achieve mutually desired outcomes
- Direct interventions with the resident to decrease the behavior that may compromise their ability to remain in their community
- Strategies for effectively relating to providers and other people in the resident's life

Client Training – Behavior Support Example:

Erin experiences delusional thoughts and is living at an AFH. Erin is currently receiving direct counseling services from her local mental health agency. Erin is often resistive to care and has been combative in the past with caregivers. The Case Manager received a phone call from the AFH explaining that providing care to Erin was increasingly difficult and has recently begun cussing at caregivers and others living in the home.

The Case Manager visits Erin at the AFH, and Erin agrees to accept services through Client Training-Behavior Support. The behavior support provider begins working with Erin and staff at the AFH to identify the causes, triggers, and purpose behind the behaviors. A behavior support plan is developed and implemented.

Community Choice Guide (CCG)

Community Choice Guide is a HCS Community First Choice (CFC) service available through Community Transition Services (CTS). Community Choice Guides help AFH residents establish or stabilize their living arrangement.

Individuals are eligible for CCG services when the person's community living situation is unstable and the person is at risk of institutionalization or when the person is transitioning to the community from a skilled nursing facility or hospital.

Community Integration (CI) - $

Federal rules prohibit resident isolation from their communities or others outside of the AFH. Community Integration focuses on residents having opportunities to engage in their communities.

To receive CI, the resident must have an assessed unmet need (a need that is not met by other resources) to access and take part in their community. For residents receiving CI, you can receive an adjusted daily rate to provide about four (4) hours of CI per month.

CI is available for both HCS and DDA residents. CI is unique to each resident based on their interests and preferences. The resident, or other resources, pay any cost for the activity.

Community Integration may include the following monthly supports provided by the AFH:

- Assisting the resident to select what they want to do and where they want to go
- 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
- Helping the resident find others who can go with them to the event or help with transportation
- Arranging for or providing transportation to and/or from the activity
- Accompanying the resident during the event to provide personal care
- Looking for more opportunities the resident may want to take part in

A CM may authorize CI along with other services, such as:

- Specialized Behavior Support
- Meaningful Day Activities
- DDA Community Guide Services
- Expanded Community Services

Community Integration Mileage Reimbursement

To be eligible to receive CI mileage reimbursement:

- You or your staff provide transportation in your vehicle
- Your CM has documented an unmet need for transportation, meaning there isn't any other transportation options available
- The resident chooses to receive transportation from you to and/or from the CI activity
- The need must be reflected in the CARE person-centered plan of care
- Be authorized by CM
- You must keep track of the specific number of miles driven each day for each participating resident for up to 100 miles per month.

Meaningful Day - $ - Contract(s)

Meaningful Day uses a person-centered approach for designing and delivering meaningful activities to HCS/DDA eligible residents.

Activities developed by the AFH provider, focus on their individual resident's interests, life experiences, and preferences. The goal is to increase the resident's participation, refocus behavior, and improve their quality of life and continuity of care.

The Meaningful Day add-on rate is part of the AFH Collective Bargaining Agreement (CBA). To receive the Meaningful Day add-on rate, you must have:

- A resident that meets the criteria for Meaningful Day
- Completed the Meaningful Day training
- Have a HCS and/or DDA Meaningful Day contract. In July 2021 the Meaningful Day contract was split into HCS and DDA contracts. The goal was to tailor the services more specifically to the types of residents each administration serves. See Dear Provider Letter: AFH #2021 -036
    - DDA requirements are found in DDA Policy 4.16 Adult Family Homes – Meaningful Day
    - HCS requirements are still under development. You can view the draft language here
- No enforcement action related to health and safety for at least one year prior to adding Meaningful Day to your contract
- No unresolved citations related to resident health and safety at the time of contracting

There is no limit to the number of HCS/DDA residents that can be eligible for this service/intervention. The resident and provider must agree to the activities in writing.

For each Meaningful Day resident, the AFH must provide the following supports:

- Collaborate with the resident on a variety of activities relevant to their interests, choices, and abilities that are planned and routinely available. The activities may include individual as well as group activities.
- Development of a Meaningful Activity Plan (MAP) that identifies client-centered strengths, preferences, and desired activities.
- Identify the basic supplies and costs needed for the planned activities keeping within the reimbursement provided or identifying an alternative source for supplies.
- Create a monthly activity calendar for each participating resident. The calendar will document their planned activities, events, appointments, and special care.
- Implement the Person-Centered Activities as outlined in the MAP and Negotiated Care Plan.
- Coordinate meaningful activities within the community the resident can take part in.
- Use the DSHS provided behavior tracking chart to observe and record identified targeted behavior(s), engagement, and activity outcomes.

NOTE:

- Meaningful Day is not available to residents receiving Specialized Behavior Support or Expanded Community Services.
- Eligible residents may receive both Meaningful Day Activities and Community Integration.
- Interested AFHs can email MeaningfulDay@dshs.wa.gov for information on HCS eligibility and training.

Resources: Meaningful Day

- Adult Family Home Meaningful Day – DDA
- DDA Meaningful Day Policy 4.16
- Dear Provider Letter: AFH #2021 - 036

Medical Escort Fee - $

You can request reimbursement for escorting a Medicaid resident to a medical appointment. To qualify, you must have used all other means of both escort and transportation options.

You can request more money for transporting and going with a resident to a medical appointment. The amount paid is a per hour rate up to no more than 24 hours per resident per calendar year. To be eligible, you must be able to provide:

- Documentation of the medical appointment
- A denial from the Medicaid transportation broker
- Documentation that informal supports were unavailable
- The date you provided the transportation
- The actual start and stop time you escorted the resident and provided transportation

Medical Mileage Reimbursement - $

Reimbursement is available for up to 50 miles per month per resident when you transport your resident to/from medical appointments. To qualify:

- The resident has an unmet need for transportation to/from a medical provider and is included in their person-centered service plan
- There are no other transportation options available
- The Medicaid brokerage transportation will not meet the resident's needs
- Be authorized by CM
- Keep track of the specific number of miles driven each day for each participating resident for up to 50 miles per month.

NOTE:

- Medical Mileage can be authorized in addition to the Medical Escort Fee and community integration
- You will need to provide specific dates and number of miles you drove to/from the medical appointment when you submit your claim for payment

Nursing Services

Nursing Services offer health-related assessment and consultation to enhance the development and implementation of the resident's plan of care. The goal of nursing services is to help promote the resident's maximum possible level of independence and contribute nursing expertise.

A nursing services provider does not provide direct care unless it is an emergency.

HCS/DDA residents may be eligible for nursing services. Nursing services cannot duplicate any service already provided by contract or another source. CARE determines the frequency and scope of the resident's nursing services.

Nursing Care Consultants (NCC) assess DDA residents in AFHs. Community Nurse Consultants (CNC), assess HCS residents. Their recommendations help CMs to develop safe plans of care.

A CM may make a referral for nursing services based on:

- An unstable diagnosis
- Issues that impact the plan of care, such as:
  - A complicated medication regimen
  - Nutritional status
  - Immobility issues
- Skin problems
- Skin Observation Protocol

Resource: Nursing Services

- Nursing Services
- Nursing Services – Developmental Disabilities Administration (DDA)

Personal Care

- Physical or verbal assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) due to functional limitations
- HCS/DDA Medicaid payment determined by the CARE assessment

Private Duty Nursing (PDN) Specialized AFH

WAC 388-106-1045, WAC 388-106-1046, WAC 388-106-1047

- A Registered Nurse must own the AFH.
- Must have an amended contract with ALTSA to provide PDN.
- A CNC/NCC, uses the CARE assessment to determine the need for PDN. To be eligible, the resident needs at least eight hours of PDN daily.
- The department will pay the AFH an all-inclusive daily rate for a PDN resident. The rate includes payment for:
  - PDN services
  - All skilled nursing tasks
  - All personal care services

- The AFH provider/resident manager must be a RN in good standing. They manage the daily operation of the AFH and oversees the care provided to the resident.
- You will not be paid for nurse delegation services in addition to the PDN all-inclusive daily rate.

Registered Nurse Delegation

Nurse Delegation is a service option that provides client assessment along with caregiver training and supervision to Long Term Care Workers who perform delegated nursing tasks.

A Registered Nurse Delegator (RND) provides Nurse Delegation (ND) in your AFH. To perform delegated tasks, the provider must be a:

- Nursing Assistant – Registered (NA-R)
- Nursing Assistant – Certified (NA-C/CNA)
- Home Care Aide – Certified (HCA-C)

The RND teaches, evaluates, and supervises the competency of the provider performing the delegated tasks. Based on this analysis, they determine if they can perform the limited nursing task(s). ND is available for both Medicaid and private pay residents.

Find more information about Nurse Delegation in Module #10 – Admitting, Monitoring, and Discharging.

Residential Support Waiver (RSW)

WAC 388-106-0336 through 0348

The RSW is a home and community-based waiver service that helps support the resident in the community. Eligible residents receive personal care, community options, and specialized services. RSW provides specialized targeted services for residents with extremely challenging behaviors. Residents may:

- Be discharging from state or acute care hospitals
- Be diverting from psychiatric units
- Have a history of frequent or extended psychiatric hospitalizations
- Have a history of being unable to remain medically or behaviorally stable for more than six months
- Have no other setting options due to behavior and clinical complexity
- Require supplementary or specialized staffing due to behavior or clinical complexity
- Require caregiving staff with specific training in providing personal care and behavior support to adults with challenging behaviors

All residents who receive RSW services also receive behavior support services. Each RSW resident has a Person-Centered Service Planning Team (PCSP Team). The PCSP Team uses a person-centered planning process to ensure consistency in the resident's:

- Behavior Support Plan
- Crisis and/or Safety Plan

RSW – Expanded Community Services (ECS) - $ - Contract

ECS Is the **First Level of Support** under the Residential Support Waiver for residents with behavioral needs.

ECS services include:

- Personal Care
- Medication oversight
- Supervision in the home and community
- 24-hour on-site response staff
- Person-centered, on-site client training for the resident and staff
- Coordination and collaboration with a contracted behavior support provider
- Development and implementation of a behavior support plan that includes a crisis and/or safety plan to address steps to take when faced with a crisis
- Modification of the behavior support plan as the resident's needs change
- Monthly psychopharmacological medication reviews

AFH Provider Requirements

- Provide enhanced care and support
- Work with the Behavior Support Provider to develop a Behavior Support Plan and Crisis Plan
- Include the services and supports developed by the Behavior Support Provider in the NCP

ECS Contract Requirements:

- You must have had a current AFH license for 12 months
- No significant enforcement during the 12 months prior to applying for the AFH-ESC contract
- AFHs with an ECS contract receive an add-on amount to their rate. The add-on amount is negotiated through the collective bargaining process. WAC 388-106-0120

RSW – Specialized Behavior Supports (SBS) - $ - Contract

SBS is the **Second Level of Support** considered under the Residential Support Waiver.

SBS services include:

- All the services available under ECS
- A written activity plan for each SBS resident that reflects activities in the resident's daily routine
- One-to-one staffing for 6-8 hours per day

AFH Provider Requirements

- Have successfully completed the specialized mental health training.
- The AFH must provide 6-8 hours of one-to-one staffing supervision and behavioral support to a SBS resident daily. This requirement increases depending on the number of residents receiving SBS (limited to 3 residents, although the HCS Regional Administrator may authorize a fourth SBS resident).
- Attend a monthly SBS meeting with the resident, HCS CM, Behavior Support Agency, and anyone else identified by the resident.
- Maintain and provide a daily activity log at the SBS meeting.

- Ensure that 10 of the 12 hours of annual continuing education for each staff includes topics relevant to the SBS residents.
- The AFH must submit the planned staffing schedule and activity log, reflecting the required 6-8 hours per day of additional staff, to the HCS CM prior to the SBS client moving into the AFH and whenever the schedule changes.

SBS Contract Requirements:

- Same requirements for an ECS contract
- Have a demonstrated history of working with people with behavioral challenges

AFHs with a SBS contract receive an add-on amount to their rate. The add-on amount is negotiated through the collective bargaining process. WAC 388-106-0120

Skilled Nursing

Skilled nursing provides direct skilled intermittent nursing tasks to residents that cannot be delegated. Some of these tasks may include administration of medications and injections, sterile catheter changes, and bowel programs. Skilled nursing cannot duplicate a service that is already provided by contract or another source.

Social Leave

WAC 388-110-100 (2)

Social Leave is for recreational or socialization purposes and is limited to no more than **18 days per calendar year**. It cannot be used for medical, therapeutic, or recuperative purposes.

You are responsible for reporting to the CM and tracking social leave for your residents.

- You must notify the resident's CM within **one working day** of the resident taking social leave.
- Inform the CM how the resident's personal care needs will be met while the resident is out of the facility
- Use the Adult Residential Care Services Notice of a Change (wa.gov) form (DSHS 05-249)

Specialized Medical Equipment and Supplies

HCS residents may be eligible for specialized medical equipment and supplies. The items must be documented in the resident's plan of care and necessary for:

- Life support
- To increase the resident's ability to perform activities of daily living, or
- To perceive, control, or communicate with the environment in which the individual lives, or
- Are directly remedially beneficial to the resident, and
- Do not replace any medical equipment or supplies provided under Medicaid or Medicare.

Transportation - $

Transportation is a service offered to enable residents enrolled in the waiver to gain access to waiver and other community services, activities, and resources as specified in the service plan.

- Provides access to community services and resources to meet a therapeutic goal
- Is not diverting in nature
- Does not replace the Medicaid-brokered transportation or transportation services available in the community
- Does not replace the services required by DSHS contract in residential facilities

Wellness Education (WE)

Wellness Education (WE) is a customized monthly newsletter available to residents authorized the service to help manage health related issues, achieve goals on their service plan, and address topics of community living. Data from a resident's assessment is used to target articles specific to the resident. If the resident has a representative, they will also receive a copy.

Wellness Education is available in 27 languages, based on the resident's preferred written language in CARE. Some residents indicate Braille in CARE but prefer to have WE read to them. If a resident with visual impairment wants, WE in Braille, please contact your CM.

Qualified Assessors

WAC 388-76-10150

Only qualified individuals can complete an AFH resident assessment. To be eligible, the assessor must meet one of these requirements:

- For Medicaid residents; an authorized department case manager:
  - HCS Case Manager
  - DDA Case Resource Manager
  - Area Agency on Aging (AAA) Case Manager

- For private pay residents, a Private Assessor who has a:
  - Master's degree in social services, human services, behavioral sciences or an allied field and two years social service experience working with adults who have functional or cognitive disabilities; or
  - Bachelor's degree in social services, human services, behavioral sciences or an allied field and three years social service experience working with adults who have functional or cognitive disabilities; or
  - Valid Washington state license to practice as a
    - nurse and three years of clinical nursing experience; or
    - physician, including an osteopathic physician

You must verify a private assessor's credentials, and they must pass a background check. You **CANNOT** use an assessor that:

- Has unsupervised access to your residents; and either
- Has a disqualifying criminal conviction or pending criminal charge for a disqualifying crime; or
- Has one or more negative actions in WAC 388-76-10180

HCS Case Manager/DDA Case Resource Managers

The CM are integral to a person's transition and ongoing residency in their AFH. Prior to transitioning to an AFH, a CM will:

- Assist Medicaid eligible clients to locate an AFH of their choice
- Provide a copy of the Assessment Details and Service Summary to the provider
- Discuss the Assessment Details and Service Summary with the provider and answer any questions
- Coordinate the move

Once placed, the CM is responsible for:

- Obtaining a provider's signature on the Service Summary (ALTSA AFH #2019-009; 42 CFR 441.540(b)(9))

- Determining ongoing functional eligibility for long-term care services
  - Conducting Initial, Annual, and Significant Change CARE Assessments

- Working with the resident to develop a plan of care

- Managing payment for services outlined in the care plan
  - Authorizing services
  - Requesting Necessary ETRs
  - Bed Hold requests
  - Monitoring Social Leave

- Ongoing Case Management
  - 30-day post-transition visit
  - Monitoring to ensure services are being provided
  - Ensuring Resident Rights
  - Coordinating with RCS
  - If necessary, helping to coordinate a Medicaid resident's move

When a new AFH is licensed, RCS will notify:

- **The local Home & Community Service (HCS) Office**
  For HCS residents you generally have one HCS Case Manager (CM). The CM will be your main contact and provide case management to HCS residents in your home. However, if you have residents with behavioral and mental health requirements, you may have a second HCS CM that specializes in behavioral health.

- **The local Developmental Disabilities Administration (DDA) Office**
  For DDA residents, you may have one or more Case Managers.

Area Agency on Aging (AAA)/Aging Network CM

ALTSA contracts with the Area Agency on Aging (AAA) to provide in-home case management. If their client wants to move from in-home to an AFH, you may work with a AAA CM to coordinate the move. When done, the AAA CM will transfer the case to the HCS CM assigned to your home for ongoing case management.

NOTES:

A Message from Your Case Manager

Did You Know…

- The #1 reason providers call us is due to a resident's behaviors. We are not the experts on this topic, but we can:
    - Discuss strategies and resources before your resident exhibits' new behaviors
    - Determine eligibility to access client training-behavior support services
    - Connect you with resources or determine if a ECS or SBS contract may be an option.

- We cannot change your AFH rate? The rate is set by the legislature and determined by an algorithm in the CARE assessment. We can see if there are other supports that may provide you with more help.

- There is no "30 day try it out" option? Once you admit a resident, that is their home. Be sure you can meet their needs, and your supporting resources are in place.

- A "Pending" assessment is not complete? Do not accept a client until the assessment has been moved to Current, you know what all the care needs are, and you have been authorized to provide care.

- DSHS is not an emergency service – you may not receive a response to your inquiry for 1-2 business days

Our Tips & Recommendations:

- Don't be too eager to admit a new resident without meeting them. It is critical that you meet your potential resident **before admission** so you can determine if you can meet their needs and have all the resources in place. Acknowledge your skills and abilities as well as your limitations.

- If you don't understand what is on the CARE Assessment/Service Plan – **ASK!** We are here to help ensure a successful transition for both you and the resident. Be sure to read the behavior section and the personal care section – do you have the staffing to support their needs or required by your specialty contract?

- It is important that you check your business email daily and quickly respond to CM requests. Slow responses may impact your services/payment.

- Take time to learn about CARE levels and coding. "Extensive assistance" is a large category as it covers 3-99% of the time and many people confuse it with "Total assistance".

- Care giving is a hard job, especially hard when you lose a beloved resident. Get emotional support – the AFH Council may have resources available.

- Mark your calendar a few days before you resident's NCP is due to the CM. That way you won't miss the 30-day timeframe.

- Notify your CM when there are major incidents – don't wait until everything has escalated.
- Complete all the paperwork that CMs may send before the assessment date. This will cut down on the time needed to complete an assessment.
- Remember new residents need time to adjust to their new home. Consider waiting for at least 30 days before you request a Significant Change assessment if you feel there is a need for one.
- Review and keep the NCP up to date. This will be helpful when it is time for your resident's assessment.
- To get paid on time, bill on time!
- Don't just hear your residents, take the time to really listen.

Assessments

An assessment is generally an in-person interview with the person requesting long-term care services. Some circumstances may allow for telephone or video conferencing. A qualified assessor uses a standardized assessment tool to gather the person's information. Discussing the person's abilities, resources, preferences, and goals are part of the assessment process. The assessor uses person-centered strategies to develop a plan of care.

Unless it is a true emergency, AFH's must get a written assessment before admitting a resident. The assessment must contain the prospective resident's current needs and preferences (WAC 388-76-10330). The AFH must verify if a true emergency exists (WAC 388-76-10395). A true emergency exists if conditions in the person's current home puts their life, health, or safety at serious risk.

Resident Assessment

If you are using a private assessor, make sure their assessment meets requirements per WAC 388-76-10335. If an assessor is unable to get all the information, all attempts should be documented. The Comprehensive Assessment Reporting Evaluation (CARE) assessment for Medicaid applicants/residents contains all elements outlined in the WAC.

The assessment must include at least the following items:

- Recent medical history
- Current prescribed medications, and contraindicated medications, including but not limited to, medications known to cause adverse reactions or allergies
- Medical diagnosis reported by the resident, the resident representative, family member, or by a licensed medical professional
- Medication management:
    - The ability of the resident to be independent in managing medications.
    - The amount of medication assistance needed.
    - If medication administration is required; or
    - If a combination of the levels above is required.
- Food allergies or sensitivities
- Significant known behaviors or symptoms that may cause concern or require special care, including:
    - The need for and use of medical devices.
    - The refusal of care or treatment; and
    - Any mood or behavior symptoms that the resident has had within the last five years.
- Cognitive status, including an evaluation of disorientation, memory impairment, and impaired judgment
- History of depression and anxiety
- History of mental illness, if applicable
- Social, physical, and emotional strengths and needs
- Functional abilities in relationship to activities of daily living including:
    - Eating
    - Toileting
    - Walking
    - Transferring
    - Positioning
    - Personal hygiene
    - Dressing; and
    - Bathing.
- Preferences and choices about daily life that are important to the resident, including but not limited to:
    - The food that the resident enjoys
    - Mealtimes; and
    - Sleeping and nap times.
- Recreational Activities

Assessments must be renewed/revised:

- When there is a significant change in the resident's physical, mental, or emotional functioning
- When requested by the resident/resident's representative
- At least every twelve months

The CM will send the Summary and Assessment Details prior to authorizing or extending services.

Preparing for your **CARE Assessment** for people with developmental disabilities in Washington State

VIDEO: Understanding the CARE Assessment min) from Informing Families | Navigating the future

CARE – HCS/DDA Assessment Tool

The Comprehensive Assessment Reporting Evaluation (CARE) tool contains all required elements required in WAC 388-76-10335. CARE establishes Medicaid functional eligibility and helps assessors look at clients holistically. The CARE assessment tool provides the following functions:

- Assessment
- Service Planning
- Care Coordination
- Authorization

A HCS/DDD/AAA CM (CM) uses CARE to determine program functional eligibility and the amount of care (daily/monthly rate) a resident is eligible to receive.

CARE helps the CM:

- identify resources and specialties the resident is eligible for
- assist residents to achieve the highest level of functioning possible and
- assist residents to maintain a sense of individuality

Assessment types include Initial, Annual, Interim, and Significant Change. All assessments, except the interim, are completed in-person.

- **Initial** – An Initial assessment is for applicants applying for Medicaid long-term services.

- **Annual** – A CM completes an Annual assessment every twelve months. An Annual assessment:
  - identifies changes in the resident's care needs or preferences and
  - establishes continued eligibility.

- **Interim** - Interim assessments document changes that do not impact the resident's classification level. A provider can call in new/updated changes. If the change does impact their classification group, the CM schedules a Significant Change assessment.

- **Significant Change** – Significant Change Assessments are completed to assess changes in a resident's condition when there has been a change that affects the care plan. The change may be an improvement or a decline in the resident's:
    - Cognition
    - Activities of Daily Living (ADLs)
    - Mood/behaviors; or
    - Medical Condition.

Activities of Daily Living (ADL) - CARE

- Bathing
- Bed mobility
- Dressing
- Eating
- Locomotion in room and immediate living environment
- Locomotion outside room
- Walk in room, hallway, and rest of immediate living environment
- Medication management
- Toilet use
- Transfer
- Personal Hygiene

CARE Definitions

ADL Self-Performance Code Definitions (WAC 388-106-0010)
Measures what the individual did, not what they might be capable of doing over the last seven days. Bathing is scored differently.

ADL Self-Performance Levels

- **Independent** – The individual received:
    - ADL: No help or staff oversight or the individual only needed help or oversight once or twice
    - Bathing: No help or staff oversight needed to complete bathing
- **Supervision** – The individual received:
    - ADL: Oversight (monitoring, standby), encouragement, or cueing three or more times
    - Bathing: Oversight (monitoring, standby), encouragement, or cueing
- **Limited Assistance: ADL Only** – The individual:
    - Is highly involved in the activity
    - Received physical help, such as guided maneuvering of limbs or other non-weight bearing help on three or more occasions
- **Physical Help, Transfer Only** – ***Bathing only***
    - To bathe, the individual only received help with transferring
- **Extensive Assistance: ADL Only** – While the individual performed part of activity over last seven days, help of following type(s) was provided on three or more occasions:

  - Weight-bearing support, full caregiver performance of activity during part (but not all) of the activity

- **Physical Help, Hands on Assistance** – ***Bathing only***
  - To bathe, the individual needed hands-on assistance, but not for the entire bath
- **Total Dependence** – The individual did not participate in any part of bathing or the ADL and required full caregiver performance
- **Did not occur -** The ADL/bathing did not occur during the entire 7-day period because:
  - **No provider available -** Individual would have accepted assistance with task if a caregiver had been available
  - **Client not able -** Individual is not capable of task
  - **Client declined** – Individual refused assistance with task

NOTE: *Do not confuse "Did not occur" with the client not receiving assistance with the activity (independent). "Did not occur" means the ADL did not happen. For example, if "Did not occur" was coded for the ADL of Toileting, which means the client did not eliminate their bowels or bladder in the entire last 7 days. Therefore, you would never code Toileting as "Did not occur."*

Examples of ADL Levels

ADL	Supervision	Limited	Extensive	Total
Locomotion (getting around) -	Supervision: You must warn your resident of obstacles or stand by and watch to make sure they do not fall.	Limited: You physically guided or steadied your resident at least three times.	Extensive: At least three times, your resident has to lean some of their weight on you as they move. For example, they put their hand on you while they walked across rough surfaces, and you helped support them or they needed your help to support them going up or down stairs.	Total: You must push their wheelchair.
Bed Mobility -	Supervision: You remind your resident to change position in bed daily or stood by while they changed position.	Limited: You help arrange bedding or pillows between your resident's legs or behind their back or guide their legs into more comfortable positions as least three times.	Extensive: You bear your resident's weight to change their position or pull them into a sitting position while in bed at least three times.	Total: Your resident is not able to help change position at all. You must turn or move their body.

ADL	Supervision	Limited	Extensive	Total
Transfer -	Supervision: You stand by or remind your resident how to get in and out of furniture safely.	Limited: You steady your resident or take their arm to get them in or out of furniture while not bearing any of their weight at least three times.	Extensive: Your resident leans some of their weight on you or needs to be lifted at least three times.	Total: You always lift your resident in and out of furniture.
Eating -	Supervision: You remind your resident to eat or monitor them for choking or swallowing problems.	Limited: You bring food to your resident, help steady their fork or cup, or wipe their face at least three times.	Extensive: You hold your resident's cup or utensils at most but not all meals.	Total: You must feed your resident. They cannot get food from their plate to their mouth at all or you manage their feeding tube or IV nutrition.
Toileting -	Supervision: You remind your resident to use the bathroom or supervise them when they do.	Limited: You steady your resident on and off the toilet without bearing any of their weight, help them wipe, or help adjust their clothing at least three times.	Extensive: You must bear your resident's weight while they get on and off the toilet, wipe for them, or change their pads at least three times.	Total: Your resident cannot help at all with changing incontinence garments or managing catheters or ostomy.
Dressing -	Supervision: You remind your resident to choose and wear weather-appropriate clothing at least three times.	Limited: You help your resident to put on their shirt over their head, put shoes on at least three times.	Extensive: You put on your resident's bra or shoes, or do their buttons, snaps, or zippers at least three times.	Total: Your resident cannot do any part of dressing on their own.
Personal Hygiene -	Supervision: You remind or supervise your resident when they comb their hair, clip their nails, shave, or brush their teeth.	Limited: You help steady your resident's arm as they brush their teeth or brush their hair at least three times.	Extensive: You wash your resident's face and hands, comb their hair, or brush their teeth for them at least three times.	Total: Your resident cannot help with any personal hygiene task at all.

Adapted from: *Understanding Your Care Assessment from* Understanding Your CARE Tool Assessment | WashingtonLawHelp.org | Helpful information about the law in Washington.

Instrumental Activities of Daily Living (IADL) – CARE

Self-Performance Code Definitions

- **Assistance:** Client received any type of assistance, including setup and/or supervision, or activity was fully performed by others
- **Activity did not occur:** Activity did not occur in the last 30 days

ACTIVITY – CARE Definitions

Match ADL level with the definition

1. **Independent _____**
2. **Supervision _____**
3. **Limited _____**
4. **Extensive _____**
5. **Total _____**
6. **Did Not Occur _____**

A. You remind your resident to use the bathroom

B. You steadied your resident at least 3 times this week due to the uneven ground outside

C. You must feed your resident

D. Your resident was resistive to care and did not perform and get assistance with any personal hygiene tasks this week

E. Your resident is able to dress themself

F. You pulled your resident into a sitting position at least 3 times this week

17 Level CARE Classification Groups

WAC 388-106-0080 - 0145

CARE uses the following criteria to place the resident in one of the following classification groups:

- Cognitive performance - WAC 388-106-0090
  - CARE uses a tool called the cognitive performance scale (CPS). The CPS results in a score that ranges from zero (intact) to six (very severe impairment)

- Clinical complexity - WAC 388-106-0095
  - CARE places the resident in the clinically complex classification group only when they have one or more of the listed WAC criteria and corresponding ADL score – For example: A person who has Parkinson Disease and an ADL score of over 14 would be placed in one of the clinically complex groups

- Mood/behaviors symptoms - WAC 388-106-0100
  - If the resident does NOT meet the criteria for clinically complex, exceptional care, or in-home only and have a cognitive performance scale score of five or six, then the mood and behavior criteria listed in subsections (3) and (4) of the WAC determines your resident's classification group. If they are eligible for more than one "B" group classification based on the two methodologies, CARE will place them in the highest group for which they qualify.

- Activities of daily living (ADLs) - WAC 388-106-0105
  - CARE determines an ADL score ranging from zero to twenty-eight for each of the ADLs. (a) Personal hygiene, (b) Bed mobility, (c) Transfers, (d) Eating, (e) Toilet use, (f) Dressing, (g) Locomotion in room, (h) Locomotion outside room, and (i) Walk in room.
  - Bathing and medication management are not included in the scoring of the classification groups.

ADL Scoring Chart	
If Self Performance is:	**Score Equals**
Independent	0
Supervision	1
Limited assistance	2
Extensive assistance	3
Total dependence	4
Did not occur/no provider	4
Did not occur/client not able	4
Did not occur/client decline	0

- Exceptional Care - WAC 388-106-0110
  - CARE determines an ADL score ranging from zero to twenty-eight for each of the ADLs. (a) Personal hygiene, (b) Bed mobility, (c) Transfers, (d) Eating, (e) Toilet use, (f) Dressing, (g) Locomotion in room, (h) Locomotion outside room, and (i) Walk in room.
  - Bathing and medication management are not included in the scoring of the classification groups.

ADL Scoring Chart	
If Self Performance is:	**Score Equals**
Independent	0
Supervision	1
Limited assistance	2
Extensive assistance	3
Total dependence	4
Did not occur/no provider	4
Did not occur/client not able	4
Did not occur/client decline	0

CARE 17 Classification Groups - WAC 388-106-0115					
Classification Group	Classification Criteria	Activities of Daily Living Score	Rate Sample		
			AFH	AFH + CI	ECS add-on for AFH
1) A Low	Not Clinically Complex or meet Mood & Behavior criteria, placed in "A" group	And ADL (0-4)	$85.24	$87.72	$49.76
2) A Med		And ADL (5-9)	$88.56	$91.04	$46.44
3) A High		And ADL (10-28)	$96.28	$98.76	$38.72
4) B Low	Mood & Behavior and DO NOT meet Classification for C, D, or E, classified as "B"	And ADL (0-4)	$86.96	$89.44	$48.04
	Behavior Points and a CPS score >2, and ADL score >1 and DO NOT meet Classification for C, D, or E, classified as "B"	And Behavior score > 1			
5) B Med	Mood & Behavior and DO NOT meet Classification for C, D, or E, classified as "B"	And ADL (5-14)	$94.56	$97.04	$40.44
	Behavior Points and a CPS score >2, and ADL score >1 and DO NOT meet Classification for C, D, or E, classified as "B"	And Behavior score > 4			
6) B Med-High	Behavior Points and a CPS score >2, and ADL score >1 and DO NOT meet Classification for C, D, or E, classified as "B"	And Behavior score > 6	$102.62	$105.10	$32.38
7) B High	Mood & Behavior and DO NOT meet Classification for C, D, or E, classified as "B"	And ADL (15-28)	$105.60	$108.08	$29.40
	Behavior Points and a CPS score >2, and ADL score >1 and DO NOT meet Classification for C, D, or E, classified as "B"	And Behavior score of 12 or higher			
8) C Low	Clinical Complex and have a CPS score of < 4, placed in "C" group regardless of Mood & Behavior or Behavior points	And ADL (2-8)	$96.05	$98.53	$38.95
9) C Med		And ADL (9-17)	$110.68	$113.16	$24.32
10) C Med-High		And ADL (18-24)	$113.20	$115.68	$21.80
11) C High		And ADL (25-28)	$115.83	$118.31	$19.17
12) D Low	Clinically Complex and have a CPS score of 4-6 placed in "D" regardless of your mood and behavior qualification or behavior points.	And ADL (2-12)	$102.51	$104.99	$32.49
13) D Med		And ADL (13-17)	$112.97	$115.45	$22.03
14) D Med-High		And ADL (18-24)	$129.07	$131.55	$5.93
15) D High		And ADL (25-28)	$136.51	$138.99	$0.00
16) E Med		And ADL (22-25)	$165.12	$167.60	$0.00
17) E High		And ADL (26-28)	$192.59	$195.07	$0.00

*CI – Community Integration *ECS – Expanded Community Services *CPS – Cognitive Performance Scale
*> - Greater than *< - Less than *Current DDA and HCS Rates

Preliminary Care Plan

Private Pay - Your private assessor must provide a preliminary service plan (WAC 388-76-10340), also known as a service summary, that includes:

- The resident's specific problems and needs identified in the assessment
- The needs/care the resident chooses not to accept or refuses
- What the AFH needs to do to ensure the resident's health and safety related to any services/care refused
- The residents' goals and preferences
- How the AFH can meet the resident's needs

Medicaid - The HCS CM works with the potential Medicaid resident to develop a preliminary care plan within the CARE assessment and the DDA CM develops a preliminary plan of care that:

- Is person-centered by incorporating the individual's choices, preferences, strengths, and goals
- Identifies items and services within resource limitations. These can be from either by paid resources or other means. Acknowledges health and safety risk factors and personal goals
- Identifies the resident's preferences (within program limits) related to services and provides clear instructions to caregivers
- Makes providers aware of the resident's authorized services. This helps them determine if they can perform the tasks assigned
- Makes appropriate referrals to community resources. The resident's abilities and preferences impact referrals. Some referrals are mandatory based on department policy

Financial Eligibility

A Medicaid resident must be both functionally and financially eligible to receive Medicaid services.

DDA Long-term care Public Benefits Specialists (PBS) and HCS PBS determine financial eligibility for long-term care services and client responsibility. Eligibility is determined using a program called Automated Client Eligibility System or ACES.

Client Responsibility (CR) is based on the three determinations listed below:

- **Third Party Resource –** Third Party Resource may include:
  - Veterans Affairs benefits
  - L&I income
  - Trusts
  - Long-Term Care insurance
- **Room and Board (R&B)** – R&B is part of the total payment paid by the resident to the AFH provider. R&B is for expenses related to food, shelter, heat, utilities, etc.
- **Participation** – the amount the resident participates towards their cost of care.

You will learn more about Client Responsibility in ProviderOne training.

Excerpt From the Medicaid Provider Contract:

"The contractor accepts the DSHS payment amount, together with any client participation amount, as sole and complete payment for the services provided under this contract. The contractor shall be responsible for collection of the client's participation amount (if any) from the client in the month in which services are provided."

Medicaid Payment

DSHS is the payer of last resort. Any available sources must be used before you can receive payment from DSHS. Other sources may include, but are not limited to:

- Private pay
- Long-Term Care Insurance
- Private Health Insurance
- Medicare
- Client Responsibility

Your case manager looks at these funding sources before creating a Medicaid authorization.

Medicaid Rates

WAC 388-106-0120

The department publishes rates and/or adopts rules to establish how much it pays a residential facility for the cost of care. As mentioned in Module 1 – I'm Interested, the rates are negotiated as part of the AFH collective bargaining agreement.

For most programs, the AFH payment corresponds to the resident's classification group.

Rates for AFHs with a Specialized Behavior Support Contract is based on the CARE classification group and an add-on amount.

Current DDA and HCS Rates

Certain Medicaid Waiver Payments May Be Excludable from Income

On January 3, 2014, the Internal Revenue Service issued Notice 2014-7, 2014-4 I.R.B. 445. Notice 2014-7 provides guidance on the federal income tax treatment of certain payments to individual care providers for the care of eligible individuals under a state Medicaid Home and Community-Based Services waiver program described in section 1915(c) of the Social Security Act (Medicaid Waiver payments).

For tax purposes, you will receive a 1099 form in January from the Health Care Authority (HCA). Get professional tax assistance to see if this tax credit may apply to you.

See Dear Provider Letter AFH #2016-008

Do NOT call DSHS/HCA or your CM - they will not be able to help you.

Supplementation for Medicaid Services or Items

WAC 388-105-0050, 388-105-0055, WAC 388-76-10205, WAC 388-76-10540, WAC 388-76-10522

The Medicaid authorization plus the amount your resident pays in Client Responsibility is payment in full for their care (42 CFR 447.15). You may not request supplemental payment of the Medicaid daily rate, for services or items that are covered in the daily rate and that are required in the contract and resident's CARE plan.

Before an AFH provider can request a supplemental payment not covered in Medicaid rate:

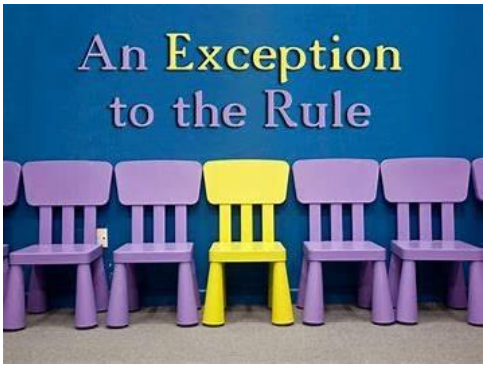
- You must have a Supplemental Payment Policy. You must give the policy to all applicants at admission and to current residents.
- Your Admission Agreement and 'Policy on accepting Medicaid as a payment source', must include what occurs if a current resident becomes eligible for Medicaid.
- Notify the HCS/DDA CM of the extra charges, what they are for, and who is paying them.

NOTE: Failure to report may result in a report to the Complaint Resolution Unit and a possible referral to the Medicaid Fraud Unit.

Examples of Supplementation

1. RCS approved a room for double occupancy and a resident's family wants to pay extra for a private room. Unless you agreed in the NCP to provide a private room for the resident, you can charge extra. You must have included this extra fee in your supplementation payment policy.
    a. If the room is a single occupancy room, you are not allowed to charge extra for the room.
    b. The extra fee associated with a double occupancy room should be a reasonable amount. If the resident or family feels it is not, they should be directed to call the RCS Complaint Resolution Unit.
    c. If the family chooses to pay this extra amount, they must pay you directly.
2. Some Medicaid resident's client responsibility may be more than their cost of care. They may use their excess income to buy more care and/or services from the AFH provider. Any purchases must follow the same guidelines for supplementation.
3. The services must be above and beyond what you already provide by contract for any resident. You cannot stop providing any current level of services to the resident. Nor can the person hired by the resident take over any services you provide under your contract or those in the resident's CARE plan.
4. If a resident prefers a brand name personal care item rather than the generic brand the home provides. The resident would be expected to pay the difference in price.
5. If a family member or friend purchases extra items or services from the AFH (not provided by contract), they must pay the AFH directly. Giving the funds to the resident may jeopardize their financial eligibility.

Exception to Rule (ETR)



An Exception to Rule to the published daily rate of a residential setting may be appropriate in situations where a resident may have exceptional needs that differ from the majority and meet additional criteria as described in WAC 388-440-0001. A new assessment may be required. ETRs are reviewed and decisions are based upon individualized needs for assistance with **personal care or skilled care**, how those differ from most residents in the same classification group, and any specific information provided by the CM and the provider. ETRs are not typically available for supervision type of support.

A resident may request an ETR, or a CM may request an ETR on the resident's behalf. After a review by the local office, the ETR committee at the ALTSA/DDA administrative office makes the final decision. ETR approvals are at the sole discretion of the department and by nature are reviewed based upon the individualized circumstances presented.

Your CM will notify you if your current or referred resident has an ETR under consideration.

NOTE: Some AFHs have threatened to discharge a resident that is not approved for an ETR because they feel the rate isn't high enough. Remember, in accepting a Medicaid contract an AFH agrees to accept the Medicaid rate. Discharging a resident based on the rate is in violation of the federal rule and is a breach of the Medicaid contract. It is also not an acceptable reason for discharging a resident under WAC 388-76-10615. In addition, resident's fearing removal from their home is extremely stressful and can impact their emotional and physical wellbeing.

Resource: Dear Provider Letter – Personal Care Exceptions to Rule 023-022

ProviderOne

The information below briefly introduces you to how payments are made in ProviderOne. There are several resources that provide in-depth detail on how to understand and claim payment for your Medicaid residents.

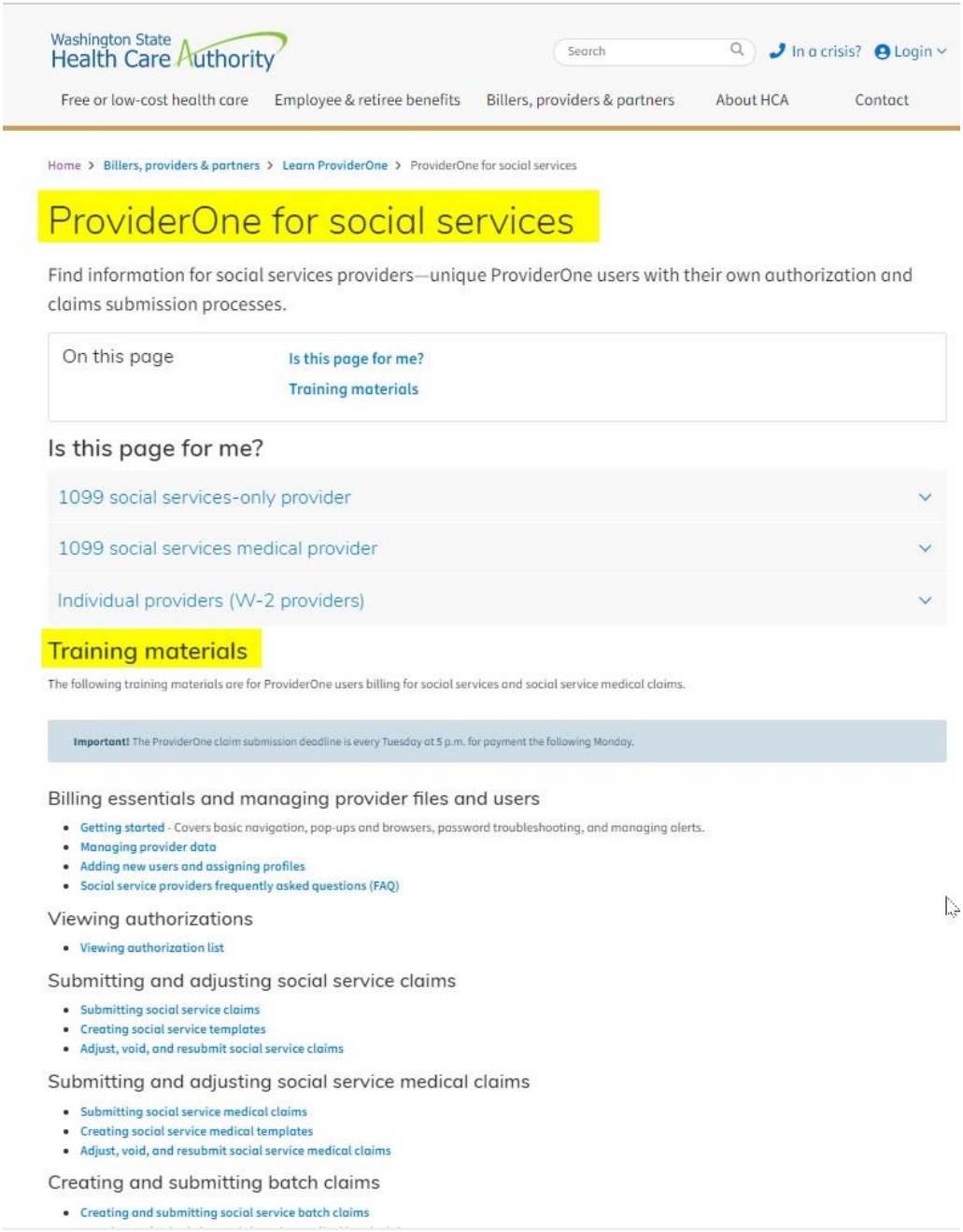
ProviderOne Application

- ProviderOne is the application administered by the Health Care Authority that processes all medical and social service Medicaid payments
- Applies client responsibility to your authorization
- Notifies you when there is a new authorization, or the authorization has changed
- In ProviderOne, you are a "**1099 social services**" provider

High Level Process Overview

- The CM authorizes services the resident is eligible for and agrees to through CARE
- CARE automatically sends the authorization information to ProviderOne
- ProviderOne receives the authorization and sends you an authorization notice
- You log into ProviderOne to
    - View authorization details; and
    - submit a claim for services you provided

- ProviderOne processes your claim and issues payment based on the authorization and claim details



Resources: ProviderOne Training

- ProviderOne for Social Services - Find Social Service billing guides and training materials
- Long Term Care Foundation – Resources

Referral Agencies

The laws relating to referral agencies are found in RCW 18.330 the Elder and Vulnerable Adult Referral Agency Act.

A referral agency can make a referral in two ways:

1. Giving a client a list of relevant AFHs, or
2. Providing the name of the client to the AFH

A referral agency keeps records of the providers they send referrals to (RCW 18.330.70). The agency must collect the following Information:

- The type of license you hold and your license number
- If you have a specialty license (mental health, dementia, or developmental disability)
- The types of payment accepted (private and/or Medicaid)
- General level of medication management services provided
- General level and types of personal care services provided
- Cultural needs that can be accommodated
- Primary language spoken by you and your staff
- Activities provided
- Behavioral problems or symptoms that can or can't be met
- Food preferences and special diets
- Other special care or services available

Fees and Refunds

- Referral agencies must clearly disclose their fees and refund policies
- If the resident dies, goes to the hospital or transfers to more appropriate care within the first 30 days, the agency must refund a prorated part of the fees based upon the days the resident resided in the AFH
- RCW 18.330.080 does not regulate, limit, or specify fees charged by an agency

Referral Agency Contracts

The agency cannot:

- Provide referral services to a client where the only names given to the client are of providers in which the agency or its personnel or immediate family members have an ownership interest in those providers.
- The agency may not create an exclusive agreement between the agency and the client, or between the agency and a provider.
- An agreement entered between an agency and a provider must allow either the provider or the agency to cancel the agreement with specific payment terms regarding pending fees or commissions outlined in the agreement.

An agreement entered between an agency and a provider must allow either the provider or the agency to cancel the agreement with specific payment terms regarding pending fees or commissions outlined in the agreement.

Medicaid or Medicare Clients

A Referral Agency cannot collect a referral fee for clients who are beneficiaries of Federal or State health care programs like Medicaid or Medicare. Should a client become a Federal or State funded consumer, then the referral fee will be prorated to cover only the private pay portion of the stay. Agencies can work on a private pay basis with family or friends of the senior.

Association of Senior Referral Professionals of Washington

Be sure you understand:

- The terms and conditions of the contract with the agency – is it per client or long term?
- The payment terms of the contract can vary greatly. For example, payment could be due:
  - Upon moving in
  - 30 days after moving in
  - On the 5th of the month for 5 months following the resident moving in
  - 10 days after moving in and 70 days after moving in
- How to terminate the contract with the agency

Residential Search Tool Locator

Room and Care is developing the **Residential Search Tool Locator** and is expected to be implemented early 2025. The goal of the Residential Search Tool Locator is to assist in matching Medicaid clients and their preferences with potential Adult Family Home (AFH) and Assisted Living Facility (ALF) providers.

- This service will be free of charge for all Medicaid contracted AFH and ALF providers.
- ALTSA contract with AIDA Healthcare ended on 12/31/2024. Home and Community Services case managers will no longer be able to share client information through AIDA Healthcare and will soon be using Room and Care.

Resources:

- WashingtonLawHelp.org – Understanding Your CARE tool assessment.
- Residential Search Tool Locator Update - Dear Provider Letter #2025-002

Summary Review

During this Module, You Learned About…

- Medicaid: it's programs and supports
- The role of the assessment/preliminary care plans
- The qualifications of a qualified assessor
- The role of the CM and how they can assist you
- How to claim Medicaid payments
- The process for requesting supplementation and ETRs

Test Your Knowledge

True/False

1. ProviderOne requires an authorization before a Medicaid payment can be made.
2. Some Medicaid services have an add on to the Medicaid rate.
3. Anyone can complete an assessment that has an in-depth knowledge of the resident.
4. A client can receive any services they want.

Get Ready for Your Next Class

- Read assigned modules
- Download and review the HCS and DDA assessment and assessment details
- Download and review the Negotiated Care Plan template
- Study for Quiz #3 (Modules 6d, 7, 8,and 9)

Acronyms Used in this Module

Acronym	Description
AAA	Area Agency on Aging
ACES	Automated Client Eligibility System
ADH	Adult Day Health
ADL	Activities of Daily Living
AFH	Adult Family Home
ALTSA	Aging and Long-Term Support Administration
Apple LTSS	Apple Health Long Term Services and Support/Medicaid
APS	Adult Protective Services
BHST	Behavior Health Support Team
CNA	Certified Nursing Assistant
CARE	Comprehensive Assessment Reporting Evaluation
CBA	Collective Bargaining Agreement
CCG	Community Choice Guide
CFC	Community First Choice
CI	Community Integration
CM	Case Manager (HCS, AAA, DDA)
CMS	Centers for Medicaid and Medicare Services
CNC	Community Nurse Consultants – HCS

Acronym	Description
COPES	Community Options Program Entry System
CPS	Cognitive Performance Scale
CR	Client Responsibility – Participation, Room and Board, Third Party Resources
CTS	Community Transition Services
DDA	Developmental Disabilities Administration
DSHS	Department of Social and Health Services
ECS	Expanded Community Services
ETR	Exception to Rule
HCA	Health Care Authority
HCA-C	Home Care Aide – Certified
HCS	Home and Community Services
IADL	Instrumental Activities of Daily Living
MACSC	Medical Assistance Customer Service Center
MAP	Meaningful Activity Plan
MCS	State – funded Medical Care Services
MDA	Meaningful Day Activities
MPC	Medicaid Personal Care
MSA	Metropolitan Service Area
NA-C	Nursing Assistant – Certified
NA-R	Nursing Assistant– Registered
NCC	Nursing Care Consultants – DDA
NCP	Negotiated Care Plan
ND	Nurse Delegation
NSP	Negotiated Service Plan
P1	ProviderOne – Medicaid Payment System
PBS	Public Benefits Specialists
PCSP Team	Person-Centered Service Planning Team
PDN	Private Duty Nursing
R&B	Room and Board
RCL	Roads to Community Living
RCS	Residential Care Services
RND	Registered Nurse Delegator
RSW	Residential Support Waiver
SBS	Specialized Behavior Support
TPR	Third Party Resources
WE	Wellness Education

Revision Table

Date	Volume	Changes	Page(s)
1/2025	V5.2	• Added/removed, and repaired links throughout • Removed information on AIDA and replaced with **Residential Search Tool Locator** information and Dear Provider Letter reference (pgs. 36-37	

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